County of San Diego
Health and Human Services Agency
Mental Health Services

Organizational Provider Operations Handbook

Child/Adolescent Mental Health Services

[Appendix to Mental Health Plan]

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Appendix R A.R.1

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ABBREVIATIONS REFERENCE GUIDE

ACL – Access and Crisis Line
AMHS – Adult Mental Health Services
A/OAMHS – Adult/Older Adult Mental Health Services
ASP – Augmented Services Program
ASW – Associate Social Worker (registered with the BBS)
BBS – Board of Behavioral Sciences
B&C – Board and Care
CA-QOL – California Quality of Life (client survey)
CMUMC – Case Management Utilization Management Committee
CCHEA – Consumer Center for Health Education and Advocacy
CCISC – Comprehensive, Continuous Integrated System of Care
CCR – California Code of Regulations
CCRT – Cultural Competence Resource Team
CFR – Code of Federal Regulations
CMHS – Children's Mental Health Services
CMS – County Medical Services
COTR – Contracting Officer's Technical Representative
DCS – Deaf Community Services
DHS – Department of Health Services (State of California)
DMH – Department of Mental Health (State of California)
DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ECR – Error Correction Reports
EPU – Emergency Psychiatric Unit
FFP – Federal Financial Participation
FFS – Fee-For-Service
FTE – Full-Time Equivalent
HHSA – Health and Human Services Agency
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IMF – Intern Marriage and Family Therapist (registered with the BBS)
IMD – Institute of Mental Disease
LCSW – Licensed Clinical Social Worker
LPS – Lanterman-Petris-Short (Conservatorship)
McFloop – Multi-Use Complete Feedback Loop
MFT – Marriage and Family Therapist
MHP – Mental Health Plan
MHS – Mental Health Services
MHSIP – Mental Health Statistics Improvement Program
MIS – Management Information Systems
MSR – Monthly Status Report

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NOA-A – Notice of Action – Assessment
NOA –B – Notice of Action
OIG – Office of Inspector General
OP - Outpatient
P&T – Pharmacy and Therapeutics Committee
PCR – Program Contract Representative (Program Monitor)
PSR – Psychosocial Rehabilitation
QI – Quality Improvement
QM – Quality Management
QRC – Quality Review Council
SMA – Statewide Maximum Allowances
SDCMHA – San Diego County Mental Health Administration
SDCPH – San Diego County Psychiatric Hospital
SF/LTC – Secure Facility/Long-Term Care
SNF/STP – Skilled Nursing Facility/Special Treatment Program
SOC – Systems of Care
TAR – Treatment Authorization Request
TBS – Therapeutic Behavioral Services
TBI – Traumatic Brain Injuries
UBH – United Behavioral Health
UMDAP – Uniform Method for Determining Ability to Pay
UR – Utilization Review
URC – Utilization Review Committee
USD – University of San Diego (Patient Advocacy Program)
W&IC – Welfare & Institutions Code (State of California)

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ABBREVIATIONS REFERENCE GUIDE

ACL – Access and Crisis Line
AMHS – Adult Mental Health Services
A/OAMHS – Adult/Older Adult Mental Health Services
ASP – Augmented Services Program
ASW – Associate Social Worker (registered with the BBS)
BBS – Board of Behavioral Sciences
B&C – Board and Care
CA-QOL – California Quality of Life (client survey)
CMUMC – Case Management Utilization Management Committee
CCHEA – Consumer Center for Health Education and Advocacy
CCISC – Comprehensive, Continuous Integrated System of Care
CCR – California Code of Regulations
CCRT – Cultural Competence Resource Team
CFR – Code of Federal Regulations
CMHS – Children's Mental Health Services
CMS – County Medical Services
COTR – Contracting Officer's Technical Representative
DCS – Deaf Community Services
DHS – Department of Health Services (State of California)
DMH – Department of Mental Health (State of California)
DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ECR – Error Correction Reports
EPU – Emergency Psychiatric Unit
FFP – Federal Financial Participation
FFS – Fee-For-Service
FTE – Full-Time Equivalent
HHSA – Health and Human Services Agency
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IMF – Intern Marriage and Family Therapist (registered with the BBS)
IMD – Institute of Mental Disease
LCSW – Licensed Clinical Social Worker
LPS – Lanterman-Petris-Short (Conservatorship)
McFloop – Multi-Use Complete Feedback Loop
MFT – Marriage and Family Therapist
MHP – Mental Health Plan
MHS – Mental Health Services
MHSIP – Mental Health Statistics Improvement Program
MIS – Management Information Systems
MSR – Monthly Status Report

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NOA-A – Notice of Action – Assessment
NOA –B – Notice of Action
OIG – Office of Inspector General
OP - Outpatient
P&T – Pharmacy and Therapeutics Committee
PCR – Program Contract Representative (Program Monitor)
PSR – Psychosocial Rehabilitation
QI – Quality Improvement
QM – Quality Management
QRC – Quality Review Council
SMA – Statewide Maximum Allowances
SDCMHA – San Diego County Mental Health Administration
SDCPH – San Diego County Psychiatric Hospital
SF/LTC – Secure Facility/Long-Term Care
SNF/STP – Skilled Nursing Facility/Special Treatment Program
SOC – Systems of Care
TAR – Treatment Authorization Request
TBS – Therapeutic Behavioral Services
TBI – Traumatic Brain Injuries
UBH – United Behavioral Health
UMDAP – Uniform Method for Determining Ability to Pay
UR – Utilization Review
URC – Utilization Review Committee
USD – University of San Diego (Patient Advocacy Program)
W&IC – Welfare & Institutions Code (State of California)

A. SYSTEMS OF CARE (SOC)

Mission of Health and Human Services Agency (HHSA) Mental Health Services (MHS)

The mission of the Health and Human Services Agency is: "Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility." Mental Health Services adds to that mission: "To provide quality, cost effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population."

Client Population served by the Mental Health Plan (MHP)

Clients who are seriously emotionally disturbed (SED), as defined below, and who are:

- Youth up to age 18 (EPSDT services up to age 21),
- Clients with co-occurring mental health and substance use,
- Medi-Cal eligible and meet medical necessity,
- Indigent, and/or
- Low income/underinsured.

Seriously Emotionally Disturbed (SED) Clients:
The priority population for Children's Mental Health Services, including clients seen under MHSA, are seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

, Seriously emotionally disturbed children or adolescents means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

System of Care Principles

Children's Mental Health Services (CMHS) programs, regardless of funding source, serve a broad and diverse population of children, adolescents, transitional youth and families throughout San Diego County. An array of services are provided through Organizational Providers, Fee For Service Providers, and Juvenile Forensic Providers. CMHS San Diego is a "System of Care" County. The System of Care is based on Child and Adolescent Service System Program (CASSP) System of Care principles and the Wraparound Initiative of the State of California (All County Information Notice 1/28/99, April 17, 1999; and SB163, Wraparound Pilot Project). System of Care Principles (May 2005) shall be demonstrated by ongoing client/parent participation and influence in the development of the program's policy, program design, and practice evidenced by:

- Individualized services that are responsive to the diverse populations served
- Cultural competence and sensitivity
- Client-focused, family-centered services
- Outcome driven services
- Collaboration of families/youth, public agencies, private organizations and education
- Community-based approach that provides maximum linkage and integration to the local community resources
- Multi-disciplinary and strength-based approach

Providers, Medi-cal and Non Medi-Cal shall plan and deliver services in a manner consistent with the Children's Mental Health System of Care philosophy and principles. Services shall be community-based and emphasize the strengths of the client and family.

Providers shall demonstrate family partnership in the development and provision of service delivery. . Providers shall also demonstrate organizational advancement of family partnership in the areas of program design, development, policies and procedures, etc.

All facilities shall comply with the requirements of the Americans With Disabilities Act (ADA) and California Title 24.

Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CMHS providers. *Specialized programs may have individual program*

outcomes either in addition to or in lieu of standard outcomes measured by all programs. These system goals are tracked and reported as system wide outcomes in an annual report.

Goals

Programs shall provide developmentally appropriate clinical services described herein to accomplish the following goals:

- Maintain client safely in their school and home environment
- Reduce recidivism related to criminal habits and activities
- Increase school attendance and performance resulting in a higher rate of successful completion of their educational program (with high school diploma or equivalent)
- Improve client's mental health functioning at home, school, and in the community
- Increase the individuality and flexibility of services to help achieve the client and family's goals
- Increase the level and effectiveness of interagency coordination of services
- Increase the empowerment of families to assume a high level of decision-making in all aspects of planning, delivering, and evaluation of services and supports

Outcome Objectives

All treatment providers shall achieve the outcome objectives as found in the Data Requirements section of this handbook.

Outpatient providers shall achieve the following *additional* outcome objectives:

- 90% of clients will avoid hospitalization or re-hospitalization during the outpatient episode as measured by client and family report.
- Outpatient programs shall maintain an average waiting time of less than 5 days for the client's initial appointment.
- Outpatient programs shall meet or exceed the minimum productivity standard for annual billable time by providing at least 59,400 minutes per year (55% productivity level) for clinic based programs per Full-Time Equivalent (FTE) and at least 54,000 minutes per year (50% productivity level) for school and community based programs per FTE, unless otherwise specified in the program's Statement of Work.
- Clinical staff shall carry a minimum client load of 30 unduplicated clients per FTE per year for clinic based outpatient programs and 40 unduplicated clients per FTE per year for school

and community based outpatient programs, unless otherwise specified in the program's Statement of Work.

Day Treatment providers shall achieve the following outcome objectives, *in addition* to those found in the Data Requirements section of this handbook:

- Contractor shall achieve the family participation rate as defined in their specific contract.

AB2726 Day Treatment providers shall achieve the following outcome objectives, *in addition* to those found in the Data Requirements section of this handbook:

- Contractor shall ensure that billable client days shall be produced for 90% of the annual available patient days, based on a 230-day year.
- AB2726 interview timelines shall be adhered to in 100% of referrals. Initial intake visit and admission into the program shall be provided within 7 to 14 days of receipt of the referral in 90% of the cases as required by Local AB2726 Interagency agreement. In extenuating circumstances, any exceptions to this standard shall be accompanied by written documentation to the Program Monitor/COTR or their designee.
- Treatment goals shall incorporate AB2726 mental health goals stated in the most current IEP, in 100% of charts.
- Target population shall be students who meet the AB2726 special education criteria for which San Diego Mental Health Services has completed an AB2726 mental health assessment and identified, on an IEP, mental health day treatment as the recommended level of mental health service.
- For 80% of discharged students whose episode lasted six months or longer, the Child and Adolescent Measurement System (CAMS) total score at discharge shall show clinical improvement compared to the client's intake score.
- 80% of clients will be discharged to a lower level of care unless otherwise specified in the contract.
- 90% of clients will avoid hospitalization or re-hospitalization during the Day Treatment episode as measured by client and family report.

Process Objectives

All providers shall achieve the following process objectives:

- 100% of all clients shall be assessed for substance use during the assessment period as evidenced by documentation in the medical record and completion of the CRAFFT measure.

- 100% of all clients, ages 16 and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed for domestic violence issues as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.

Client satisfaction

- Provider shall ensure completion of the following surveys, in accordance with the CMHS Organizational Provider Handbook.
- Submission rate on Youth Services Survey (YSS) and Youth Services Survey-Family (YSS-F) shall meet or exceed the 80% standard established by the County of San Diego Children's Mental Health.
- Aggregated scores on the Youth Service Survey (YSS) and the Youth Services Survey Family (YSS-F) shall show an average of 80% or more of respondents responding in the two most favorable categories (e.g., 25% Agree plus 55% Strongly Agree) for at least 75% of the individual survey items.

All outpatient providers shall achieve the following *additional* process objective:

- Outpatient programs shall achieve a family participation rate of at least 55%.

All AB2726 Day Treatment providers shall achieve the following *additional* process objectives:

- Contractor shall ensure and document that eighty percent (80%) of the students' families or surrogate-families participate in weekly family therapy and/or regular alternate activities made available on a regular basis to encourage and maximize family participation in the treatment program and education of the student.
- Contractor shall ensure that eighty percent (80%) of families be involved in treatment team reviews/meetings each month either by attendance, conference calls, or written input.

Additional Data Information:

Additional data may be required in a specific contract or program. This may involve additional tools for specific parts of the system, such as wraparound and residential programs. Contractors may also require manual collection of certain outcomes from charts, such as number of

hospitalizations, arrests, or changes in level of placement/living situation. The data collected is submitted by contractors on the Monthly Status Report or as directed by the County.

Services for Dual Diagnosis (Mental Illness and Co-occurring Substance Use Disorders)

San Diego County Adult/Older Adult Mental Health, Children's Mental Health Services and Alcohol and Drug Services, (Behavioral Health Services) recognizes that clients with a dual diagnosis, a combination of mental illness and substance use disorders, may appear in all parts of the system. These–conditions are associated with poorer outcomes and higher cost of care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

CMH has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model that espouses a treatment and recovery philosophy that promotes the integrated treatment of clients with mental illness and substance use issues. Individuals who meet mental health treatment eligibility criteria and who also have a secondary diagnosis of substance use shall receive treatment focused on the mental health diagnosis and the impact of the substance use issue. Upon intake to a mental health program, the presence of substance use by clients shall be assessed. During treatment, substance use is reassessed on an ongoing basis and discussed with the client in terms of its impact on and relationship to the primary mental health disorder. Client Plans shall clearly reflect any services that may be needed to address the co-occurring substance use problems. Progress notes shall meet all Medi-Cal and Title 9 documentation requirements and must list a mental health diagnosis or problem as the focus of the intervention. Exceptions exist for clients who are dually diagnosed in EPSDT programs.

To support the implementation of the Dual Diagnosis Initiative, Mental Health Services recommends the development of Dual Diagnosis Capable programs. Programs participating in the CCISC Initiative shall demonstrate the following to be considered dually capable:

- San Diego Charter adoption and implementation
- Co-morbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS) completion
- Action Plan development
- Program Policies:
    - Welcoming Policy/Statement
    - MHS Co-occurring Disorders Policy
    - Other
- Training and supervision of staff in Integrated Treatment Practice Model
    - Integrated Screening
    - Integrated Clinical Assessment
    - Integrated Psychiatric Assessment

  - Implementing Stage of Change Interventions
  - Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)
- QI Baseline Monitoring Tool compliance

Dually enhanced services differ from dually capable services by the intensity of services provided and severity of mental illness and substance abuse of the client. Dually enhanced services are provided to "Quadrant Four" individuals, who are the clients with the most serious and persistent mental illness and substance dependence.

Dually enhanced programs must meet the following criteria:
Dual Capable criteria plus:

Advanced staff and supervision competencies:

- Some direct service staff have certification in motivational therapy
- Some direct service staff are certified as an Alcohol and Drug Counselor

Specialized Programming such as

- Intensive case management services
- Dual Inpatient Unit
- Dual Residential Program
- Array of supported housing for dual diagnosed clients that include:
  - Dry/Damp/Wet Housing
  - Supported Sober Living

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Adult/Older Adult Mental Health, Children's Mental Health Services, Alcohol and Drug Services Charter and Consensus Document for Co-occurring Psychiatric and Substance Abuse Disorders, March 2003; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No. 01-06-117, February, 2004, and the HHSA, Dual Diagnosis Strategic Plan, 2002.

Services to Youth in Transition

In recent years, the existence of a significant mental health service gap for youths 18-24 transitioning from the Children's Mental Health (CMH) System of Care to the Adult Mental Health (AMH) System of Care has been identified. To address this issue, the County of San Diego, HHSA MHS has implemented the Youth Transition Services Plan. This plan identifies transitional youths' needs and existent resources, addresses services gaps, and makes recommendations to the AMH and CMH Systems of Care. This transition plan is the blueprint for the improvement of youth transition services within the mental health system.

The mission of the Youth Transition Services Plan is for CMH and AMH Systems of Care to work in partnership with youths to develop and implement services that are developmentally and culturally appropriate. To accomplish this mission, both systems are working together to address the unique needs of youths and to integrate a seamless referral process. Procedures have been developed to support the implementation of this process. The Youth Transition Self-Evaluation begins the process for identifying the mental health needs of transitional age youths and ensuring that comprehensive services are available to youths transitioning from the CMH system to the AMH system.

Adult and children's mental health providers shall coordinate with each other and seek appropriate consultation to ensure that the unique needs of this population are met. An ongoing workgroup shall work to address issues regarding services and coordinate the varied agencies that provide services for this population. This group developed the Transitional Youth Resource Directory to ensure that those working with this population have accurate information on available services for these youths.

For additional information on the Youth Transition Services Plan, please refer to the County of San Diego, HHSA MHS, Mental Health Youth Transition Services Plan, July 2000. You may also obtain further information by referring to the policies required for county-owned and -operated programs: County of San Diego, HHSA MHS Transitional Age Youth Referral Policy (No. 01-01-114) and County of San Diego, HHSA, MHS Youth Transition Self-Evaluation Policy (No: 06-01-113).

B. COMPLIANCE AND CONFIDENTIALITY

The County of San Diego Health and Human Services Agency (HHSA) is committed to maintaining a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to laws, rules, regulations, or County policies or procedures.

County Compliance Programs

As part of this commitment, all County Mental Health Services employees are expected to be familiar with and adhere to the HHSA Compliance Program that includes all of the required elements of a compliance program as stated below. In addition, County Programs must have processes in place to ensure that they are adhering to all requirements in the HHSA Code of Conduct and Statement of Incompatible Activities, including but not limited to the Compliance Standards listed below.

For more information:

HHSA Code of Conduct and Statement of Incompatible Activities:
http://hhsa_intranet.co.san-diego.ca.us/policy/mpp/m/m1_2.pdf

HHSA Compliance Program:
http://hhsa_intranet.co.san-diego.ca.us/policy/index.html

Provider Compliance Program

Each provider entity is required to have an internal compliance program to ensure that all applicable state and federal laws are followed. At all times during the terms of their contracts, providers shall maintain and operate a compliance program that meets the minimum requirements for program integrity as set forth in 42 CFR 438.608. Failure to establish and maintain a compliance program as required by this section shall be considered a material breach of contract.

Elements of a compliance program

1. Code of Conduct and Compliance Standards, as described below.
2. Compliance Officer, who is a senior manager charged with responsibility for overseeing and monitoring implementation of the compliance program.
3. Communications, which create avenues for employees to raise complaints and concerns about compliance issues, including billing fraud, without fear of retribution.
4. Training and Education for employees regarding compliance requirements.

5. Auditing and Monitoring Systems, designed to reasonably detect and prevent potential violations of laws and regulations relating to health care and human services funding and programs.
6. Enforcement and Disciplinary Actions, within labor guidelines, to enforce the program including discipline of individuals for engaging in wrongful conduct or for failing to detect or report noncompliance.
7. Response and Prevention, which consists of mechanisms to respond to and investigate all reasonable concerns regarding compliance and suspected noncompliance and of taking necessary corrective action to prevent recurrence.

Code of Conduct

A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level.

Compliance Standards

All programs, both County and contracted, shall have processes in place to ensure at the least the following standards:

- Staff shall have proper credentials, appropriate experience and expertise when providing client treatment and services in the area in which they function.
- Staff shall accurately and completely document all client encounters in appropriate records in accordance with funding source requirements and County guidelines.
- Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.
- Staff shall take reasonable precautions to ensure that billing and/or coding of client services are prepared and submitted accurately, timely, and in compliance with all applicable federal, State, local laws, rules and regulations and HHSA's policies and procedures.
- Staff shall provide that no false, inaccurate or fictitious claims for payment or other reimbursement are submitted, by billing only for eligible services actually rendered and fully documented. When coding for services, only billing codes that accurately describe the services provided will be used.
- Staff shall act promptly to report and correct problems if errors in claims or billings are discovered.

MHP's Compliance Hotline

The MHP has created a Hotline for its own staff as well as Contractors to report concerns about a variety of ethical, legal, and billing issues. The confidential Hotline is toll-free and available 24 hours per day, 7 days per week. Callers may remain anonymous if they wish. The number of the Compliance Hotline is 866-549-0004.

Documentation Requirements

All organizational providers are recipients of Federal funds and as such are required to prepare and maintain appropriate medical records on all clients receiving services in compliance with Title 9, Chapter 11 and 42 CFR guidelines. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. This includes all providers of outpatient, day treatment, and case management services The MHP has the responsibility to prepare and maintain the Documentation and Uniform Clinical Record Manual (DUCRM), which outlines the MHP's requirements and standards in this area. Also contained within the DUCRM is the Documentation Requirements Grid. This grid lists detailed and specific documentation requirements for the most commonly used CPT and HCPCS codes of the MHP. The Quality Improvement Unit distributes copies of the MHP's most recent version of the DUCRM annually throughout the organizational provider system. A copy may also be obtained at anytime by contacting the County QI Unit (619) 584-5026 or County Medical Records (619) 692-5700, extension 3.

Many of the requirements present in the MHP's DUCRM are derived from the contract to provide specialty mental health services between the California Department of Mental Health and San Diego County Health and Human Services, Exhibit A, Attachment 1, Appendix C "Documentation Standards for Client Records". Other documentation requirements have been established by the MHP's Uniform Medical Record Committee, which is an ad hoc committee chaired by the Quality Improvement Unit.

In order to ensure that organizational providers are knowledgeable of documentation requirements, the Quality Improvement Unit provides the following on an ongoing basis:

- Annual in-service training for all provider program managers that reviews the most current edition of the DUCRM, highlighting modifications or additions to the manual;
- Quarterly in-service documentation trainings for all new clinical staff, or any clinical staff that may need a documentation review;
- In-service trainings that are provided on-site at program's request, tailored to program's specific documentation training needs; and
- In-service trainings provided on-site at a program when QI has identified a specific documentation training need.

Compliance in documentation requirements by all organizational and county providers is monitored on an annual basis via medical record reviews. A Quality Improvement Specialist performs the medical record reviews. The Quality Improvement Unit has the responsibility to track and monitor results of these medical record reviews, and may require a provider to develop a Plan of Correction to address specific documentation requirements that are found to be out of compliance.

CONFIDENTIALITY

The maintenance of client confidentiality is of primary importance, not only to meet legal mandates, but also because of the fundamental trust inherent in the services provided through the MHP.

MHP Responsibilities

In order to ensure compliance with confidentiality policies and protocols, the MHP enforces the following procedures:

- Every member of the workforce* is informed about confidentiality policies, as well as applicable state and federal laws regarding client anonymity and the confidentiality of clinical information.
- As a condition of employment, each member of the workforce signs a confidentiality agreement, promising to comply with all confidentiality protocols.
- Any client treatment records gathered during the course of provision of services, provider site and record reviews, or as necessary, are protected through strictly limited access. Internal clinical staff has access to case data and files only as necessary to perform their jobs.

**Workforce is defined as employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the provider, is under direct control of the provider, whether or not the individual is paid by the provider.*

Provider Responsibilities

Each provider will act in accordance with good judgment, clinical and ethical standards and State and Federal law to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept strictly confidential.

Every provider must have policies, procedures and systems in place to protect the confidentiality (or security) of health information and individual rights to privacy. Requirements include

safeguards to prevent intentional or accidental misuse of protected health information and sanctions for employee violations of those requirements.

Each provider must train all members of its workforce on the policies and procedures with respect to protected health information. The provider must document that the training on confidentiality has been provided. At a minimum, documentation of training shall consist of a signed acknowledgement by the member of the workforce specifying which training has been received and the date the training was taken. The provider must retain the documentation of the training for six years. These training records will assist the provider in identifying where supplementary training needs to be conducted, if there are changes in the privacy or security regulations.

Every provider must have in place a Confidentiality Agreement for all workforce members. The Confidentiality Agreement should sufficiently identify the type of information to be protected, the worker's /vendor's responsibility to protect it, and methods that must be used to protect it in order to assure confidentiality and to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. The Agreement must include a signed statement from the workforce member/vendor saying that he or she has received the information related to the maintenance, disclosure, or destruction of confidential information. This statement must be signed within a reasonable period of time after the person joins the provider's workforce. Additionally providers must be able to also access documentation showing that all vendors and business partner personnel with access to protected information have also signed such agreements with their employers.

Contractor and its agents and employees are subject to and shall comply with the Child Abuse Reporting Law (California Penal Code section 11164) and Adult Abuse Reporting Law (California Welfare and Institutions Code section 15630).

Since April, 2003 providers must provide a written notice of information practices –"Notice of Privacy Practice"—to all clients. This notice must include:

- Mandated reporting requirements when a client presents as an imminent danger to self or others;
- Mandated reporting requirements concerning the abuse or neglect of children or older adults;
- The review of records by third party payers for authorization or payment purposes.

Providers should disclose to clients the fact that records may be reviewed in the course of supervision, case conferences, and quality management.

Additionally, providers are to distribute the County Mental Health Plan (MHP) Notice of Privacy Practice to all new clients. A notation is made on the Assessment form (MHS-650 and/or MHS-663 and/or MHS 680) when the MHP-Health Plan NPP has been offered.

Providers are encouraged to have young clients (age 12 and over), and a child's legal guardian, read and sign a consent for treatment. There are special considerations with children and adolescents who are Dependents of the Juvenile Court. With these youth, Children's Welfare Services obtains consent for medical and mental health care treatment (not including psychotropic medications or hospitalizations) by having parents or the Court sign the appropriate version of HHSA 04-24, or an ex parte. For consents for treatment and releases of information and whenever in doubt, please contact the client's child welfare worker for assistance with obtaining the needed information. If the youth is a Dependent of the Court, without parental or legal guardianship rights involvement, then the youth will need an ex parte from the court for consent to treat. Providers may share information freely with an attorney (or his or her investigator) representing a Dependent child, if needed to assist in the legal representation. In regards to clients receiving AB2726 services, the Education Code (Section 56504) states that a parent may request to examine and receive copies of all school records within 5 days of a written or oral request. Since AB2726 is defined as school related mental health services, this request also pertains to a parent's request for copies of the medical record.

For further information regarding legal and ethical reporting mandates, please contact your agency's attorney, the State licensing board or your professional association.

Specific Procedures for Providers

Each provider and its agents, employees and representatives shall comply with all applicable provisions of the California Welfare and Institutions Code. Provider shall follow all pertinent County, State and Federal regulations for safeguarding client medical records and confidentiality. Before services commence, provider shall have in place County-approved policies and procedures for:

- Release of Information
- Storage and maintenance of open and closed cases;
- Limiting access to medical records and any other client information among levels of staff;
- Assuring that the Children's Mental Health Documentation and Uniform Clinical Records Manual standards for the type of service provided are adhered to;
- Assuring that information in the medical record is organized, clear, legible, complete and current.

Claiming and Reimbursement of Mental Health Services

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many clients have one or

more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility each program to appropriately bill and collect reimbursement from primary and secondary insurance sources. For all clients receiving mental health services, programs are required to be aware of all available payor sources, be able to verify eligibility and covered benefits, obtain an Assignment of Benefits (AOB), track and process Explanation of Benefits (EOBs) and primary insurance denials, in order to seek reimbursement from secondary payor sources. All billing and submission of claims for reimbursement must be in accordance with all applicable County, State and Federal regulations.

For detailed guidelines and procedures regarding insurance billing, claims processing, assignment of benefits, determining eligibility, and accounts collection and adjustment, please refer to the **Financial Eligibility and Billing Procedures** . You may obtain a copy of this manual by visiting the Technical Resource Library at www2.sdcounty.ca.gov/hhsa. Click on All Services A-Z, then Mental Health Services Act, and select Technical Resource Library from the drop down menu.

Coding and Billing Requirements

The Federal Health Insurance Portability and Accountability Act (HIPAA) includes requirements regarding transactions and code sets to be used in recording services and claiming revenue. The rule, contained in CFR Chapter 42, took effect in October 2003 and includes a requirement for both standard Procedure Codes and Diagnosis Codes. Uniform Medical Record forms (see Section F, Quality Improvement) of this Manual reflect the required codes, and County QI staff regularly provides training on the use of the forms. Additional requirements for medical records come from the County's contract with the California Department of Mental Health; these requirements determine the nature of chart reviews during a Medi-Cal audit and the items for which financial recoupment of payment for services will be made by State or County reviewers. Following are current requirements and resources related to coding and billing:

- Services must be coded in compliance with Current Procedural Terminology (CPT) standards, or with Healthcare Common Procedural Coding System (HCPCS) if there is no CPT code.
- Diagnoses must be coded using the International Classification of Diseases (ICD-9 CM, or ICD-10 when adopted). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, 4th Edition, Text Revision (DSM-IV TR) and "crosswalked" to the ICD by the Management Information System software (currently InSyst) or the clinician. The crosswalk should result in the highest level of specificity in recording the diagnosis.
- Services are recorded on the Billing Record, which includes the CPT code, the ICD-9 codes, and the staff number. The Billing Record is used to enter services to the MIS and

will reflect the range of services actually in the provider's budget. Each service also carries a 3 digit InSyst procedure code which is related to the CPT or HCPCS code.

- The Code Map for Outpatient services is appended to this manual. InSyst and CPT codes for Day Mode and Inpatient services are unchanged by the HIPAA requirement. The Code Maps include CPT codes, HCPCS codes, service descriptions, the 3 digit InSyst codes for AB 2726 and non-AB 2726 versions of each service, InSyst Code Names (long and short), Service Function Codes, Location Codes, Default Medi-Cal Modifiers, InSyst Mask for Service Entry, and the InSyst Staff Mask. Services with a restricted Staff Mask (e.g., physicians only) may not be entered for staff whose profile and scope of practice do not match the mask.
- The **Crosswalk** between DSM-IV TR and ICD-9 is appended to this manual (*Appendix B. B.2*.)
- A grid describing documentation standards for each procedure code (the "**Rainbow Grid")** is appended to this manual (*Appendix B. B.3*). Documentation of services must comply with HIPAA, State, and County requirements.

FALSE CLAIMS ACT

All HHSA employees, contractors and subcontractors are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:

- Billing for services not rendered or goods not provided.
- Falsifying certificates of medical necessity and billing for services not medically necessary.
- Billing separately for services that should be a single service.
- Falsifying treatment plans or medical records to maximize payments.
- Failing to report overpayments or credit balances.
- Duplicate billing.
- Unlawfully giving health care providers, such as physicians, inducements in exchange for referral services.

Any indication that any one of these activities is occurring should be reported immediately to the compliance officer:

Robert Borntrager
HHSA Compliance Officer
619.515.4246
Compliance.HHSA@sdcounty.ca.gov

HHSA employees, contractors and subcontractors may also use the HHSA **Compliance hotline** at **(866) 549-0004** to request information or report suspected in appropriate activities. This line provides direction to the caller on the option to remain anonymous.

The Federal False Claims Act

The Federal False Claims Act ("FCA") helps the federal government combat fraud and recover losses resulting from fraud in federal programs, purchases, or contracts. 31 U.S.C. §§ 3729-3733.

Actions that violate the FCA include:

- Knowingly submitting (or causing to be submitted) a false claim to the U.S. Government for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved by the Government;
- Conspiring to get a false claim allowed or paid by the Government;
- Delivering (or causing to be delivered) less property than the amount of the receipt, where the person with possession or control of the Government money or property intends to deceive the agency or conceal the property;
- Making or delivering a receipt without completely knowing that the receipt is true, where the person authorized to make or deliver the receipt intends to defraud the Government;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from an officer or employee of the Government or a member of the Armed Forces who has no legal right to sell or pledge the property; or
- Knowingly making or using a false record to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.
-

<u>"Knowing" and "Knowingly" means a person:</u>

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
-

<u>"Claim"</u> includes any request or demand for money or property (including those made under contract) to the Government or to a contractor, grantee, or other recipient, if any portion of the requested money or property is funded by or will be reimbursed by the Government.

A person or organization may be liable for:

- A civil penalty $5,500 to $11,000 for each false claim;
- Three times the amount of damages sustained by the Government due to the violations; and
- The costs of a civil suit for recovery penalties or damages.

If a *qui tam* plaintiff alleges a false claims violation, the complaint and a written disclosure of the evidence and information that the person possesses must be served on the Government. Once the action is filed, no person other than the Government is allowed to intervene or file a lawsuit based on the same facts.

Whistleblower Protection

An employee who has been discharged, demoted, suspended, threatened, harassed, or in any way discriminated against by his or her employer because of involvement in a false claims disclosure is entitled to all relief necessary to make the employee whole, including:

- Reinstatement with the same seniority status that the employee would have had but for the discrimination;
- Two times the amount of back pay plus interest; and
- Compensation for any special damage sustained because of the discrimination (including litigation costs and reasonable attorney's fees).

The protected false claims activities include investigation for, initiation of, testimony for, or assistance in a false claims action that has been or will be filed. An employee is entitled to bring an action in the district court for such relief.

The California False Claims Act

The California False Claims Act ("CFCA") applies to fraud involving state, city, county or other local government funds. The CFCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims. Cal. Gov't Code §§ 12650-12655.

Actions that violate the CFCA include:

- Knowingly submitting (or causing to be submitted) a false claim for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved;
- Conspiring to get a false claim allowed or paid by the state or by any political subdivision;
- Benefiting from an inadvertent submission of a false claim, subsequently discovering the falsity of the claim, and failing to disclose to the state or political subdivision within a reasonable time after discovery;
- Delivering less property than the amount of the receipt, where the person has possession or control of public property;
- Knowingly making or delivering a false receipt, where the person is authorized to deliver a document;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from any person who has no legal right to sell or pledge the property; or
- Knowingly making or using a record to conceal, avoid, or decrease an obligation to pay money or transmit property to the state or local government.

"Knowingly" means the person or organization:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

"Claim" includes any request for money, property, or services made to the state or any political subdivision (or to any contractor, grantee, or other recipient), where any portion of the money, property, or services requested was funded by the state or any political subdivision.

The maximum civil penalty is $10,000, per claim. Persons who violate the CFCA may be liable to the state for three times the amount of damages that the state sustains because of the violation. The court can waive penalties and reduce damages for CFCA violations if the false claims are voluntarily disclosed. The CFCA does not apply to false claims of less than $500. Lawsuits must be filed within three years after the violation was discovered by the state or local official who is responsible for investigating the false claim (but no more than ten years after the violation was committed).

Liability to the State or Political Subdivision

A person or organization will be liable to the state or political subdivision for:

- Three times the amount of damages that the state or local government sustains because of the false claims violations;
- The costs of a civil suit for recovery of damages; and
- A civil penalty of up to $10,000 for each false claim.

Whistleblower Protection

Employers are prohibited from:

- Making or enforcing any type of rule or policy that prevents an employee from disclosing information to a government or law enforcement agency, or from investigating, initiating, testifying, or otherwise assisting in a false claims action; or
- Discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee because of his or her involvement in a false claims action.

If you have any questions about the HHSA Compliance Program or the Federal or State False Claims Acts please contact:

- **Bob Borntrager, CHC Compliance Officer at 619.515.4244 or by e-mail at: Compliance.HHSA@sdcounty.ca.gov**

C. ACCESSING SERVICES

Consistent with the Health and Human Services Agency's "No Wrong Door" policy, clients may access behavioral health, which encompasses mental health and alcohol and drug services through multiple points of entry. Clients may call the Access and Crisis Line (ACL), be referred by school personnel, CWS, Probation, or other child-serving organizations, or call or walk into an provider's program directly. The ACL is the point of entry for accessing Fee-for-Service (FFS) providers.

In accordance with Title 9, California Code of Regulations requirements, organizational providers and County-operated clinics must maintain logs of all persons requesting Specialty Mental Health Services. Required information includes date of inquiry, Medi-Cal eligibility, ethnicity/language, name, phone number and relationship of caller, nature of request (emergent, urgent or routine) disposition with date/time and if/where referred. A sample copy of the **Request for Services Log** Form is located in *Appendix C. C.2.*

In addition, clinics are now required to make referrals, track and report the number of families referred for Medi-Cal or Healthy Families insurance. There is a space provided to track this on the Request for Services Log in *Appendix C. C.2.*

Emergency Psychiatric Condition

Title 9 defines an "Emergency Psychiatric Condition" as a condition in which the client, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter or clothing. This situation indicates an immediate need for psychiatric inpatient hospitalization or psychiatric health facility services.

Goal for Services: Face-to-face clinical contact within one (1) hour of initial client contact/ referral.

Urgent Psychiatric Condition

Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition.

Goal for Services: Face-to-face clinical contact within seventy-two (72) hours of initial client contact/referral.

Routine Condition

A "Routine Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services.

Goal for Services: Face-to-face clinical contact within five (5) calendar days of initial client contact/referral.

Accessing Organizational Provider Outpatient Services

If a client first accesses services by calling or walking into an organizational provider site or a county-operated program, the client can be seen and assessed, and the organizational provider authorizes services based on medical necessity and/or the SED criteria as outlined in California Welfare & Institutions Code Section 5600.3. (See Systems of Care section of this handbook for elaboration of the content of this code.) See Authorization/Reimbursement Section of this handbook for a description of organizational provider and county-operated program responsibility for registration of clients. AB2726 clients are assessed and authorized by the County of San Diego Special Education Services (SES) and referred to organizational providers as appropriate.

Accessing Day Intensive and Day Rehabilitative Services

Day treatment services are both school/community based and enhanced treatment services in residential facilities for the most severely emotionally disturbed children and youth who meet medical necessity. Referral and admission to all day services may come from AB2726 programs, Juvenile Probation, Child Welfare Services, or schools. All programs are MediCal certified and comply with MediCal standards regardless of funding source.

Preauthorization is required for all day treatment services. Clients referred to day services shall begin treatment services within contract guidelines. Upon admission of the client, day programs shall comply with authorization procedures for day services as set forth in the DMH Letter No.: 03-03. An Administrative Services Organization (ASO) provides authorization for all day services. Reauthorization is required every three months for day intensive services and every six months for day rehabilitative services. A copy of UBH's current Specialty Mental Health Services DPR form is included in *Appendix C. C.4.*

ACCESS AND CRISIS LINE: 1-800-479-3339

United Behavioral Health (UBH) operates the statewide San Diego Access and Crisis Line (ACL) on behalf of the Mental Health Plan (MHP). The ACL, which is staffed by licensed and master's level counselors, provides telephone crisis intervention, suicide prevention services, mental health, alcohol and drug services information and referral 24 hours a day, 7 days a week. The ACL may be the client or the family's initial access point into the MHP for routine, urgent or emergency situations.

All ACL staff are trained in crisis intervention, with client safety as the primary concern. Staff evaluates the degree of immediate danger and determines the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation).

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the TTY line at (619) 641-6992.

Provider Interface with the ACL

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state, "If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-800-479-3339."

- If a client is high risk and may be calling the ACL for additional support, the client's therapist or care coordinator may call (with client's approval) the ACL in advance on behalf of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client's needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Hours of Service Availability

In accordance with 42 CFR, providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial clients. If the provider serves only Medi-Cal clients, the hours of service availability must be the same for fee-for-service and managed care clients. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities. The MHP QI Unit will monitor availability of service hours at the annual Site Review.

Available Language Assistance

Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs.

According to 42 CFR, clients shall be routinely asked, at the time of accessing services, about their needs for free language assistance. According to Title 9, providers must document the offer and whether linkage was made to interpreter service for clients requesting or needing translation services in threshold or other languages. BHS prohibits the expectation that family members,

including minor children will provide interpreter services; however, if clients choose to use family or friends, this choice also should be documented.

Interpreters can be qualified staff members at the provider site. Consistent with the Cultural Competency Standards, contractors are encouraged to develop and maintain staff's language competency for threshold languages. If no qualified staff is available, with the approval of the program manager or designee, program staff can contact Interpreters Unlimited (for language interpreting) at (800) 726-9891 or Deaf Community Services (DCS) (for hearing impairment) at (619) 398-2488 to arrange for free language assistance. If for some reason DCS is unable to provide for sign language services, providers may call Network Interpreting as a back up only at (800) 284-1043. If there is a need to use Network Interpreting, providers should document why DCS was not utilized. As soon as the services have been rendered, the provider will fill out a **Service Authorization Form** (See *C . C.3.* See also *Appendix C. C.5* for instructions on this use of this form.)

The completed form will be faxed to Interpreters Unlimited or Deaf Community Services or Network Interpreting (back up only). The interpreting services will then submit an invoice to the MHP.

To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

Service Priority for Outpatient Services

High

- Children and adolescents requiring emergency services should be assessed within one hour of contact with program. They may be seen at the program or referred to Emergency Screening Unit.
- Children and adolescents requiring crisis services different from Urgent services should be assessed within one (1) day.
- Children and adolescents with Urgent referrals, defined as a condition that, without timely intervention, would very likely become an emergency, should be seen within 72 hours of contact with program.
- Children and adolescents being discharged from acute psychiatric hospital care shall be seen within one week of contact with program unless the referral is deemed Urgent, in which case they should be seen within 72 hours of contact with program.

- AB 2726 students stepping down from higher level of care (day treatment or residential) shall be assigned for treatment in a timely fashion as defined in the inter-agency agreement.
- Seriously Emotionally Disturbed (SED) children and adolescents take priority over routine admissions.
- AB 2726 students with outpatient services on the IEP shall be assigned for treatment as specified in Interagency Agreement.

Moderate

- Children and adolescents with moderate mental health needs who meet medical necessity criteria shall be provided with appropriate services for up to 6 months, at which time the need for continued services shall be referred to a Utilization Review Committee. Services for these youngsters may typically include short-term individual (8 – 16 visits), family, and/or group sessions.

Low

- For children and adolescents with moderate to low-level mental health needs clinicians at all programs shall assist the parent/caregiver in accessing services within the region through the United Behavioral Health individual/group provider network, if the child is Medi-Cal eligible.

Client Selection of a Provider

In accordance with 42 CFR and Title 9, providers are reminded that clients have the right to choice and to obtain a list of MHP providers, including information on their location, hours of service, type of services offered, and areas of cultural and linguistic competence. Information about organizational providers is posted on the *Network of Care* website (www.networkofcare.org), and in the *Organizational Provider Resource Manual,* which may be obtained through the Quality Improvement Unit by calling (619) 584-5026. Information on fee-for-service providers is available from UBH. When feasible, beneficiaries will be provided with the initial choice about the person who provides specialty mental health services, including the right to use culturally specific providers.

Note: Contractors shall report to the CMHS QI Unit any changes in location, hours or types of services offered to keep the Organizational Provider Resource Manual current. Providers will be surveyed periodically about cultural and linguistic capabilities.

Clients Who Must Transition to a New Provider

Good clinical practice indicates that the following should be implemented whenever possible:

- The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first program/provider.
- The client and caregiver should be informed of the client's right to request a new provider.
- Client and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.
- Report transfer on **Suggestion and Provider Transfer Log, which is part of the Monthly Status Report**, *Appendix G. G.13.*
- The client should be assisted in making a first appointment with the new program.
- The old and new program must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials.
- A thorough discharge summary (or a transfer note, if the client will continue in the same program) should be written and incorporated into the chart.
- Final outcome tools should be administered if the client will go to another provider program.
- A plan for emergency services should be developed with the client and caregiver, to include the ACL, the new program, and informal supports.

DUAL DIAGNOSIS CAPABLE PROGRAMS

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. CMHS has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) Model for individuals and families with co-occurring substance use and mental health disorders. Programs must organize their infrastructure to routinely welcome, identify, and address co-occurring substance use issues in the clients and families they serve. They shall provide properly matched interventions in the context of their program design and resources. For specific information regarding CCISC and dually diagnosed clients, please see **Section A** of this handbook.

UNDOCUMENTED CLIENTS

In accord with County and State policy, the Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition, and is established by the client's verbal declaration. This applies to foreign nationals, including undocumented immigrants. Without intent to reside in San Diego County, any client, regardless of citizenship, must be billed at full cost. However, persons known to be undocumented

immigrants are eligible only for emergency services, such as an acute care hospital or the Emergency Screening Unit, and services pursuant to an Individualized Education Program under Assembly Bill 2726.

D. AUTHORIZATION OF REIMBURSEMENT FOR SERVICES

All authorization requirements in this section must be completed for all clients even if the services will be funded by a source other than Medi-Cal, such as SB90 and Mental Health Services Act (MHSA).

MEDICAL NECESSITY

Provider must demonstrate that each client receiving Specialty Mental Health services meet medical necessity. Authorization is performed through the MHP Utilization Management Process, using Title 9 (Section 1830.205) Medical Necessity criteria as summarized below. A complete description of Title 9, Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services can be found on the State website at www.calregs.com. For a copy of Title 9, please call the State Office of Administrative Law at 916-323-6225. Services provided to clients are reimbursable when the following criteria are met:

Outpatient and Day Treatment Clients:

- The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for outpatient services as described in Title 9, Section 1830.205 (1).

AND

The client must have at least one of the following as a result of the mental disorder(s):

- A significant impairment in an important area of life functioning,
- A probability of significant deterioration in an important area of life functioning, or
- A probability that the client will not progress developmentally as is individually appropriate (for Medi-Cal beneficiaries under age 21).

AND

All of the following:

- The focus of proposed intervention is to address the impairment or potential impairment identified immediately above,
- The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning, and
- The condition would not be responsive to physical healthcare treatment.

Seriously Emotionally Disturbed (SED) Clients:

The priority population for Children's Mental Health Services, including clients seen under MHSA, are seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

For the purposes of this part, seriously emotionally disturbed children or adolescents means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Note: AB2726 CLIENTS are not eligible for services through MHSA because MHSA services may not supplant other services.

OUTPATIENT SERVICES

Authorization of Reimbursement of Services

The San Diego County MHP defines Children's Mental Health clients as children and youth under 18 years of age. At times young adults may be served if they are receiving services pursuant to SB90 or if continuing in a CMHS program is clinically indicated. Clients may access the services of organizational providers and county-operated facilities in the following ways:

- Calling the organizational provider or county-operated program directly
- Walking into an organizational provider or county-operated program directly
- Calling the Access and Crisis Line at 1-800-479-3339
- Referrals from ESU

If a client first accesses services by calling or walking into an organizational provider or county-operated program, the client can be seen and assessed without contacting UBH for an authorization. After completion of an assessment and when additional services are offered, that

provider is responsible for entering administrative and clinical information into all the appropriate fields in MIS. Providers must register clients, record episode and service activities, and update the CIS information in MIS. (See the Management Information Systems section of this handbook for a description of how MIS supports these provider activities.)

If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the MediCal client will be issued an **NOA-A** (*Appendix D. D.2 & 3*) (which must also be documented in the **NOA log** tab of the Monthly Status Report (*Appendix G. G.13*) and their beneficiary rights shall be explained. If a client will receive day treatment services (either intensive or rehabilitative) on the same day that the client receives Mental Health Services (Individual, Group, or Collateral), authorization for the Mental Health Service must be obtained from United Behavioral Health through the day treatment provider.

If the Access and Crisis Line (ACL) refers a client to an organizational provider or to a county-operated facility, an authorization letter will be sent to the provider. The ACL opens a record in eCura (a computerized client data system) for each client it refers to an organizational provider or a county-operated program; if the client is new, he or she will be concurrently registered in MIS. The provider is then responsible for insuring all client information is correct and complete. Staff is also responsible for recording all ongoing activity for that client into MIS. This information includes, but is not limited to, episode and service activities, the primary diagnosis, the name of the primary clinician, and all client episode closings.

Utilization Review

The MHP has delegated responsibility to County operated and contracted organizational providers to perform utilization management for specialty mental health services, crisis stabilization services, outpatient services, medication services, and case management services. Authorization decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. Each delegated entity shall be accountable to the Children's Mental Health Director and shall follow the Utilization Review processes established for children's mental health programs.

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. The clinician shall complete the County's MHS 650 or MHS 663 Assessment Form or its successor and ensure that all required domains are completed.

The MHS 650 or MHS 663 Assessment, the Client Plan, and progress notes will be reviewed during County and State medical record reviews with respect to whether medical necessity has been documented.

The Utilization Review Committee operates at the program level and must include at least one licensed or waivered clinician. The Utilization Review Committee bases it decisions on whether medical necessity is still present *and* whether the proposed services are likely to assist in meeting the Client Plan goals. To assist in its determination, the Utilization Review Committee or clinician receives a UR Request and Authorization form (which reports current client functioning in quadrants for various domains) and a new Client Plan to cover the interval for which authorization is requested. Medication only clients are not included in the Utilization Review process as they are subject to medication monitoring.

For outpatient programs, a UR Committee shall review all outpatient clients' cases (excluding medication only cases) if the case is still open six (6) months after intake. If client is concurrently in day treatment and outpatient services, then ancillary authorization must occur through day treatment and United Behavioral Health (UBH) because the day treatment cycle supersedes outpatient UR. In these cases the outpatient program must also continue to complete UR for case management services when provided concurrently with day treatment services. However, if the client is terminated from the Day Program they shall revert to the cycle for outpatient UR, based on the first planned service in the current treatment episode. If the initial six (6) months from the admission date have passed, the case shall be reviewed at the next UR meeting.

DAY REHABILITATION AND DAY INTENSIVE

Authorization of Reimbursement of Services

Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity. The assessment must document that a recommendation for day program was made in the course of a formal assessment, lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted, and a highly structured mental health program is needed to prevent admission to a more intensive level of care.

The Initial Day Program Request must be submitted along with a Specialty Mental Health Services DPR if the client receives ancillary services on the same day as day program services. Continued Requests that are made must be accompanied with a Specialty Mental Health Service DPR if applicable. Utilization review will be completed by United Behavioral Health according to necessity criteria for the level of day service.

These service criteria essentially state that the client cannot be served at a lower level of care and that a recommendation for day services has been made. Day treatment services must be reauthorized every 3 months for day intensive and every 6 months for day rehabilitative. If medical or service necessity criteria are not met, the MediCal client will be issued an NOA-A (which must also be documented in the NOA log) and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from United Behavioral Health, an **NOA-B** (*Appendix D . D.5*) shall be issued by UBH.

When the day treatment services are provided out of county, an alternative Day Program Request Form may be used if it contains all required elements. Approval for its use is to be obtained by either the Program Monitor/COTR or Chief of Quality Improvement.

Notes: *DPRs are to be completed for all day treatment clients.
*ONLY DPRs for MediCal clients are faxed to UBH for review.
*Initial authorizations may not be submitted prior to the opening of the episode.
*Authorization cycles are based on months and not days (i.e. for Day Intensive an authorization cycle may look like: Initial DPR 1/1/06 - 3/31/06, Continued DPR 4/1/06 - 6/30/06, etc.).
*UBH will generate an authorization letter within 14 business days. If the Provider does not receive this, they may check InSyst directly or contact UBH.
*Authorization letters will include day treatment and ancillary services for each client.
*Authorization letters are to be attached to the corresponding DPR.
* DPRs should be filed in the medical record in the Plans section, or be accessible upon request.
* Retroactive authorizations should not be requested for services more than 9 months in the past. Inform your Program Monitor/COTR via e-mail when submitting a retroactive authorization request.
* If you have any questions regarding the DPR process including following up with Authorization Letters, please contact: United Behavioral Health at (619) 641-6829.

Utilization Review

Utilization management of day intensive and day rehabilitation services is delegated to UBH.

THERAPEUTIC BEHAVIORAL SERVICES

Authorization of Reimbursement of Services

Prior to approval for services, the referred client must be assessed for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. The County of San Diego conducts this assessment, and eligible clients are referred to a contract provider. If class, service, or other TBS Criteria are not met, the MediCal client will be issued an NOA-B by County TBS (which must also be documented in the NOA log) and their beneficiary rights shall be explained. A record of this action shall be documented in the NOA Log. Qualifying clients receive an initial authorization of services for 30 days or 60 hours, whichever occurs first. This initial authorization allows the contract provider to complete a behavioral assessment and TBS treatment plan, and to provide initial services. Additional payment/service reauthorizations are requested by the contract provider and are authorized by the County for 60 hours or 120 days, whichever occurs first. If a reauthorization request is modified or denied by the County, the client will be issued an NOA-B and their beneficiary rights shall be explained. A record of this action shall be documented in the NOA log.

Utilization Review
Authorization management for Therapeutic Behavioral Services is retained by the MHP.

QI PROGRAM MONITORING

The MHS Children's Quality Improvement Unit shall monitor each organizational provider's compliance with these requirements, to assure that activities are conducted in accordance with both State and MHP standards. If the delegated entity's activities are found not to be in compliance, the MHP shall require that a corrective action plan be formulated. Progress toward change will be effected through direct management, in the case of a County operated program or through contract monitoring in the case of a contractor. The Quality Improvement Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing and collections. The *Organizational Provider Financial Eligibility and Billing Procedures Handbook* is provided by CMHS for providers as a guide for determining financial eligibility, billing and collection procedures. This handbook includes the following procedure categories:

- Using InSyst System.
- Registering a new client.
- Episode opening/closing and recording services.
- Determining financial eligibility.
- Claims, billing, and posting procedures.
- Training and technical assistance.

This handbook is not intended to replace the InSyst Users Manual or intended to be a comprehensive "Insurance and MediCal Billing" guide. It is meant to augment existing resource materials.

E. INTERFACE WITH PHYSICAL HEALTH CARE

COORDINATION WITH PRIMARY CARE PHYSICIANS

Coordination of care between mental health care providers and health care providers is necessary to optimize the overall health of a client. All providers are expected to coordinate mental health care with a client's Primary Care Physician and should have a policy and procedure in place regarding this coordination of services. Over 50% of Medi-Cal beneficiaries are enrolled in one of seven Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. They are required by the MHP to obtain a Release Of Information (ROI) from the client during the first visit to facilitate coordination with the client's Primary Care Physician. Included as an Attachment to this handbook is the Healthy San Diego Physical and Mental Health Care Coordination Form, which providers may use to facilitate or enhance coordination of care with the client's Primary Care Physician. **When a client comes in with no healthcare coverage, provider shall refer the client to Medi-Cal or the Healthy Families Program.**

NOTE!

See the "**Plan Partner Identification for Pharmacies**" (*Appendix E. E.2*) for contact information for the Healthy San Diego Health Plans.

Pharmacy and Lab Services

HMO Medi-Cal Beneficiaries

Each HMO has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each client's HMO in order to refer the client to the appropriate pharmacy or lab. (See the chart of such affiliations in the Attachment Section of this Handbook.) The client's HMO enrollment card also may have a phone number that providers and clients can check in order to identify the contracted pharmacy or lab.

Psychiatrists may order the following lab studies without obtaining authorization from the client's Primary Care Physician:

- CBC
- Liver function study
- Electrolytes
- BUN or Creatinine
- Thyroid panel
- Valproic acid
- Carbamazapine
- Tricyclic blood levels
- Lithium level.

All other lab studies require authorization from the client's Primary Care Physician. It is recommended that each provider contact the client's HMO Member Services Department or Primary Care Physician to determine which lab test(s) require authorization from the client's Primary Care Physician.

Medi-Cal Beneficiaries Not Enrolled in an HMO

Medi-Cal beneficiaries who are not members of an HMO may use any pharmacy or lab that accepts Medi-Cal reimbursement.

Non-Medi-Cal Beneficiaries

Non-Medi-Cal beneficiaries who meet financial eligibility requirements being seen at County operated clinics may have their prescriptions filled at little or no cost at a county mental health clinic, or the Health and Human Services Agency Pharmacy at the Health Services Complex, 3851 Rosecrans Street, San Diego, California, 92110.

Contracted providers shall provide medications to non-Medi-Cal clients who meet financial eligibility requirements.

Contractor shall comply with the Medi-Cal Drug Formulary for Mental Health Services.

Providers shall make every effort to enroll clients in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

PHYSICAL HEALTH SERVICES WHILE IN A PSYCHIATRIC HOSPITAL

Healthy San Diego Recipients

The client's Healthy San Diego HMO is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The client's HMO also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The HMO contracted provider must perform these services unless the facility obtains prior authorization from the HMO to use another provider.

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission and for ordering routine laboratory services tests. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed,

the contracted hospital must obtain the necessary authorizations from the client's HMO. (See *Appendix E. E.3* – **Healthy San Diego Physical and Mental Care Coordination Form**).

Medi-Cal Beneficiaries Not Enrolled in Healthy San Diego Health Plans)

For those Medi-Cal eligible clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

TRANSFERS FROM PSYCHIATRIC HOSPITAL TO MEDICAL HOSPITAL

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange such a transfer for physical health treatment. It is the responsibility of the HMO to pay for transportation in such cases. The UBH Medical Director and the HMO Medical Director will resolve any disputes regarding transfers.

Medical Transportation

Healthy San Diego HMOs will cover, at the Medi-Cal rate, all medically necessary emergency and non-emergency medical transportation services to access Medi-Cal covered mental health services. HMO members who call the ACL for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

HOME HEALTH CARE

Beneficiaries who are members of one of the Healthy San Diego HMOs must request in-home mental health services from their Primary Care Physician. The HMO will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHS. The MHP will pay for services solely related to the included mental health diagnoses. The HMO case manager and the Primary Care Physician coordinate on-going in-home treatment. The HMO is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the HMO.

HEALTHY FAMILIES ENROLLEES WHO ARE REFERRED FOR SERVICES AT CMHS

The Healthy Families Program provides health insurance for children up to their 19th birthday whose family income is between 100 and 250 percent of the federal poverty level, and are

therefore not eligible for Medi-Cal. The Healthy Families Program (HFP) provides a basic mental health benefit, including psychiatric hospitalization, but some youngsters cannot be adequately served within the limits of the HFP. Such youngsters are referred to the Emergency Screening Unit (ESU) to determine if they meet the criteria for Seriously Emotionally Disturbed youth as defined by the California Welfare and Institutions Code 5600.3. If the determination is positive, the youngster becomes eligible for the full range of medically necessary mental health services available though Short/Doyle Medi-Cal and MHSA. These services are to be provided to the extent resources allow. Referrals to Organizational Providers will be through the ESU only. Provider Programs who receive such a referral are required to verify monthly that the child or adolescent has a Medi-Cal aid type of 9H. The services should be billed under the program's usual procedure codes. Date of discharge shall be determined by the treating program in accordance with current outpatient Utilization Review criteria, or by agreement with the child and caregiver. Contact the Program Manager at ESU for more information.

(Coordination of Physical and Mental Health Care) Clinical Consultation and Training

Beneficiaries with less severe problems or who have been stabilized may be referred back to their Primary Care Physician for continuing treatment. To help support treatment by the Primary Care Physician, the MHP as well as organizational providers and county operated programs shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP. Efforts shall be made to provide consultation and training to Medi-Cal Managed Care Providers, Primary Care Providers who do not belong to a Medi-Cal Managed Care Plan and to Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

F. BENEFICIARY RIGHTS & ISSUE RESOLUTION

Client Rights and Protections Under Federal Code

According the Title 9 and 42 CFR 438.100, the MHP is responsible for ensuring compliance with consumer rights and protections. Providers, as contractors of the MHP, are also required to comply with all applicable regulations regarding consumer rights and protections. These rights and protections from 42 CFR can be summarized as follows:

- *Dignity, respect, and privacy*. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the managed care plan and available treatment options*. Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions*. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- *Copy of medical records*. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, Part 164.
- *Free exercise of rights*. Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the County MHP, its providers or the State agency treat the enrollee.

In accordance with 42 CFR and Title 9, the MHP Quality Improvement Unit distributes the Guide to Medi-Cal Mental Health Services, which contains information on client rights, as well as a description of the services available through the MHP, and the avenues to obtain resolution of dissatisfaction with MHP services.

Note: *New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages of English, Spanish, Vietnamese and Tagalog.) Additional copies may be obtained from the MHP Quality Improvement Unit at (619) 563-2788.*

Additional Client Rights

- **Provider Selection**

  In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence. (See Accessing Services section in this Handbook for details.)

- **Second Opinion**

  If the MHP or its designee determines that a client does not meet Title 9 Medical Necessity Criteria for inpatient or outpatient mental health services, a client or someone on behalf of the client, may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care. As the MHP designee, UBH is responsible for informing the treating provider of the second opinion request and for arranging the second opinion with an MHP contracted individual provider.

  The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor/COTR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the MHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

- **Transfer from One Provider to Another**

  Clients have a right to request a transfer from one Medi-Cal provider to another within or outside of a program. These transfer requests shall be recorded on the **Client Suggestions and Provider Transfer Request tab of the Monthly Status Report** (See *Appendix G. G.13*). Documentation in the Log shall include the date the transfer request was received, whether the request was to a provider within or outside of the program, and the relevant code showing the reason for transfer if specified by the client. The Log shall be submitted with the provider's Monthly Status Report.

- **Right to Language, Visual and Hearing Impairment Assistance**

  Clients shall be routinely informed about the availability of free language assistance at the time of accessing services. CMHS prohibits the expectation that the client use family or friends for interpreter services. However, if the client so chooses, this choice should be documented in the client record. For more complete information about linking clients to free interpreter services, please see the Accessing Services section of this Handbook.

Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and CMHS.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adults over age 18 and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all eligible clients be informed of the right to have an Advance Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation). An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new adult or emancipated clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.
3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.
5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. Copies may be obtained through the MHP QI Unit by calling (619) 563-2788, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Clients' Rights

In accordance with DMH regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to Mental Health Services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Admission Checklist Form. Information on the Beneficiary Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented in the medical record. It is strongly recommended that this information be tied to the anniversary date of admission for services.

BENEFICIARY PROBLEM RESOLUTION PROCESS

San Diego County Mental Health Services is strongly committed to honoring the rights of every consumer to have access to a fair, impartial, effective process through which the consumer can seek resolution of a problem encountered in accessing or receiving quality mental health services. All contracted providers are required to participate fully in the Beneficiary Problem Resolution Process (**Grievance and Appeal Process** (Appendix F, F.3**)**). Providers shall comply with all aspects of the Process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the Process. When a provider is notified by the contracted advocacy organization, the Consumer Center for Health Education and Advocacy (CCHEA) or USD Patient Advocacy Program that a client has filed a grievance or appeal about that provider's program or staff, the provider shall cooperate with the investigation and resolution of the client's concerns in a timely manner as specified in the Process.

Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the consumer is not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

In accord with 42 CFR and Title 9, the County of San Diego Mental Health Beneficiary Problem Resolution Process has been streamlined, some terms redefined, and strict timelines added. An opportunity for provider appeals has also been added, as well as a clinical review of grievances and appeals concerning clinical issues. The provider continues to play an important part in this process as follows:

Problem Resolution at Provider Sites

In a continuation of past practice to most quickly and efficiently make providers aware of and resolve problems, clients are encouraged to direct their suggestions to program staff or management. This can be done orally or in writing. In attempting to reach resolution consistent with confidentiality requirements, staff or management shall utilize whatever information, resources and/or contacts the consumer agrees to. Provider will log all client reported problems in the Client Suggestions and Provider Transfer Request Log. In order to preserve client confidentiality, this log must be kept in a secure area. This Log shall be submitted with the provider's Monthly Status Report.

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

At all times, Grievance and Appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place.

Grievance Process

Timeline: 60 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

A "grievance" has been defined as an expression of dissatisfaction about any matter other than an action. USD Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within three (3) days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. In order to be in compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and USD Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client's condition to review and make a decision about the case.

Appeal Process

Timeline: 45 days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

Appeals are reviews of actions by the MHP regarding provision of services through an authorization process, including:

- Reduction or limitation of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner.

See the Beneficiary Problem Resolution Process for details. The Advocacy organization will contact the provider within three (3) working days of receiving the written permission to represent the client. Again, the provider's cooperation with the Advocacy organization to find a mutually agreeable solution is necessary to meet the strict mandated timelines in resolving the problem. The advocacy organization shall investigate the appealed matter and make a recommendation to the MHP. The MHP (Local Mental Health Director or designee) will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

Expedited Appeal Process

Timeline: Three (3) working days, with a possible 14-day extension for good cause.

When the standard appeal process could jeopardize a client's life, health or functioning, an expedited appeal may be filed for by the Advocacy organization, necessitating a very rapid turnaround from grievance to resolution. The advocacy organization will notify the provider as soon as possible, but in less than two (2) working days. The Mental Health Director or designee will make a decision on the appeal on the third working day.

State Fair Hearings

Medi-Cal beneficiaries filing an appeal may request a State Fair Hearing, after using the County Beneficiary Problem Resolution Process whether or not they have received a Notice of Action within 90 days after the completion of the Beneficiary Problem Resolution Process. State Fair Hearings are further discussed in the Beneficiary Problem Resolution Process.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Mental Health Director or designee in 10 days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Mental Health Director within 10 days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary Problem Resolution Process for details of this portion of the process.

Monitoring the Beneficiary Problem Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and service, will view feedback from the grievance/appeal process as a reflection of potential problems with service effectiveness and/or efficiency and as an opportunity for positive change. Information on problems may be incorporated into the ongoing contract monitoring and/or credentialing process.

CLIENT NOTIFICATION OF ACTION ON SERVICES (NOA PROCESS)

The State has developed the following forms to be used to notify clients about service provision:

Notice of Action-Assessment (NOA-A)

All Children's programs (County and contract) serving Medi-Cal clients shall follow procedures for issuing NOA-A forms and maintaining a Notice of Action Assessment Log for Medi-Cal beneficiaries. In accordance with Title 9, Section 1850.210, an NOA-A shall be issued to a Medi-Cal client when services are requested and medical necessity criteria are not met upon a face to face assessment and therefore no services are appropriate in the mental health system. Issuing of an NOA-A begins the 90-day period that a beneficiary has to file for a State Fair Hearing.

The NOA-A form informs the Medi-Cal beneficiary of the following:

- Reason for denial based on Title 9, California Code of Regulations
- Beneficiary's right to a second opinion
- The grievance/appeal process

- Right to a State Fair Hearing (once local process has been exhausted)
- Criteria for an expedited State Fair Hearing
- Explanation of the circumstances under which a specialty mental health service will be continued if a State Fair Hearing is requested
- Method by which a hearing may be obtained
- Beneficiary may be either self represented or represented by an authorized third party such as legal counsel, relative, friend or any other person.

The following procedures shall be followed by Children's County and Organizational providers when issuing an NOA-A:

1. The Notice of Action-Assessment (NOA-A) form shall be issued to a Medi-Cal beneficiary following a mental health screening and/or assessment (face to face or phone) when it is determined by the provider that the beneficiary does not meet medical necessity criteria, resulting in denial of all specialty mental health services.
    a. If upon screening/assessment, the beneficiary is identified as currently receiving specialty mental health services, an NOA-A shall <u>not</u> be issued.
    b. As part of the screening/assessment process, the beneficiary may be informed of the option to obtain care outside the Mental Health Plan. When a beneficiary verbalizes interest only in information gathering or in obtaining a referral outside of the Mental Health Plan (thus declining or modifying the original inquiry for specialty mental health services), no NOA-A needs to be issued. Services outside of the Mental Health Plan may not be reimbursable by Medi-Cal.
2. The NOA-A shall outline the action taken by the Mental Health Plan (MHP) or provider, reason for the action, beneficiary's rights, and citation of the specific regulations or MHP payment authorization procedures supporting the action.
3. In accordance with federal regulations, the NOA-A may be hand delivered on the date of the notice or deposited with the United States Postal Service in time for pick-up no later than three (3) working days of the decision by the provider.
4. All above cited programs shall maintain a Notice of Action Assessment Log on the program site.
5. The NOA-A Log shall document all NOA-As provided to Medi-Cal beneficiaries and their response to the NOA-A, if known.
6. The NOA-A Log shall contain the following information:
    a. Date the NOA-A was issued
    b. Beneficiary identification number, if known
    c. Response, including requests and provisions for second opinions, initiation of grievance/appeal procedure, and/or request for State Fair Hearing, if known.
7. The original NOA-A Log will be maintained at the program site, with a copy of each NOA-A issued attached. When no NOA-As are issued in a given month, the Log shall reflect this information with a check in the appropriate box. The Monthly Status Report shall identify the number of NOA-As issued during the report period.
8. When an NOA-A is issued, the Log shall be submitted with the provider's Monthly Status Report.

Notice of Action (NOA-B)

In response to a provider's request for continued treatment authorization, if the MHP or its designee should determine that a Medi-Cal client's treatment be denied or reduced, the provider and the client will receive an NOA-B form. The NOA-Back form describes the Medi-Cal client's right to file a grievance/appeal, and the right to a State Fair Hearing. Please review the NOA-B with the client and request that he/she sign the form, and return the signed NOA-B to the point of authorization.

If the Medi-Cal client chooses to exercise the right to file an appeal, or request a State Fair Hearing, the appropriate State office to contact is given on the NOA-Back form.

Note: A copy of the NOA-A, NOA-A Log, NOA-B and the NOA-Back forms are included in *Appendix D* and may be copied.

Additional Types of Notices of Action

In response to 42 CFR, Notices of Action must be sent out for two additional reasons:

1. A Notice of Action form will be sent to a client from an advocacy organization (CCHEA or USD Patient Advocacy) or the MHP, as appropriate, if a grievance, appeal, or expedited appeal is not completed in accordance with federal timelines. (NOA-E)

2. A Notice of Action form will be sent to a client from UBH if a Treatment Authorization Request (TAR) has been denied as a result of insufficient information submitted by the provider. (NOA-C)

It is expected that issuing these types of NOAs will be infrequent, but may result in clients approaching providers with a few questions. The State has provided the counties with specific forms for these new NOAs.

G. QUALITY IMPROVEMENT PROGRAM

The MHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the MHP Quality Improvement Program is to ensure that all clients **regardless of funding source** receive mental health care in accordance with these principles. Each program in the system is expected to have internal quality improvement controls and activities in addition to those provided by the MHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected offenses. In addition, all provider programs are required to attend monthly Program Manager meetings, quarterly Leadership Plus meetings, quarterly behavioral health meeting, documentation training and other trainings. These meetings are essential to keep abreast of system changes and requirements as part of our continuous improvement efforts.

The quality of the MHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, Title 9, Chapter 11, of the California Code of Regulations,
- State Department of Mental Health (DMH) Letters and Notices,
- the MHP Managed Care contract with the State DMH, and
- the Annual State DMH Protocol.

The evaluation process is also being reformulated and expanded to meet a number of new Federal regulations and legislative mandates including the following:

- Mental Health Services Act (MHSA),
- MHSA System Transformational Goals for the County of San Diego,
- State mandated Performance Improvement Projects (PIP) --- the State has mandated that each county undertake one administrative and one clinical improvement project yearly.

Through program monitoring, program strengths and deficiencies are identified and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Improvement Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, para professionals, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services.

Indicators of care and service, currently being evaluated, include, but are not limited to, client satisfaction, effectiveness of the service delivery system, performance and treatment outcomes,

accessibility of services, cultural competency, adherence to health and safety standards, and preservation of client rights.

CLIENT AND PROVIDER SATISFACTION

The MHP is committed to assessing client satisfaction with the quality of care and provision of mental health services. A satisfaction survey, developed in accordance with State Mental Health mandates, is conducted within all organizational programs as required by the County to assess client satisfaction. The MHP provides education and training to providers regarding the survey, its development, utilization and implementation. See Section N for more information.

Client Satisfaction:

Youth Services Survey (YSS)- State Requirement

Survey Period: *Currently administered twice a year for a two week period in May and November as specified by the State DMH, to all clients and families who are receiving services (excluding detention program, medication only cases, inpatient, and crisis services).*

Providers will be notified by the MHP of the exact State selected time period; historically, survey periods have been in May and November. The survey returns are scanned in directly to the State, therefore original printed forms provided by the MHP must be used. Providers shall administer and collect this survey in a confidential manner. However, because of the limited window for submitting this information to the State, providers are strongly requested to send in completed survey envelopes at the end of the first week and immediately at the end.

a) Youth aged 13 and over complete the Youth Services Survey with attached comments page.
b) Parents/caregivers of children and youth up to age 18 complete the Youth Services Survey-Family.
c) Surveys are to be administered in a manner that ensures full confidentiality and as directed by the Child and Adolescent Services Research Center (CASRC).
d) Surveys shall be delivered by hand or mailed to CASRC within 7 days after the completion of each survey interval.
e) Effective September 2006, medication only cases are excluded from the YSS measure.

Family Centered Behavior Scale (FCBS)

a) Parent / Guardians of clients shall be administered the Family Centered Behavior Scale (FCBS) at each UR / Authorization cycle, and additionally at discharge, along with the other assessment tools.
b) When no measure is obtained (caregiver refuses / not available), enter that information into DES.

Organizational providers are also encouraged to provide feedback regarding their interaction with the MHP by direct communication with the Program Monitor/COTR and MH Contract

Administration Unit. Communication can occur at the contractor's request, at periodic, scheduled meetings, and through the monthly status report narrative.

MONITORING THE SERVICE DELIVERY SYSTEM

The MHP mandates internal and external site and clinical monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate level of service. The Quality Improvement Unit conducts program site and chart reviews of both Medi-Cal and Non Medi-Cal clients. Site visits and chart reviews are scheduled a minimum of two (2) weeks in advance, and, as applicable, a copy of the site and clinical record review tool is distributed to the provider at that time. Upon selection of records to review, no revisions shall be made to the clinical record or submitted claims.

Using the Uniform Medical Record

All programs are required to utilize the forms specified in the San Diego County Children's Mental Health Services Documentation and Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. The standards for documentation shall be consistent across all clinical programs, regardless of funding source. Programs may adapt forms for specific program needs upon review and approval by the Quality Improvement Unit. The Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Each legal entity shall develop forms for legal consents and other compliance related issues. **Out of county** mental health programs may utilize non-San Diego County medical record forms, but they must be in compliance with all State and Federal and requested County guidelines.

County providers are to retain a medical record for 10 years after the discharge date of adult clients, or until a minor has reached the age of 19, but in no case less than 10 years. Organizational providers are to develop their own standard which follows all applicable guidelines/laws or adopt the county's. County providers are required to retain all Billing Records for a minimum of 5 years in the office, and 2 years off site (for a minimum total of 7 years) when the program is funded with State or Federal dollars. Organizational providers may seek their own legal counsel, adopt the County standard or set an internal standard which follows all applicable guidelines, which include, but are not limited to California Code of Regulations Title 22.

Documentation and in-service trainings are offered by QI to keep providers informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual can be obtained by calling the QI Unit at (619) 584-5026.

Standards for "Late Entry" Documentation

All services provided to a client shall be documented into the client's medical record within a timely manner. Documentation should occur on the date the service was provided. If, however, this documentation does not occur on the date of service, the following shall apply:

- A "late entry" is defined as any documentation that is done on a calendar day other than the date the service was provided.
- When documenting a late entry in the client's medical record, "late entry" should be written at the beginning of the note.
- Late entry notes should be filed in the medical record chronologically to when written, not filed by the date the service was provided.

Claiming for a Late Entry

- Late entries will be accepted for claiming purposes up to 14 days after the date of service.
- If a late entry has not been documented within 14 days from the date of service, the service must still be documented but may not be claimed. The late entry would be considered a non-billable service and would be entered into InSyst as such.
- A recoupment will be made for a late entry with a documentation date of over 14 days from the date of service if this late entry has been claimed and the claim is included within the audit period of a medical record review.

Meeting Quality Management & Short-Doyle/Medi-Cal Requirements

Programs will be monitored for compliance by CMHS Quality Management (QM) Program. Programs shall be required to submit and implement a Plan of Correction for issues/problems identified by the QM Program. The deadline for a Plan of Correction shall be established by the QM Program.

Plans of Correction

The QI Unit monitors organizational and County providers on a regular and annual basis to evaluate the provider's performance in various delegated activities. Medical record reviews are conducted to ensure that MHP contract requirements are met pertaining to documentation standards. Site certification and recertification reviews are also conducted to ensure that all MHP onsite requirements are being adhered to by the provider. If the provider's performance is found to be inadequate, or areas for improvement are identified, a request for Plan of Correction (POC) will be issued by the MHP to the provider. The provider will have 14 days, or another identified time frame, after receipt of the MHP's written report of findings to complete and submit their POC to the QI Unit. The POC must describe the interventions or processes that the provider will implement to address items that have been identified out of compliance or that were identified as needing improvement. In some instances, the QI Unit will be making more specific process improvement recommendations to the provider that must be included in the POC. When appropriate, the POC must include all supporting documentation (i.e. copy of a

policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the POC, the program is still required to keep this documentation on-file at their program. The POC must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a POC may result in withholding of payment on claims for non-compliance.

Upon receipt of a POC, the QI Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the POC does not adequately address these items, the QI Unit will request that an addendum POC be submitted within a specified time frame.

Programs will be monitored for trends and patterns in their out of compliance items or areas needing improvement. Additional QI reviews may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with adhering to standards. These determinations will be made under the direction of the QI Program Manager and may take place within 30 days, 60 days or some other identified time frame depending upon the severity of the noncompliance. For medical record reviews, these additional reviews will include the billing audit and will be subject to recoupment.

When a program's identified trends and patterns for out of compliance items or areas needing improvement are not responding to the program's written POC, QI may issue a POC to the program's Legal Entity. This POC to the Legal Entity will include a description of the noncompliance categories, history of program's POC actions, and statement of minor to no improvement having been made. QI may recommend identified interventions or process changes to be implemented. If a POC is issued to a Legal Entity, the following will also be notified: County Contracts Unit, County Executive Management, and County Program Monitor/COTR. Failure to respond adequately and in a timely manner to a request for a POC may result in a withholding of payment on the claims for non compliance and could result in putting the contract at risk.

Medical Record Reviews

The MHP mandates site and medical record monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate levels of service. The Quality Improvement Unit conducts program site and medical record reviews. Site visits and medical record reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and medical record review tool is distributed to the Program Manager prior to the scheduled review.

Organizational Providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

During the medical record review, a Quality Improvement Specialist will review clinical records for items such as:

- Assessment/Appropriateness of Treatment
- Evaluation for co-occurring substance use issues
- Medical Necessity
- Clinical quality
- Client Treatment Plan and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance for County providers
- Implementation of transition issues when applicable
- Care Coordination
- Discharge

Medi-Cal Recoupment and Appeals Process

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of the County of San Diego Mental Health Services to potentially disallow billing by Organizational, County, Individual and Group providers that do not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current *California State Department of Mental Health Reasons for Recoupment of Federal Financial Participation Dollars, Non-Hospital Services* (*see Appendix G. G.2.*)

Per the current California State DMH Reasons for Recoupment of FFP Dollars, CMHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes.

Located in *Appendix G. G.2* is the complete listing of **recoupment criteria** based on the above categories. Organizational and County providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

All programs, regardless of funding source are subject to corrective action for items found not in compliance on the Medical Record Review tool. **Only Medi-Cal claims are subject to fiscal recoupment.**

At the conclusion of each medical record review, the provider will receive a Medi-Cal Recoupment Summary listing all disallowed billings based on the DMH reasons for recoupment

criteria. If the provider disagrees with a Medi-Cal recoupment, CMHS Quality Improvement Unit has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their first or second level appeal in writing to the Quality Improvement Unit within required timelines. Located in ***Appendix G. G.3*** is the complete description of the **step-by-step appeal process** with timelines for first and second level appeals.

Actions Regarding Reasons for Recoupment

The MHP will perform all required service deletions at the time the results of the medical record review are considered final, i.e. after completion of the appeal process or provider's decision not to appeal. These specific service deletions are not to be done by the provider. There are, however, actions regarding the reasons for recoupment that the service provider is required to perform. On certain of the progress note reasons for recoupment, the provider must re-enter the service. Re-entry of the service deleted by the MHP will be re-entered as one of the following: billable service, non-billable service. This re-entry by the provider into InSyst may be performed at any time after the medical record review is considered final. Re-entry by the provider may occur even if the MHP has not yet performed the service deletion. Specific instructions on how each re-entry should be performed by the service provider are explained in the table "**Actions Regarding Reasons for Recoupment**" located in ***Appendix G. G.4***.

Under some circumstances, a provider will be directed to remove claims that are not subject to recoupment, yet identified as a non claimable service (e.g. services outside of the audit period which are not covered by a Client Plan). Provider is to remove claims as outlined in the Medical Record Review, confirming removal in POC response, or outline reason/rationale for not removing the identified claims.

Medi-Cal Certification, Recertification, and Annual Site Reviews

Provider's site must be Short-Doyle/Medi-Cal (SD/MC) certified prior to commencing services. Providers shall comply with all SD/MC requirements as delineated in the Managed Care Contract, the California Code of Regulations, Title 9, and California DMH Letters and Information Notices, etc. See Provider Contracting section for additional information about site visits.

Providers who bill for Medi-Cal services require a site recertification every three years, and upon any structural changes. Providers are responsible to inform the Program Monitor/COTR and Quality Improvement Unit prior to any planned moves or structural changes, or in the event of any unplanned events such as a fire which may lead to relocation or structural changes. In addition, the Quality Improvement Unit is responsible for completing annual site reviews for all providers. Annual site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, and store and dispense medications in compliance with all pertinent Federal and State standards. Certification, recertification and/or annual site visits may include review of the following:

- Compliance with all pertinent State and Federal standards and requirements including professional licensing and certification laws;
- Maintenance of current licenses, permits, notices and certifications as required;
- Any changes such as service location, legal entity, modes of services (day rehab, outpatient, case management), service functions (mental health, medication, crisis intervention, etc.) staffing ratios, and licensure/certifications;
- Operational policies & procedures;
- Compliance with the standards established in the Mental Health Services Quality Improvement Plan;
- Physical plant/facility requirements;
- Adherence to health and safety requirements;
- Adherence to requirements for insuring the confidentiality and safety of client records;
- Medication oversight;
- Cultural competence;
- Consumer orientation, including those with co-occurring disorders;
- Staff knowledge of current Organizational Provider Operations Handbook;
- Staff Training & Education;
- Client Rights, Grievance & Appeal Process, and Advance Directives;
- Availability of beneficiary materials.

In addition, program participation in the CADRE may also be monitored through annual site reviews (may be concurrent with QI site review). Programs shall also submit a quarterly monitoring tool, summarizing implementation of CCISC model, when applicable. This shall be submitted to the Program Monitor/COTR. Program Monitor/COTR may also conduct site reviews with priority elements in the Statement of Work and this manual.

Cited problems and areas of non-compliance from a site visit, certification, re-certification and/or medical record review are summarized into a report which is given to the provider, County QI Management, and the provider's Program Monitor/COTR. The MHP may require the provider to submit a Plan of Correction based on the areas of non-compliance. Providers have 14 days to submit a Plan of Correction in writing to the QI Unit. The QI Unit is available to providers to discuss problem areas, offer technical assistance/training, and develop Plans of Correction. The QI Unit reviews and approves Plans of Correction and verifies compliance achievement when indicated.

Medication Monitoring

State and County CMHS regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. Out of County Providers shall adhere to their own County's Medication Monitoring process. Current State Department of Mental Health (DMH) requirements for Medication Monitoring (MM) are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DMH,

Exhibit A, Attachment 1, Appendix A, B.4. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs prescribed
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and his/her degree of knowledge regarding management of medications.

Within the MHP system, open records of medication services for all County-operated and contracted programs are sampled on a 5% per annual basis.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility, using the Medication Monitoring Screening Tool. Psychiatrists may not review their own prescribing practices. If a variance is found in medication practices, a Medication Monitoring Feedback Loop (McFloop) form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval. Results of medication monitoring activities are reported quarterly by the 15th of each month following the end of each quarter to the QI Unit on the Medication Monitoring Committee Minutes form. All completed McFloop forms shall be sent to the QI Unit within 30 days of the reporting deadline for each quarter. *(The Medication Monitoring Screening Tool (Appendix G. G.5, Committee Minutes form (Appendix G. G.6 and McFloop form (Appendix G. G.7)*

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly report that includes results of screening and clinical review activities to the clinic program managers and the Mental Health Quality Improvement Unit.

The QI Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Council (QRC), Program Monitor/COTR, and County Pharmacy and Therapeutics Committee (P&T) quarterly. If a problematic trend is noted, the report is forwarded to the Medical Director for recommendations for remediation.

Storage, Assisting with Self Administration, and Disposal of Medications

Only authorized California licensed personnel within the scope of their practice and in accordance with all Federal laws and regulations governing such acts shall administer

medications. These licensed personnel include; physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses and licensed psychiatric technicians. In instances where clients must take medications during the provision of mental health services, and licensed personnel are not present, the following procedures shall be in place:

1) ***Storage of Medications***
   a) The client's parent/guardian shall bring in the prescribed medication which is packaged and labeled in compliance with State and Federal laws.
   b) Medications shall be logged in on the " Perpetual Inventory Medication Log" (See Attachment 25)
   c) All medications shall be stored in a locked, controlled and secure storage area. Access to the storage area shall be limited to authorized personnel only.
   d) The storage area shall be orderly, well lit and sanitary. It shall have the proper temperature, light, moisture, ventilation and segregation that is required by Federal, State and County laws, rules and regulations.
   e) All controlled substances shall be double locked for security and shall only be accessible to authorized personnel.

2) ***Assisting in the Self Administration***
   a) Careful staff supervision of the self administration process is essential. Program staff shall provide the individual dose from the packaged and labeled container for client to self administer.
   b) Staff shall record the self administration of all medications on the "**Perpetual Inventory Medication Log**." (*Appendix G. G.8*).

3) ***Disposal of Medications***
   a) Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal, or dispose of medications by placing them in biohazard sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport and disposal. Examples include: Stericycle 1 (866) 783-7422 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing in the trash are both prohibited under environmental and safety regulations.
   b) Disposal shall be documented and co-signed on "**Medication Disposal Log"** (*Appendix G. G.9*).

ACCESSIBILITY OF SERVICES

The provider is responsible for preparing and maintaining appropriate records on all clients receiving services in compliance with CCR, Title 9, Chapter 11 and 42 CFR guidelines. This includes on site and secure maintenance of a written Request for Services Log (located in *Appendix C. C.2*). At a minimum, the log must contain the name of the individual, the date of

the request, the nature of the request, the initial disposition of the request, and whether the request was routine, urgent or an emergency. County and Organizational providers are to retain log for a minimum of 5 years in the office, and 2 years off site (for a minimum total of 7 years).

The provider is expected to meet the MHP standards for access to emergency, urgent and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for triage, intake, assessment, and clinical evaluation.

Wait Times

Another measure of system efficiency is the amount of time that clients need to wait to receive services. County operated and designated County contracted organizational providers of outpatient assessments and medication evaluations report Wait Time information each month to CMHS. This information shall be reported on the Monthly Status Report to the Program Monitor/COTR, the Contract Administration Unit, and other designated staff. The procedure for calculating and reporting wait times shall be as specified by CMHS. The standard for outpatient waiting time is an average of 5 days or less across the system, and no more than 30 days per individual client. If a client is unwilling to wait as long as necessary in a given program, the program must refer to another provider (including emergency rooms, if needed) who can offer a more timely appointment. Requests for services must be logged on the Request for Services Log. (*Appendix C. C.2.)* The Wait Time (for both Mental Health and Psychiatric Assessments) is defined as the time between the initial contact from a new client requesting services until the first *available* appointment.

Wait Time benchmarks have been established for each outpatient program based on historical data. Wait Times are monitored by CMHS, and any program that consistently exceeds its Wait Time benchmark will be required to submit a quality improvement plan.

Wait Times for Emergency and Urgent Services:

- Any client who needs emergency service shall have his/her needs addressed within one hour.
- Any client who meets the criteria for needing "urgent" services shall be seen within 72 hours. Any client being discharged from a psychiatric hospital facility, or who calls for services and is screened as needing services urgently meets the "urgent" criteria and shall be seen with 72 hours.

CLIENT AND PERFORMANCE OUTCOMES

In April of 2004, the Mental Health Board adopted new outcome measures for Children's Mental Health programs. These measures include the Child and Adolescent Measurement System (CAMS) and the Family Centered Behavior Scale (FCBS). The outcome tools measure the effectiveness and appropriateness of County funded Children's Mental Health programs. Section M details the system-wide outcome measures for CMHS. Additional performance requirements are described in that section.

Some data is obtained via the InSyst system. Other data is manually collected by providers and submitted in the Monthly Status Report. The data is useful in determining trends and patterns in service provision and demand, as well as identifying opportunities for improvement.

Monthly Status Report (MSR)

Providers are required to submit a monthly status report which gives the MHP vital information about provider services. All sections of the report must be completed. Instead of twice yearly reports on staffing for cultural competence, the new form includes a place to report monthly on staffing and training. This report form is updated periodically in accordance with changing State, Federal and County regulations. **A current sample of the MSR form** is included in *Appendix G. G.13*.

Client Outcomes

In conjunction with new State and Federal mandates to show program effectiveness and client progress, the MHP is extending the Client Outcomes tracking to all programs. **See section N – Data Requirements and Section A – Systems of Care for client outcomes indicators determined by the MHP.**

Participating programs shall report their outcomes data on the *Monthly Status Report* according to defined timelines. The Program Monitor/COTR will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QI unit will track trends for the data provided on the MSR. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by contacting your Program Monitor/COTR and/or Child and Adolescent Research Center (CASRC).

Mental Health Services Act (MHSA) Outcomes

Under the MHSA in San Diego, new programs are being started while others are expanding. As the MHSA is implemented across the State, new requirements for outcome reporting are anticipated to document how these funds are changing the lives of mental health clients. Providers receiving MHSA funding will be responsible for complying with any new requirements for additional outcome data. Currently, programs that have entered into Full Service Partnerships under the MHSA are required to participate in a direct State data collection program which tracks initial specialized client assessments, ongoing key incident tracking, and quarterly assessments.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term study which includes a commitment to improving quality through problem identification, evaluating interventions and making adjustments as necessary. It

may provide support/evidence for implementing protocols for "Best Practices". Progress on each PIP is evaluated annually by the External Quality Review Organization (EQRO), an independent State contracted organization.

The MHP may ask for your involvement in the PIP by:

- Implementing current PIP interventions/activities/procedures at your programs
- Supporting survey administration and/or focus group coordination at your programs
- Developing your own program's PIP projects

Serious Incident Reporting (Unusual Occurrences)

An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County program, client, or community. Unusual occurrences are categorized as follows:

- Adverse drug reaction resulting in severe physical damage and neurological, respiratory and/or circulatory difficulties requiring medical attention.
- Suicide attempt resulting in severe physical damage and neurological, respiratory and/or circulatory difficulties requiring medical attention.
- Medication error resulting in severe physical damage and, neurological, respiratory and/or circulatory difficulties requiring medical attention.
- Injurious assault on a client occurring on the program's premises resulting in severe physical damage and, neurological, respiratory and/or circulatory difficulties requiring medical attention.
- Injurious assault by a client occurring on the program's premises resulting in severe physical damage and, neurological, respiratory and/or circulatory difficulties requiring medical attention.
- Serious physical injury occurring on the program's premises resulting in a client experiencing severe physical damage and, neurological, respiratory and/or circulatory difficulties requiring medical attention.
- Serious property destruction on the program's premises, or any major accidents.
- Use of physical restraints (excluding ESU).
- Felony arrests or convictions, as well as police involvement including PERT 5150.
- Death of a client, excluding natural causes.
- Others such as epidemic outbreaks, poisonings, fires, AWOL, and inappropriate sexual behavior.

<u>Notification to Agencies for Safety and Security Purposes</u>

When unusual occurrences are identified, the appropriate agencies will be notified within their specified timeline and format:

1. Children's Services Bureau Hot Line for child abuse reporting and injuries.
2. Intended victim and law enforcement, for Tarasoff reporting.

3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.
4. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Notification by County and Contract Programs

County-operated or contracted Children's Mental Health program providers are required to complete the Unusual Occurrence Report when any unusual occurrences occur. An Unusual Occurrence Report shall be retained in an administrative file by the facility for a minimum of three years. (See *Appendix G. G.11* for the **Unusual Occurrence Report Form**.)

The Unusual Occurrence Report shall be faxed within 24 hours (or upon the resumption of business hours of the County Office) to the Program Monitor/COTR.

The Program Monitor/COTR shall forward all Unusual Occurrence Reports to the Quality Improvement Unit which will retain all copies for tracking and evaluating purposes.

The following providers who serve the client involved in the unusual occurrence shall be **notified** within 24 hours (or upon the resumption of business hours of the County Office) when an Unusual Occurrence Report is completed. The Unusual Occurrence Report only needs to be forwarded upon request. This includes but is not limited to:

- Mental Health Case Manager
- Children's Services Bureau social worker
- Probation Officer
- Regional Center Case Manager
- Special Education Services (SES) Case Manager
- Therapeutic Behavioral Services (TBS) – Both County and Contractor
- When SES and/or TBS are involved, the following additional issues require an Unusual Occurrence Report to be completed by the observing provider within 24 hours (or upon the resumption of business hours of the County Office) and forwarded to the Program Monitor/COTR. All Case Management programs that are serving the client shall be **notified** of the unusual occurrence within 24 hours (or upon resumption of business hours of the County Office).

  1. A school suspension
  2. A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
  3. A referral for acute psychiatric hospital care

4. An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
5. A significant problem arising while TBS worker is with the child

Major Unusual Occurrence Reporting

In the event of *any* physical injury resulting in a client experiencing severe (serious or grievous) physical damage, loss of consciousness, respiratory or circulatory collapse, death, or any other unusual occurrence that may indicate potential risk/exposure for the County program or community (e.g. serious suicide attempt, severe arson, shooting), the County Program Monitor/COTR shall be notified by telephone and in writing by using the "Unusual Occurrence Report" form (fax preferred) within 24 hours (or upon resumption of business hours of the County Office). This type of incident may trigger the quality review process.

The County Program Monitor/COTR will determine the appropriate method of investigation within thirty (30) business days and notify the Program Director if an ad hoc major unusual occurrence committee is required. Depending upon the nature and seriousness of the incident, the County may choose to:

- investigate the incident itself, or
- oversee the program provider's investigation with an ad hoc Major Unusual Occurrence committee

Major Unusual Occurrences Ad Hoc Committee

When the County Program Monitor/COTR determines that the nature and seriousness of the occurrence warrants the formation of an ad hoc unusual occurrence committee, the following steps shall be followed:

1. Ad Hoc Committee members shall be designated by the Program Director and shall convene within three (3) business days from the date of notification by the Program Monitor/COTR to review the major unusual occurrence.
2. The committee will summarize findings, draw conclusions, make written recommendations and determine appropriate action plans utilizing the **Major Unusual Occurrences Review Summary** form. (See *Appendix G. G.12*)
3. The completed **Major Unusual Occurrences Review Summary** form shall be forwarded within two (2) business days of the convening of the committee to the County Program Monitor/COTR, Children's Mental Health Administration and County Quality Improvement Department.
4. County Mental Health Administration and the County Program Monitor/COTR may recommend areas for improvement and/or corrective action.

Quality Review and Improvement Process

County Children's Mental Health Administration shall review and/or report all occurrences that may be potential quality of care concern to the following as required:

- County Counsel
- Patient Right's Advocate
- Center for Consumer Health, Education and Advocacy (CCHEA),
- District Attorney's Office
- Attorney General's Office
- Mental Health Board

1. The County Program Monitor/COTR and Quality Improvement Unit shall monitor all unusual occurrences and major unusual occurrences. One hundred percent (100%) will have appropriate disposition and resolution.
2. The County Program Monitor/COTR, Quality Improvement Unit and Quality Review Council shall review unusual occurrence issues and may recommend areas for improvement and/or corrective action.

QUALITY REVIEW COUNCIL (QRC)

The Quality Review Council (QRC) is a collaborative group that is chaired by the MHP Clinical Director and consists of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss and make recommendations regarding quality improvement issues that affect the delivery of services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, please contact the QI unit at (619) 563-2771.

H. CULTURAL COMPETENCE

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's demographic dynamics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2000 United States Census reports that racially and ethnically diverse groups comprised 25% of the total population, with continued growth expected. The demographics for San Diego County reveal magnification of that trend. According to the San Diego Association of Governments (SANDAG) growth forecast, ethnically diverse populations will increase from 40% of the population of San Diego County in 2000 to 51% in the year 2020.

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The child population is the most rapidly increasing portion of the population. The number of older adults living in San Diego is also growing, with 18% of the target population being 56 plus years of age.

Cultural Competence Plan

To address these issues in the 2003-2004 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

1) Conduct an ongoing evaluation of the level of cultural competence of the mental health system, to be based on an analysis of gaps in services that are identified by comparing the target population to provider staffing
2) Investigate possible methods to mitigate identified service gaps
3) Enhance cultural competence training system-wide
4) Evaluate the need for linguistically competent services through monitoring usage of interpreter services
5) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs
6) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable

about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region. Providers are to adhere to the current Culturally Competent Clinical Practice Standards.

Clinical Practice Standards:
The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS were originally written in 1998. These standards have now been revised by the Cultural Competence Resource Team (CCRT) in order to ensure that the Clinical Practice Standards would: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The revised standards are as follows:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.
10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.

13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
14) Staff actively seeks out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Staffing Requirements:
To support the cultural competence standards, providers are required to take the following steps:

1. Develop policies and procedures that support culturally competent services and provide training to staff.
2. Include questions regarding experience in working with ethnic/minority clients, and/or culture communities in job applications for direct service or interpreting positions.
3. Require that at a minimum, all provider staff, including support staff dealing with clients or anyone who provides interpreter services, must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, review of published articles, web training, viewed videos, or attended a conference can count the amount of time devoted to cultural competence enhancement. A record of annual minimum four hours of training shall be maintained at the program site.
4. Train direct services staff on MHP Cultural Competence Clinical Practice Standards and establish a process for monitoring adherence to the standards.
5. Establish a method or process for ensuring that staff who indicate they are bi/multi-lingual have the language capability to appropriately communicate ideas, concerns, and rationales.
6. Establish a method or process for ensuring that staff who indicate they are bi/multi-cultural have knowledge of culturally appropriate evaluation, diagnosis, treatment, referral resources, and familiarity with culturally variant beliefs regarding mental illness.
7. Staff shall reflect the specific cultural patterns of the region.
8. Providers are to recruit staff who can meet the language needs of their clients.
9. Contractor shall ensure that program staff is knowledgeable of the culturally diverse backgrounds of the clients.
10. Contractor shall provide a Human Resource Plan that includes how contractor will recruit, hire and retain bilingual and culturally diverse staff.

Specific Contract Requirements

- Contractor shall provide all services to meet the cultural and linguistic needs of the region.
- Outreach strategies and efforts furthering cultural competence shall be reported in the Monthly Status Report.
- Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County.

- Contractor shall submit cultural competence staffing and training information on the Monthly Status Report using format specified by CMHS. (See Monthly Status Report Form in *Appendix G. G.13*)

Cultural/Ethnicity Requirements:
Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers.

Language Requirements:
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free language assistance services. When provider does not have specific language capability, they shall arrange for appropriate interpretation services through a County contract (see section I under Language Assistance for details). All efforts shall be reflected in the assessment, client plan, progress notes, and discharge summary of client's medical record. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available (for example via the AT&T line) to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the ESU, and the Center for Community Health Education and Advocacy are Mandated Key Points of Entry for all threshold languages (currently English, Spanish, Vietnamese, Arabic, and Tagalog).

All other County and Contracted providers must at a minimum be able to link clients and families with appropriate services that meet the clients/caregivers language needs whether the language is a threshold language or not.

Facility Requirements:
The program site shall demonstrate cultural competence and be appropriate to the various age groups being served by providing culturally competent materials, brochures, posters and other information. In order to present a welcoming environment to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and

linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Additional Program Recommendations

Programs are encouraged to do the following:

1) Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, assess community needs and what efforts the program is making to meet those needs. Recommended topics to cover in the survey or focus group are:
   - Regarding Language:
     - Offers of providers who speak the client's language, or interpreter services
     - Linguistic proficiency of staff providing services or of interpreter if one is used
     - Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language
     - Availability of written materials, including alternate formats in client's preferred language
   - Regarding Cultural/Ethnicity:
     - Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment
     - Direct services staff's knowledge of culturally appropriate referral resources
     - Direct services staff's familiarity with variant beliefs regarding mental illness
     - Appropriateness of clinic environment
   - Results shall include outcomes, findings, and plans for interventions as needed.
   - The County can provide technical assistance with developing survey/focus group questions.
2) Conduct a survey or focus group at least once and periodically if needed in the community to assess broader cultural competence issues that may be creating barriers to services.
   - The County can provide technical assistance with developing survey/focus group questions.

Monitoring Cultural Competence

The MHP QI Unit is responsible for monitoring compliance with cultural competence standards as outlined in the County's Cultural Competence Plan, submitted to the State Department of Mental Health as part of the overall Mental Health Plan requirements. The QI Unit utilizes both the medical record and site review process to monitor providers regarding cultural competence. To assist in the assessment of the cultural competence of staff system-wide, providers are required to report the cultural and linguistic background of all staff members in the Monthly Status Report (MSR) including experience and training with any diverse population so that QI may compare the availability of staff to target population. In addition, the MHP may choose to periodically administer a Cultural Competence Survey.

I. MANAGEMENT INFORMATION SYSTEM

InSyst ®

The San Diego County Mental Health Plan (MHP) currently uses the InSyst system to register clients into the mental health system and to record each client's episode of service activities. The InSyst system also tracks Short-Doyle/Medi-Cal, MHSA, SB90, AB2726 and third-party billing. The MHP contracts with the UBH MIS Department to support and maintain the InSyst system.

Using the InSyst system, organizational providers enter the data for client registration, episode and service activity on line. InSyst performs various validations to assist with accurate data entry: for example, InSyst will show a provider if a client being registered is already open in that provider's program, and will indicate whether a particular staff member is qualified to bill for a specific service. InSyst can provide the following client tracking and billing information to authorized users 24 hours a day, seven days a week:

- On-line Client Locator
- Instant Client Status Information
- Medi-Cal Eligibility Inquiry
- Client Registration
- Service History Inquiry
- Utilization Review
- "Significant Other" Tracking
- Financial Information and UMDAP (Uniform Method for Determining Ability to Pay) Tracking

The InSyst system supports on-line financial assessments. It will perform Medi-Cal, Medicare, third party insurance, and client billing functions as well as electronic payment processing and many accounts receivable tasks.

The InSyst system resides on a VAX 7820, which is housed in a secure computer room at the office of the County's Information Services vendor.

Provider Support through UBH Customer Service (Help Desk) for InSyst

MHP Organizational Providers can obtain support for InSyst through the UBH MIS Customer Service Desk (Help Desk). The Help Desk can assist a provider with technical support or special requests and may be contacted as follows:

Phone: 619-641-6928
Fax: 619-641-6975

Emails: helpdesk@sdubh.com

All requests received by the UBH MIS Help Desk are logged and a Technical Support Specialist will be assigned to follow up on each provider request.

Help Desk support is available as follows:

During Business Hours

Normal business hours: Monday through Friday, from 8 a.m. to 5 p.m**.** (Holiday coverage is detailed below.)
Staff is available to handle problems, which include:

- Password expired; cannot log on to system
- Printer won't print a face sheet or a report
- Cannot obtain reports
- Need to use a different printer
- Creation of new user accounts
- Training issues and questions

After-Hours Support
UBH provides after-hours technical support for InSyst users. UBH MIS staff is available through a voice messaging pager system, which allows a caller to leave a detailed message for the support center. The pager system is operational on the following schedule

Monday through Friday: 6:30 a.m.- 8:00 a.m. and 5:00 p.m.- 9:00 p.m.
Saturday and Sunday: 9:30 a.m.- 5:00 p.m.

The customer service pager number is: 619-893-4839

Some examples of support calls that may be handled after hours are:

- Can log on to network, but cannot log on to DOC or InSyst.
- When dialing the County modem, there is no response or the modem disconnects immediately.
- Logged in, but InSyst seems frozen. No data can be entered.
- Program errors in Service Entry screen or other data entry areas.

Emergency-Only Support

In some rare instances, providers may have serious problems with InSyst after hours, revealing an emergency situation, which affects all users. (Individuals or organizations experiencing a problem unique to their site must seek assistance from their technical support department, since UBH cannot support any non-UBH equipment.) Such emergencies may include:

- InSyst application failure – application is not available or system error messages indicate a fatal error
- Operating system failure
- VAX system hard disk failure; need to restore from backup

Journaling files or database files are corrupt

In such an emergency, contact the Customer Service through its pager number 619-893-4839.

Holiday Support

Provider support is available through the pager system for emergency problems which occur on the following holidays: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and the day after, and Christmas Day. Please note that when holidays fall on a Saturday, they will be observed the preceding Friday and when holidays fall on a Sunday, they will be observed the following Monday.

Connecting to the System

Most County-operated facilities have a direct connection to the VAX via the County's INET. Several larger contractors have dedicated data lines that support continuous connection to the VAX. However, most MHP organizational provider contractors connect to the VAX and log on to InSyst via dial-up modem connections or Remote Access Server (RAS) connections. The County's information services vendor has established both telephone and access code numbers for this purpose.

Note: New providers should contact the UBH MIS Help Desk at 619-641-6928 to determine their best dial-in solution and to establish the appropriate access codes.

System Training

Training is available for providers who use the InSyst system. InSyst data entry and look-up training is offered monthly and reports training or special module training is also available. For training inquiries, please contact UBH MIS at the above numbers. Users may also access: http://www.ubhpublicsector.com/sandiego/sdmishelp.htm to see the latest training schedule.

Note: Users must apply for or have an InSyst user account to attend InSyst basic training.

System Authorization

The County's Health and Human Services Agency (HHSA) Information Technology System Security Department coordinates access to the agency's computer systems. Since the InSyst system is the County's mental health database and resides on a County computer network operated by the County, the System Security Department must authorize all requests for user access. Providers who need access to InSyst must complete the following forms to establish a User Account:

- Computer Services Registration Form
- Remote Access Form—for modem users only
- Confidentiality Policy (included in County Summary of Policies)
- InSyst User Authorization Form (for UBH)

The forms are processed by the County's information services vendor in coordination with the County's Internal Security to set up the VAX user account and AS5200 (Secured Modem) user account. The vendor or Internal Security notifies UBH who then creates a user account for the new agency within InSyst. The vendor or Internal Security then calls the provider and informs them that the account has been set up and presents the provider with their user name(s) and password(s). Forms can be obtained by contacting the UBH MIS Help Desk at 619-641-6928, and completed forms can be mailed or faxed to UBH for processing at the following address:

UBH MIS
3111 Camino Del Rio North, Suite 500
San Diego CA 92108
Fax 619-641-6975

NOTE !

For system security, providers must notify UBH when staff with access to InSyst move, change jobs, or are terminated.

Users are given general lookup privileges for client, episode, and service information. However, data entry and update privileges for specific reporting units must be authorized by the user's program director.

Clinical Staff Profiles

Each person whose services or Medial Administrative Activities (MAA) Activities are recorded through InSyst must have a Staff Identification Number. This number is tied to a profile specifying the training and duties of the staff person to whom it belongs. The information is used in determining whether a given activity may be billed if provided by that

staff member, e.g., certain procedure codes may be used only by Physicians, some only by Psychologists and Interns, others by All Licensed and Waivered staff, and others by All Staff. As a consequence it is essential to update the profile when a staff member's status changes, for example when a waivered intern becomes licensed. Requests for Staff Identification Numbers are made to UBH by the organizational provider program employing the individual, and UBH will seek approval of the application from the Program Monitor/COTR. Download the form, "New Staff Provider Assignment Form" from the UBH Website at http://www.ubhpublicsector.com/sandiego/sdmis.htm. UBH must also be informed when staff member leaves your program.

Security and Confidentiality

The County's mental health database must be protected from unauthorized use. Providers must ensure that only users with "need to know", who have signed confidentiality statements, are permitted to use the database. Sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. All terminals, computer screens, printers, fax machines and other electronic devices must be protected from the view of unauthorized persons. Reports with confidential client information are required to be stored in a secure place and properly destroyed when no longer needed.

In order to preserve the integrity of InSyst, providers must notify UBH Help Desk (619-641-6928) when a person with InSyst access moves, is terminated, or changes jobs. The InSyst User Authorization Form and the Computer Services Registration Form must be faxed to the UBH Help Desk 619-641-6975 with the "Terminate" box checked off. UBH will remove the person's InSyst access and add the replacement's name. UBH will also notify the vendor to have them 'deactivate' the accounts.

User Manual and Reports Manual

Every program using the InSyst system is expected to maintain updated copies of the UBH InSyst User Manual and the UBH InSyst Reports Manual. These manuals were given to all contracted organizational providers and County-operated facilities during system implementation. New programs coming online, or existing programs with a need for new manuals, may obtain them online or request them by calling 619-641-6928.

The appendices to the User Manual contain important information related to data codes allowed by the system. These appendices are updated from time to time and are available to providers at the UBH Website: http://www.ubhpublicsector.com/sandiego/sdmishelp.htm . Managers must ensure that the updated appendices are inserted in the User Manual and that staff is informed about the changes.

Contractors shall follow billing procedures contained in the organizational Provider Financial Eligibility & Billing Procedure manual.

InSyst Reports

A number of reports may be generated directly from the InSyst Reports Menu and printed at local or remote printers. Most reports may be requested directly from the system by authorized system users, while other InSyst reports are generated by UBH MIS personnel and distributed to the programs on a monthly schedule. Some of the most frequently used InSyst reports available to programs are listed below. Please note that some reports require a significant block of time to run, which can slow system performance if run during the business day; these reports should be run after hours, as noted in the "When Run" column.

Report Number	Report Name	When Run	Notes
PSP100	Primary Staff Caseload Report	After 5:30 P.M.	This report shows clients assigned to a caseworker and identifies if the client is also open to another program. Some users prefer the less detailed MHS802 report.
PSP101	Service Detail Report	After 5:30 P.M.	This is the standard Service Detail Report. This report sorts by staff and includes demographic and diagnostic information. Many users prefer the less detailed MHS801 report.
PSP102	Daily Service Audit Report	Immediat ely	This report may be run for one day at a time. The report shows all services entered for a specific day
PSP104	Indirect Services	Immediat ely	Use this report to monitor Medi-Cal Administrative Activities (MAA).
PSP117	Provider Staff Activity Analysis Report	After 5:30 P.M.	This report may be used to see the hours of service provided by staff.
PSP118	Client Episode History Report	Any Time	See InSyst Reports Manual.
PSP119	Absence of Service Report	After 5:30 P.M.	This report may be used to see clients open to a program who have had no service since a target date

Report Number	Report Name	When Run	Notes
MHS 120	Morning Report	After 5:30 P.M.	This report is produced automatically by the system every morning and distributed to programs whose clients have been admitted to a hospital, crisis house, EPU, ESU Forensic program, etc.
PSP121	Program Caseload Report	Immediat ely	This is an alphabetical roster of all clients open to a program. It is a snapshot report for the day the report is run..
PSP123	24-Hour Daily Attendance Log	Any Time	See InSyst Reports Manual.
PSP131	Reporting Unit Service Summary Report	After 5:30 P.M.	This report provides a summary of service provided by a program sorted by procedure code. The report includes a count by procedure code and hours provided. Some users prefer the MHS831 created by UBH
PSP138	Service Entry Performance	After 5:30 P.M.	This report may be used to see the lapsed time (in days) between the service event and the data entry into the system
MHS140	Client Information Face Sheet	Immediate ly	This is the standard client face sheet which shows client information, episode history, diagnosis, last service date, care coordinator and other staff assigned to the case among other information.
PSP186	Missing Social Security Number	Any Time	See InSyst Reports Manual.
MHS164	Liability Due Report	Submitted Monthly by UBH	This report lists clients who should be reviewed to determine their liability. It lists clients with open episodes who have received services in the past 90 days and whose liability period will ex pire within a specified number of days from the run date, or whose

			liability has expired and the been replaced by a rollover liability. This report is distributed by MIS and is directed to go to the program's default printer.
	Unbilled Medicaid Services	After Hours Monthly	See InSyst Reports Manual. Day Programs may use this report to see unauthorized services. This report is distributed by MIS and is directed to go to the program's default printer.
	Accounts Needed	After Hours Weekly	See InSyst Reports Manual. This report is distributed by MIS and is directed to go to the program's default printer.
	Staff Caseload Summary Statistics	Submitted Monthly by UBH	The report shows the caseload by staff at the beginning of the period, cases added, cases closed and ending caseload. The report also shows the unduplicated count of clients served, units of service and time provided.
PSP280	Physician Caseload Report	Immediate ly	This is the caseload report by physician for a program. The report is similar to the PSP100
PSP577	Insurance Approval Report	After Hours Monthly	This report is distributed by MIS and is directed to go to the program's default printer. The report helps staff identify insurance policies that need attention in InSyst.
MHS800	Episode Face Sheet	Immediate ly	This face sheet shows the detail of a client's episode.
MHS801	Service Detail Report	After 5:30 P.M.	This report is sorted by client and has less demographic and diagnostic data than the PSP101

MHS802	Primary Staff Caseload Report	After 5:30 P.M.	This report shows less detail than the PSP100.
MHS804	Staff Service Detail Report	Any Time	Use this report to review the activity of one staff at a time. To review the activities of the entire staff, use the MHS801 or PSP101.
MHS807	Admits & Discharges Report	Any Time	Users may run this report to show admissions and discharges at their program during a given period of time.
	Program Caseload Report for CSI Required Data	After Hours	Users may run this report to review caseload for CSI required data elements. The report is used as a tickler to remind program staff to update required data in InSyst.
MHS831	Service Summary Report	After 5:30 P.M.	This report is similar to the PSP131 but includes a column for total time in minutes. This report also calculates group size, including the number of staff assigned to the group, to determine total hours for group procedure codes. UBH distributes this report on the 1st and 7th of each month.
			This report shows all services that could have been billed to Medicaid but were not, either because there was not a current Utilization Control Authorization, or because there was no medical necessity.
	Annual Review Report	After Hours	This report is submitted by MIS and directed to the program's default printer. The report is used as a tickler to remind program staff to update required data in InSyst.

Note: If you do not see one of these reports on your Reports Menu and you wish to receive it, please call the UBH MIS Help Desk at 619-641-6928.

NOTE: Failure to receive an InSyst report (including client Face Sheets), password resets, training questions or scheduling are not considered an emergency and will be handled the next business day.

Other Reports

UBH produces many other reports that are made available to programs via the Internet. Some of these reports include:

- Report 4a – Medi-Cal Claims Summary Report
- Report PSP354 – Units of Service Report
- Report PSP356 – Cost Report (Medi-Cal Units Report)
- Report MIS-6 – Admissions, Discharges and Census Report
- Provider Tracking Report

Users may visit the web site at:
http://www.ubhpublicsector.com/sandiego/sdprovreports/sdoprpts.htm
Note: A username and password is required to download the reports from the website. Users may contact 619-641-6928 to obtain a password and directions.

J. PROVIDER CONTRACTING

Note: References to contracting do not apply to County-operated programs.

All Medi-Cal providers shall adhere to the Managed Care Contract executed between San Diego County and the California State Department of Mental Health. As outlined in that contract, Medi-Cal contractors are prohibited from subcontracting with a "legal entity" as defined in the California State Medicaid Plan for Short-Doyle/Medi-Cal services. The California State Medicaid plan defines legal entity as each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency. The prohibition on subcontracting does not apply to providers and their relationships with vendors such as nursing registries, equipment, part-time labor, physicians, etc. Such providers do not meet the legal entity definition cited above. The legal entity concept prohibits a county from contracting with a legal entity to provide Short-Doyle/ Medi-Cal services that in turn contracts with another legal entity to provide Short-Doyle/Medi-Cal services.

All non-County-operated organizational providers must contract with the County of San Diego in order to receive reimbursement for Specialty Mental Health Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Budget schedules; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds.

All contracted providers will be expected to adhere to these requirements. Please contact the Mental Health Services Contract Administration Unit (CAU) at 619-563-2733 if you have any questions regarding your contract.

NOTE!

Please read your contract carefully and keep it in a place where you can refer to it easily.

If you have any questions regarding your contract, please contact the Mental Health Services Contract Administration Unit at 619-563-2733.

Program Monitoring

Each provider will have assigned to their program a Program Monitor (also known as Contracting Officer Technical Representative – COTR), who will monitor compliance with outcome measures, productivity requirements and other performance indicators, analyze reports from providers, and provide programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/COTR's hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COTR.

Contractor Orientation
All new contracts require a contractor orientation meeting within 45 days of contract execution. Agency Contract Support shall, in conjunction with the Mental Health Contract Team, be responsible for contractor orientation. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation.

Notification in Writing of Status Changes
Providers are required to notify the Mental Health Services (MHS) Contract Administration Unit (CAU) COTR and QI in writing if any of the following changes occur:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to CAU);
- Additions or deletions from your roster of Medi-Cal billing personnel (only to CAU); or
- Proposed change in Program Manager or Head of Service.

Site Visits
The County MHP will conduct, at a minimum, an annual site visit to all organizational providers. The County MHP includes MHS Program Monitor/COTR/Designee, MHS CAU, MHS Quality Improvement (QI) Unit, and the Health and Human Services Agency (HHSA) Contract Support. The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Client medical records (where applicable);
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure and certification documentation;
- Fiscal and accounting policies and procedures;
- Compliance with standard terms and conditions.

Information from the site visit will be included in the contract monitoring process. For Medi-Cal providers, the site review is due at least annually. When a re-certification is due, the annual site review will be completed with the re-certification. Please see the *Quality Improvement Program* section of this handbook for a more detailed discussion of Medi-Cal provider site visits.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COTR or Designee within 2 work days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Corrective Action Notice
Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Monthly Status Reports
Contracted providers are required to submit a completed Monthly Status Report (MSR) within 15 calendar days after the end of the report month. The MSR includes the NOA Log and Suggestion / Provider Transfer Request Log. Twice yearly, in July and December, the County submits a Cultural Competency Report to the State by extracting information provided on the MSR from the Staffing and Personnel as well as Training section of the MSR. Please see the attachments to the Handbook for sample of the MSR.

Contract Issue Resolution
Issues, problems or questions about your contract should be addressed to your
Contracting Officer's Technical Representative (COTR) at their respective addresses.

Disaster Response
- In the event that a local, state, or federal emergency is proclaimed within San Diego County, contractors shall cooperate with the County in the implementation of the Mental Health Services Disaster Response Plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters and/or other designated areas.
- Contractor shall provide CHMS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.

Contractor shall identify 25% of direct service staff to receive Disaster Orientation Training by the County in 2007. The identified staff will be added to the Disaster roster maintained by the County for possible deployment in critical incidents.
Contractor shall advise COTR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover.

Transportation of Clients
Contractors shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego.

CLAIMS AND BILLING FOR CONTRACT PROVIDERS

Contractor Payments

Contractors will be paid in arrears. After the month for which service has been given, the MHS CAU will process claims (invoice) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)

- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures in the State of California, Department of Mental Health, Cost Reporting/Data Collection Manual, dated July 1989.
- Quarterly Cost Reports are due by October 31, January 31, April 30.
- Year-end Cost report is due by August 31.

Submitting Claims (Invoice) for Services

Please submit all claims (invoice) for payment to:

Mental Health Services
Contract Administration Unit (CAU) (P531K)
P O Box 85524
San Diego, CA 92186-5524
Fax: (619) 563-2730, Attn: Lead Fiscal Analyst

Overpayment

In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion

Beginning April 1, 2003, all claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment or exclusion from services. The details of this new procedure are laid out in the February 21, 2003, Letter from Health and Human Services Agency (HHSA) Contract Support and Compliance directed to all HHSA contractors.

In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employee professional licenses with both the Office of the Inspector General (OIG) and Government Services Agency (GSA).

To verify through the Internet if someone is on the OIG Exclusion list or the GSA debarment list, go to:
http://oig.hhs.gov/fraud/exclusions/listofexcluded.html

To view the list of what will get someone placed on the OIG list, go to:
http://oig.hhs.gov/fraud/exclusions/exclusionauthorities.html

Please remember the following:

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on either the OIG or GSA lists are prohibited from working in any County funded program
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

License Verifications
As of July 1, 2003 all HHSA contractors are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with Section 8.1 "Conformance with Rules and Regulations", 8.2 "Contractor Permits and Licenses" and 13.7 "Reports" of your contract(s). In order to ensure the license is valid and current, the appropriate website must be checked and documented.

SHORT-DOYLE MEDI-CAL

Per Cost Reporting/Data Collection Manual the "policy of the State Agency is that reimbursement for Short-Doyle Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMA), negotiated rates or actual costs if the provider does not contract on a negotiated rate basis."

I. Definitions

Provider means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.

Published Charge or Published Rate is a "term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance."
Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure the County's MIS has the accurate information as well as ensuring no potential loss of Medi-Cal revenue.

The published rate for a specific service should, at a minimum, reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue.
Published rates are to be submitted to United Behavioral Health and MHS CAU no later than June 14 of each year.

Statewide Maximum Allowances (SMA) are upper limit rates established for each type of service, for a unit of service. SMA is an annual rate for reimbursement of a SD/MC unit of service.

Negotiated Rate is a fixed prospective rate subject to the limitations of rate setting requirements.

Actual Cost is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR Part 413 and HCFA Publication 15-1.

Federal Financial Participation per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

II. Medi-Cal Revenue

MIS will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. For services that do not clear the billing edits, the State will issue Medi-Cal Error Correction Reports (ECRs) to the MHP's agent, United Behavioral Health (UBH). UBH will mail the ECRs to the appropriate providers. Providers need to make the necessary corrections to the ECRs and resubmit them to UBH within ten (10) business days at the following address:

UBH Financial Management Unit
3111 Camino Del Rio North, Suite 500
San Diego, CA 92108

III. *Medi-Cal Disallowance/Recoupment of Federal Financial Participation (FFP) Dollars*

Per the current California State DMH Reasons for Recoupment of FFP dollars, CMHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes.

Located in *Appendix G. G.2*, is the complete listing of recoupment criteria based on the above categories. Organizational providers shall be responsible for ensuring that all medical records

comply with federal, State and County documentation standards when billing for reimbursement of services.

The federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In accordance with State guidelines, these disallowances may be subject to future change.

Contractor shall reimburse CMHS for any disallowance of Short-Doyle/Medi-Cal payments, and reimbursement shall be based on the disallowed units of service at the Contractor's approved budgeted unit cost. The Federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In FY 04-05, the State announced that the State (non-Federal) share of EPSDT claims will also be subject to recoupment if any current or new recoupment criteria issued by the Department of Mental Health are met.

IV. ***Billing Disallowances – Provider Self Report***

The policy of San Diego County Mental Health Administration (SDCMHA) is to recoup Federal Financial Participation (FFP) and Early Periodic Screening and Diagnostic Treatment (EPSDT) dollars by disallowing billing which has been identified and reported to the SDCMHA by the Contracted Organizational Providers and County Owned and Operated Clinics in accordance with documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars."

PROCEDURES

The following are the procedures to be followed for Self Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Mental Health Administration by providers.

Provider Requirements

1. Providers are required to conduct internal review of medical records on a regular basis (i.e. monthly) in order to ensure that the documentation meets all County, State and federal standards and that billing is substantiated.
2. If the review of a Medi-Cal client's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal

Financial Participation Dollars" the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with SDCMH.

3. To file a self-report of billing disallowances with SDCMH providers shall fill out the Provider Self-Report Billing Disallowance and Deletion form (*Appendix J. J.3*) and e-mail the form to Mental Health Administration, Quality Improvement Unit (QI).
4. All services that are disallowed will also be deleted from Insyst. Providers are responsible for re-entering corrected service information for all billable and non-billable services for services that are identified as billing disallowances. Corrected service information may only be entered once provider has confirmed that the incorrect service has been disallowed and deleted.
5. Providers shall ensure that the services listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.
6. In order to remove billing from EPSDT review, providers must send the Provider Self-Report Billing Disallowance and Deletion form prior to receipt of notification that an EPSDT review has been scheduled for that provider. Items received less than 21 calendar days prior to the receipt of notification that an EPSDT review has been scheduled may not be fully processed and therefore may not be removed from the EPSDT review, and may still be subject to recoupment by DMH.

Contract Administration Unit Procedures

1. On a quarterly basis, the Contract Administration Unit staff (CAU) will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.
2. Within 90 days of the end of the fiscal year, CAU staff will ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.
3. Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.
   - If the contractor pays by check, the check is received by CAU staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
   - If no check is received by CAU within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Billing Inquiries

Questions regarding claims (invoice) for payment should be directed in writing to:

Mental Health Services
Contract Administration Unit (P531K)
P O Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Questions can also be addressed by calling the Lead Fiscal Analyst 619-563-2722.

K. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns or complaints to the Program Monitor/COTR or designee. The Program Monitor/COTR or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of complaint materials will be sent to the County Mental Health QI Unit.

If the provider is not satisfied with the result or the informal process or any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns or complaints to the MHS Contracts Manager or designee, using the Formal Complaint by Provider form (located in *Appendix K. K.2.*)
2. Written narration shall include all relevant data, as well as, attachment of any documents, which support the provider's issue(s).
3. Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
4. The Contracts Manager or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the Formal Response to Complaint form (see *Appendix K. K.3.*)
5. The written response from the Contracts Manager or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Problem Resolution documentation is to be directed to:

   Mental Health Services Contracts Manager
   P O Box 85524
   San Diego, CA 92186-5524
   Mail Stop: P531-K

7. A copy of all complaint materials shall be sent to the County Mental Health QI Unit.

Formal Provider Appeal Process

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. An appeal from Children's Mental Health services providers shall be submitted in writing, using the **Formal Appeal by Provider form** (see *Appendix K. K.4*), to the Assistant Deputy Director (ADD) for CMHS.
3. The Appeal Form shall summarize the issue(s) and outline support for appeal. Previous documents on the issue(s) shall be attached.
4. The ADD shall notify the provider, in writing, of the decision within 60 calendar days from the receipt of the appeal and supporting documents, using the **Formal Appeal Response form** (see *Appendix K. K.5.*)
5. The written response from the ADD shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Appeal documentation is to be directed to:

   Assistant Deputy Director of
   Children's Mental Health Services
   P.O. Box 85524
   San Diego, CA 92186-5524
   Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QI Unit:

   Quality Improvement Unit
   P.O. Box 85524
   San Diego, CA 92186-5524
   Fax: (619) 584-5018
   Mail Stop: P531-Q (Children)

Complaints and Appeals for Denial of Authorization or Payment for Services

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 authorization or a problem with processing of a payment, or a billing disallowance.

Providers appealing a denial of authorization or payment must submit a written complaint within 90 days of the receipt of the denial to their County Regional Coordinator/Program Monitor/COTR. The written complaint should include the client name, InSyst #, date of authorization/payment denial and/or dates of all service(s), along with any specific information relevant to the complaint. (See Authorization of Reimbursement for Services section of this Handbook for more information on denials.)

All such complaints will be logged and a response will be issued within 30 days about action or denial. At any time within 90 days of the original attempt to resolve the issue informally, providers may appeal any decision made by the Regional Coordinator by submitting an appeal to the County Mental Health Director or his designee. The appeal should include the client name, InSyst #, date of authorization/payment denial and/or dates of all service(s), along with a copy of the Program Monitor/COTR's letter of response. The County Mental Health Director or his designee will have 30 days to make a final decision on the appeal and respond back in writing to the provider.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.

L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. They are based on clinical consensus and research findings as to the most effective best practices and evidence-based practices available. Because they reflect current interpretations of best practices, the guidelines may change as new information and/or technology becomes available. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. Providers shall comply with standards as may be adopted by the Children's Mental Health Clinical Standards Committee. This Committee sets standards of care for Children's Mental Health within the county, develops system-wide guidelines, and includes representatives from County and Contract programs.

Comprehensive, Continuous, Integrated System of Care (CCISC) Model

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. Therefore, San Diego County has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) Model, which is an integrated treatment approach for individuals with co-occurring psychiatric and substance disorders. This model encourages programs to complete a Welcoming Statement as one of the first steps of becoming integrated. In addition, all clients must be routinely assessed for co-occurring disorders, and younger children may be impacted by substance use or abuse on the part of their caretakers. Be aware that some children in San Diego have been identified as beginning to use substances as early as age 6 and this must be assessed, particularly in high risk family situations. When serving a child, adolescent, or family that meets the criteria for co-occurring disorders these guidelines must be followed:

- Include substance use and abuse issues in your intake assessment and assessment updates, included on the Behavioral Health Assessment (MHS 650) & Behavioral Health Update (MHS 663), and also use any additional screening tools that may be adopted or required such as the CRAFFT.
- If both types of disorders are present in the client at diagnostic levels, list the mental health diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.
- Report substance use or abuse, including in a caretaker, in the Axis IV rating and/or in the Other Factor code in InSyst as appropriate.
- Treatment planning should deal with the substance use issue, either by referral or direct treatment. Even if the client or family is referred for substance abuse treatment, the client plan should document how that treatment will be coordinated or integrated into mental health treatment.

- Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use is in a collateral person, the progress note must focus on the impact of the substance use on the identified client. Though notes may focus solely on substance use in an EPSDT client, this is permissible only if treatment for the substance use disorder is not otherwise available. In most instances, it is preferable to approach the substance use in the context of the mental health disorder, and create an integrated note and treatment regime.
- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

CMHS dual diagnosis capable programs must self monitor their capability by using the COMPASS survey (for programs on an annual basis) and the CODECAT (for clinicians). Programs must have an identified lead and selected CADRE members available for trainings. Indication of designated staff and completion of surveys will be made on MSR's.
After a program completes the COMPASS, they must develop an action plan which incorporates:

- ✓ Screening
- ✓ Assessment
- ✓ Treatment Plan
- ✓ Progress Notes
- ✓ Discharge summary
- ✓ Medication planning when appropriate
- ✓ Referrals

Programs in the system are dual diagnosis capable, in that they address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning. In addition, there are some dual diagnosis enhanced programs that have a higher level of integration of substance abuse and mental health treatment services and provide treatment to clients who are more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder.

The MHP's Access and Crisis Line is also available for mental health and alcohol and drug services information and referral 24 hours a day, 7 days a week.

Drug Formulary for Mental Health Services

The Medi-Cal Formulary shall be adopted by all programs and physicians as the San Diego County Mental Health Services (MHS) formulary.

All clients, regardless of funding, must receive equivalent levels of care at all MHS programs. This includes the medications prescribed. The guidelines below will allow clinical discretion while including fiscal restraints in order to maximize available resources.

The criteria for choosing a specific medication to prescribe shall be:

1. The likelihood of efficacy, based on clinical experience and evidence-based practice
2. Client preference
3. The likelihood of adequate compliance with the medication regime
4. Minimal risks from medication side-effects and drug interactions.

If two or more medications are equal in their satisfaction of the four criteria, choose the medication available to the client and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication or the side-effect profile favors the brand name medication.

Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary. TARs are required for both Medi-Cal and non-Medi-Cal clients.

- County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication.
- Contractor operated programs shall develop an internal TAR process for dispensing non-formulary medication.

There shall be an appeal process for TARs that are not accepted.

Assembly Bill 2726

AB 2726 is a program designed to provide mental health services to special education students who need the services to benefit from their education. All AB 2726 services are provided on a voluntary basis. Students are eligible for services from three years old up to age twenty-two or until graduation. The students must have a mental health issue that prevents them from benefiting from educational services, and who do not respond to counseling provided by the school. School districts are responsible for the identification and referral for assessment of students who may require services under AB 2726. CMHS/AB2726 staff is responsible for providing a mental health assessment and referral to appropriate mental health services based on the results of the assessment.

Assessments, referrals, placement, and case management services are provided at the request and acceptance of the parents and are free of charge. Upon completion of the assessment, the mental health services that are the least restrictive and appropriate are identified on the student's Individualized Education Program (IEP). Possible recommendations for mental health services include outpatient, day treatment, residential, or no services. The Mental Health Treatment Plan developed by the assessor identifies the areas of need and establishes treatment goals. Upon parental acceptance of AB2726 services, the Mental Health Treatment Plan becomes part of the student's IEP and is included in the referral to the appropriate provider. Case management services for outpatient and day treatment students are provided by contractors while case management for residential students remains the responsibility of the AB2726 staff. Case management services are designed to promote access to educational, medical, social, pre-vocational, vocational, rehabilitative, or other needed community services for the eligible individuals by providing consultation, coordination, referral, and linkage.

All AB2726 mental health providers shall abide by the rules and regulations as set forth in the Local AB2726 Interagency Agreement and the California Education Code as related to Mental Health Services. If the County is required to pay for the cost of private treatment as a result of an AB2726 due process action where the Contractor has not complied with the AB2726 policies and procedures, Contractor shall reimburse the County for the cost of the private treatment paid by the County.

AB2726 Clients: Discharge

Discharge of may occur when a student has met the mental health IEP goals, a change in the mental health level of care may be indicated, or the client is refusing mental health services. The mental health program will coordinate discharge planning with the school district liaison(s) before providing any specific information to the client. Programs shall not discharge a student without requesting an IEP review. Discharge recommendations regarding need for mental health services will be developed in accordance with AB2726 guidelines and may require a request for reassessment through the IEP process. Stay put orders apply in cases of Due Process.

Any and all changes to the student's IEP must be reviewed by the IEP team members, which include at a minimum: a program clinician, the district of residence, and the client/parent. Discharge summaries shall clearly address student progress on IEP goals and other treatment issues.

AB 2726 Clients: Medication Monitoring

Medication evaluation and/or medication management services are provided under the required provisions of the AB 2726 program and are at no cost to the client/parent (per Section 60020, Education Code. Authority: Section 7587, Government Code). The medication itself is not a benefit covered by the AB 2726 program nor does the County incur this service or cost.

The following are some general guidelines to assist clients and families in obtaining assistance with medication and laboratory costs:

AB2726 Clients: IF CLIENT HAS MEDI-CAL
Program Psychiatrist can write a prescription and have the client fill it at a Medi-Cal participating pharmacy, as is the current procedure.

AB2726 Clients: IF CLIENT HAS HEALTHY FAMILIES
Program staff, clinician, or Psychiatrist should work with the client's Primary Care Physician to see if they will provide medication if provided with a consultation or Psychiatric Evaluation by the program Psychiatrist. Providers should be aware that Healthy Families may refer the student back to County Mental Health for an assessment. If this occurs and the client is diagnosed with a Severe Emotional Disturbance (SED), then the program would be responsible for medication under the Healthy Families carve-out.

AB2726 Clients: IF CLIENT/FAMILY HAS PRIVATE INSURANCE
Refer to services covered by family's private insurance plan.
(Parents/Clients with private insurance coverage will be helped by the passage of The Mental Health Parity Law (AB 88) in 1999. AB 88 requires most California health care plans to cover the diagnosis and medically necessary treatment of serious mental illness and emotional disturbances of a child on terms equal to their health plan medical coverage.)

AB2726 Clients: IF CLIENT'S/FAMILY'S PRIVATE INSURANCE HAS NO MENTAL HEALTH BENEFIT
Program should verify with insurance plan if mental health is a covered benefit due to the Mental Health Parity Law (AB88). Mental health program Psychiatrists may be able to provide sample medications or work with the client's Primary Care Physician to see if they will provide medication if provided with a consultation or Psychiatric Evaluation by the program Psychiatrist.

AB2726 Clients: IF CLIENT IS INDIGENT
Every effort must be made to link the family to other resources in the community.

Program Psychiatrists may be able to provide sample medications or work with the client's Primary Care Physician to see if they will provide medication if provided with a consultation or Psychiatric Evaluation by the program Psychiatrist.

Program can provide financial screening to determine the annual client liability for mental health services using the "Uniform Method for Determining Ability to Pay" (UMDAP) method. Following the financial screening, the Program Manager must approve all clients who will be receiving medication through the program.

AB2726 Clients: Outpatient Standards

Outpatient service requirements for standards of practice with regard to provider/school interactions on behalf of AB2726 students have been established and are to be documented in the medical record as follows:

- Timeline for Intake within 7-10 calendar days
- Upon receipt of assignment the clinician shall contact the school contact person
- A face-to-face contact between the therapist and school person (teacher or other designated contact person) within the first 60 (sixty) days of treatment.
- A minimum of monthly contact with the school contact thereafter to include discussion regarding medication effectiveness as well as academic status and behavioral management.
- A home visit by the therapist during the course of treatment. Exception shall include justification in the medical record as to why a home visit is not clinically indicated. (Justification for exception of the home visit for existing clients who have been in treatment a year or more may be the length of time they have been in treatment already and the move to termination).
- Attendance of therapist, or knowledgeable representative from the mental health program, at IEP meetings when a major educational placement change may occur, at annual review and at the end of treatment.
- Quarterly Progress Mental Health IEP Reports shall be submitted to the client/parent and the teachers—(refer to Mental Health IEP Reporting section below)
- Comply with Time lines for Requests for Information and Records. Under the Individuals with Disabilities Education Act, pupil records are subject to the federal FERPA and state pupil records provisions, including state rules on providing copies to parents. All AB2726 parent/client requests for pupil records are to be completed and delivered to the parent/client within 5 (five) calendar days. Any request for release of pupil records must be accompanied by a signed authorization for release of those records.

AB2726 Clients: Mental Health IEP Reporting

- The outpatient clinician shall contact the student's teacher monthly to discuss progress and concerns. This contact shall be recorded in the client's medical record.
- The outpatient clinician shall submit the "Quarterly Progress Mental Health IEP

Report" (*Appendix L. L.2*) to the parent/caregiver and school contacts on a quarterly basis. This report shall document the student's progress on the Mental Health IEP goals addressed through outpatient services. A copy of this report shall be maintained in the client's medical record.

- The outpatient clinician shall coordinate the AB 2726 outpatient mental health services with all other counseling services the student is receiving that are documented on the IEP. Evidence of such service coordination shall be documented in the client's medical record.

- The outpatient clinician shall update the "Mental Health Treatment Plan" (*Appendix L. L.3*) at the Benchmark/Short Term Objective time frames listed on the form. Clinician shall complete an updated "Mental Health Treatment Plan" every six months, and request an IEP meeting for IEP team to review and accept updated plan. (Note: to reconvene an IEP meeting, the outpatient provider completes a "Need for IEP Review"- {*Appendix L. L.4*} and forwards it to the school contact). Please note that the Clinician needs to maintain all signed, updated IEP's in client's medical record.

AB2726 Clients: Medication Only Cases

If a client is assessed to solely need medication management services during their intake period, Program Monitor/COTR approval is required for initial Medication Only cases. Every medication only case must have, at a minimum, one assessment (MHS-650) and it is important to remember that if an MHS-650 is imported, a Behavioral Health Update (MHS-663) must be completed within the 30 day intake period.

When a therapist and psychiatrist in the same clinic are seeing a client, and a determination is made that the case shall be transitioned to a medication only case, the following shall occur :

1. Clinician completes a progress note to outline rationale for transitioning case to medication only.
2. Clinician completes a discharge summary that outlines the dates and progress of treatment and continuation of a medication only case.
3. The most recent Assessment (650 or 663) is updated to briefly outline move to medication only date / rationale and refers reader to Discharge Summary for full details.
4. The case is kept open in InSyst. However, the name of the clinician field is amended to reflect the name of the physician. On the face sheet (MHS 140) it will be apparent that an episode is that of medication only due to having the physician and clinician name be one and the same. Caution: If the episode was not a medication only case from the onset then the face sheet shall not track when it became a medication only case. The discharge summary in the medical record shall provide that information.
5. The following are no longer applicable when transitioning to a medication only case:
    a. Utilization Review; process is replaced by medication monitoring
    b. Client Plan (MHS 646) is replaced by Medication Follow-Up (MHS 689)

   c. Mental Health Updates (MHS 663) is replaced by Psychiatric/Medication Evaluation (MHS 645). *Note: every medication only case must have at a minimum one assessment (MHS-650).
6. If during the medication only time frame the client experiences a crisis and is in need of therapeutic services, a clinician can provide Crisis Intervention without needing to begin a therapeutic episode. Although there is no limit on the number of CI contacts, each of the CI contacts must clearly document acuity.
7. Annual beneficiary protection materials and quadrant information continue to be required, and are to be documented on the Initial/Annual Client Functioning form (MHS-680).

In incidents where it is determined that the client is again in need of ongoing therapeutic services (mental health services and/or case management), the following shall occur:

1. Program shall determine if current Utilization Review (UR) authorization is in place.
   a. Client may still be covered by initial 6-month time frame from opening of episode.
   b. Last UR Authorization conducted may still be current.

2. When authorization is in place, therapy may resume, however a new Client Plan is indicated.
3. When authorization for outpatient services has expired, the UR Committee must first authorize services for therapy to resume (in a case of a crisis, refer to item 5 above).
4. Update InSyst to reflect the name of the clinician. Caution: amending InSyst will eliminate any evidence on the Face Sheet (MHS 140) that the case was ever a medication only case.
5 Once case transitions back to mental health and/or case management services, the UR Cycle is once again tracked to insure all services provided are authorized.
6. The episode opening date continues to guide the requirement for completing the Mental Health Assessment Update, and in some instances triggers the need for other expired paperwork (such as exchange of information) to be updated.
7. When an existing Assessment (650 or 663) is still valid, it is to be updated with the date as to the transfer out of medication only status with rationale.

<u>AB2726 Clients: Day Treatment Standards</u>

The goal of the AB2726 Day Treatment program is to re-integrate the students into a less restrictive educational setting in an appropriate school district classroom or non-public school. Consideration shall be given to developmental age as well as chronological age of student. Any exception to the age range specified for the program requires the approval of the Chief, Mental Health Special Education Services or designee.

Services shall maximize involvement of the family by providing opportunity for families to be involved and support the students' mental health treatment and education. These opportunities shall be in addition to family participation in family therapy sessions. For family therapy sessions, evening appointment hours shall be available at least two different nights per week. Evening hours shall be prominently posted in reception area and printed on all documents containing hours of operation information. **For specific process and outcome objectives for AB2726 Day Treatment programs, please see the Systems of Care section of this manual.**

Core services for AB 2726 day treatment shall include:

- Weekly individual and family (biological and /or extended) therapy.
- Three times weekly group therapy, including specialty groups designed to address specific needs of students in the program (for example, to address depression, anger management, substance abuse, social skills). Title 9 and CMHS guidelines, when indicated, shall provide alcohol and drug assessment and treatment services including COD groups, and referrals, as specified.
- Psychiatric Services and Medication Support shall be included in program service functions.
- Other services to be provided may include but are not limited to, art and music therapy; home visits; and recreational therapy focused on the interpersonal and therapeutic goals of the student.
- Multiple family groups, parenting training, parent support groups and/or other alternate activities designed to involve the family, including siblings, in the treatment and educational program.
- Day Treatment staff may provide in-class interventions to support a student's ability to remain in the classroom. Daily community meetings shall be held and may include the teacher(s) and aides as well as mental health staff.
- Case management services to student and family including, but not limited to:
    - Participation in Treatment Team meetings and IEP meetings.
    - Monthly contact with the parents.
    - Monitoring and reporting to IEP team the student's progress towards achieving the mental health IEP treatment goals.
    - Updating mental health IEP goals as appropriate.
    - Acting as a liaison with the student's home school district.
    - Linkages to other appropriate community resources.

Contractor shall adhere to youth transition planning in accordance with CMHS guidelines. Contractor shall coordinate transitional services between its program and HHSA Adult / Older Adult Mental Health Services. (Adolescent Programs Only).

Regional Mental Health AB2726/Special Education Services program managers:

North Coastal/Poway
Program Manager
340 Rancheros Dr., Suite 298
San Marcos, CA 92069
(Tel.) 760-752-4900
(Fax) 760-752-4924

Central Region
Program Manager
3320 Kemper St., Suite 104
San Diego, CA 92110
(Tel.) 619-758-6205
(Fax) 619-758-6209

North Inland/East Region/South
Program Manager
3692 Midway Drive
San Diego, CA 92110
(Tel.) 619-758-6240
(Fax) 619-758-6250

Administration
3320 Kemper Street, Suite 206
San Diego, CA 92110
(Tel.) 619-758-6227
(Fax) 619-758-6255

M. STAFF QUALIFICATIONS AND SUPERVISION

Each provider is responsible for ensuring that all staff meets the requirements of federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct client care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor/COTR or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and ASW/IMF certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

Staff Qualifications

- Contractor's program staff shall meet the requirements of Title 9, Division 1, Article 8 and Title 9, Chapter 11 of the California Code of Regulations as to training, licensure, and clinician/client ratios. All staff shall operate within the guidelines of ethics, scope of practice, training and experience, job duties, and all applicable State, Federal, and County standards. Contractor shall provide sufficient staffing to provide necessary services and Medicare approved services to Medicare covered clients. Current and previous documentation of staff qualifications shall be kept on file at program site.
- Psychotherapy shall be performed by licensed, registered, waivered, or trainee (with co-signature by LPHA) staff in accordance with State law.
- Psychiatrists shall have completed a training program in a child or adolescent specialty (must be Board eligible in child and adolescent or adolescent psychiatry), for programs that serve youngsters under 13 years of age, or have 5 years of experience offering psychiatric services to children and adolescents. Any exception to this must be approved by the Mental Health Services Clinical Director and the Program Monitor/COTR.
- Nurses and Psychiatric Technicians may bill Medication Support to Medi-Cal under the non-MD InSyst code 362 or AB2726 code 388, provided the service provided is within the individual's scope of practice and experience and documentation supports the service claimed.
- Qualified Mental Health Professionals (QMHP) / Mental Health Rehabilitation Specialist who provide direct, billable service must hold a BA and 4 years experience in a mental health

setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirements on a year for year basis. Up to two year of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting. Staff work under the direction of a licensed or waivered staff member.

- Rehabilitation Staff (non-licensed, non waiverable, also referred to as Para Professionals) who provide direct, billable service at a minimum must have a high school diploma/GED, be 18 years old, have at least one-year full time (or equivalent) experience working with children or youth, a positive reference by a supervisor from that work experience, and must work under the direction of a licensed or waivered staff member.
- Family / Youth Support Partners who provide direct, billable service must have direct experience as the parent, care giver, or consumer in a public agency serving children, and demonstrate education and/or life experience commensurate with job duties. Youth (at least 12 years of age and up to 25 years of age) must meet work permit requirements when applicable. Partners must receive on going training and work under the direction of a licensed or waivered staff member.
- All direct service staff shall have had one year of supervised experience with children and adolescents.
- Any exceptions to these requirements must be approved by the Program Monitor/COTR.

Clearances for Work with Minors.

Contractor's employees, consultants, and volunteers, who work under given contract and work directly with minors, shall have clearances completed by the contractor prior to employment and annually there after.

- Employees, consultants, and volunteers shall successfully register with and receive an appropriate clearance by "Trustline"http://www.trustline.org/ or equivalent organization or service that conducts criminal background checks for persons who work with minors. Equivalent organizations or services must be approved by the COTR prior to use by contractor.
- Employees, consultants, and volunteers shall provide personal and prior employment references, Contractor shall verify reference information, and employees, consultants, and volunteers shall not have any unresolved negative references for working with minors.
- Contractor shall immediately remove an employee, consultant, or volunteer with an unresolved negative clearance.

Professional Licensing Waiver Guidelines

The Welfare and Institutions Code Section 5751.2(a) states that "persons employed or under contract to provide mental health services shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs and provide services for which a license is required, unless the person possesses a valid license." Some categories of persons employed as psychologists, clinical social workers, marriage, family and child counselors, however, may be exempt from the requirement of subsection (a) for a time-limited period. The general guidelines for the professional waiver process are as follows:

1) W&IC Section 5751.2 refers to psychologists, social workers and marriage and family therapists providing mental health services in local mental health programs. Mental health services are defined as those services that can only be performed by a licensed professional or by one who is obtaining qualifying experience under the supervision of a licensed professional.

2) W&IC Section 5751.2 refers to those persons employed in local mental health programs or under contract to provide those services. This means all individual, group and organizational provider staff, both County and contract.

3) Each psychologist candidate must obtain a waiver, even though he/she is registered with the Board of Psychology. Each LCSW and MFT candidate is to remain registered with her/his licensing board until such time the candidate is licensed. The candidate must remain registered, even though he/she is no longer accumulating qualifying hours. No waiver is needed, nor can one be obtained; the only exception pertains to license-ready candidates recruited from out of state—consult the Code for details.

4) Each license-ready psychologist, LCSW or MFT recruited from out of state must obtain a waiver.
5) A waiver candidate must be obtaining post-graduate experience. Therefore, a graduate student cannot receive a waiver.
6) A waiver granted in one county is valid for any program in any county in the State of California for the life of the waiver.
7) The waiver period commences the date of employment in a local mental health program (County or contract) anywhere in the State of California in a position that requires a license or whenever the applicant is gaining qualifying clinical experience.
8) A volunteer may gain waiver status if the County provides evidence that this applicant is "employed" or under "contract" to provide mental health services. This evidence shall take the form of written confirmation from the County Mental Health Director or designee.
9) All applicants will receive the maximum waiver period, unless requested differently by the County; five years for the standard psychologist waiver and three years for the license-ready psychologist, LCSW, and MFT candidates recruited from outside the state.
10) There are no provisions for waiver extensions beyond the maximum waiver periods.

11) All waiver requests are to be submitted by the MHP and signed by the local mental health director or the director's designee (the QI Unit). Contractors may not submit waiver requests directly to the State.

12) All items on the waiver request form must be completed to the best of the applicant's and provider's knowledge.

13) The applicant's employment history should be attached to the waiver request form. This can take the form of a current resume, an employment application, or other such documents.

14) Use the "**Mental Health Professional Licensing Waiver Request**" form (and instruction sheet) included in *Appendix M. M.2.* (Note: Do not sign in the space "Request Submitted By" – this requires the signature of the Mental Health Director or his Designee.)

15) Contractors who employ waivered staff receiving supervision for licensure must offer experience and supervision that meet the requirement of the licensing board to which waivered person is registered.

Documentation and Co-Signature Requirements

Staff that provide mental health services are required to adhere to certain documentation and co-signature requirements. For the most current information on co-signature requirements, please refer to the Documentation and Uniform Clinical Record Manual. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

Staff Supervision and Management Requirements

- Programs must provide supervision in amount and type that is adequate to insure client safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program.
- Programs who employ waivered/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered.
- Supervisors may supervise up to 8 clinical staff (licensed, registered, waivered, and trainees) and up to 12 total staff, to include clinical staff.
- Any exceptions to these requirements must be approved by the Program Monitor/COTR.
- Contractor shall notify Program Monitor/COTR prior to personnel change in the Program Manager position. A written plan for program coverage and personnel transition shall be submitted to CMHS at least 72 hours prior to any personnel change in the Program Manager position. In addition, the resume of candidate for replacement shall be submitted to the Program Monitor/COTR for CMHS review and comment at least 72 hours prior to hiring.

- Program shall provide the Program Monitor/COTR an organizational chart identifying key personnel and reporting relationships within 72 hours of any changes to organizational structure.

Staffing Requirements

- All providers shall have staff in numbers and training adequate to meet the needs of the program's target population.

- Psychiatry time: Day Treatment programs, including Intensive and Rehabilitation, shall have psychiatry time sufficient to provide psychiatrist participation in treatment reviews, plus one hour per week for medication management per 8 clients on medication (Intensive) or 10 clients on medication (Rehab). Outpatient programs must also have psychiatry time sufficient to allow the psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus up to one hour per month for each new client to be assessed and one half hour per month per client on medications, for medication follow up.

- Head of Service and providing clinical direction: Most programs' contracts require that the Program Manager (Head of Service) be licensed. If the Program Manager is not licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waivered persons.

- Day Treatment staffing: per the requirements of Title 9, the program must maintain a client to staff ratio of 8:1 (for Intensive programs) and 10:1 (for Rehab programs) at all times. Staff counted in the ratio must be Qualified Mental Health Professionals or licensed or waivered. In addition, County guidelines requires that at least half the clinical staff in Intensive programs be licensed/waived.

- Outpatient providers' ratio of clinicians/therapists to interns and trainees shall be no more than 1:3 FTE, i.e., there must be at least one FTE licensed clinician per 3 FTE interns and trainees. Interns and trainees may provide psychotherapy services, under the close supervision of the clinician/therapist.

- Any exceptions to these requirements must be approved by the Program Monitor/COTR.

Use of Volunteers and Interns/Trainees

- Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients. Particular emphasis shall be made to recruit volunteers from diverse communities within program region.

- Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also clients/caregivers.
- Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct client care.
- Interns/trainees assigned to a program must have on file the written agreement between the school and agency with specific time lines which will act to demonstrate the official intern status of the student which determines scope of practice. Copy of document can be maintained in the Signature Log which often stores copies of staff qualifications.

Signature Log and Documentation of Qualifications

- Each program shall maintain a signature log of all individuals who document in the medical record.
- Signature log contains the individual's typed/printed name, credentials/job title and signature.
- Included with the signature log, or in another accessible location, a copy of each individual's qualifications shall be stored (license, registration, waiver, resume, school contract, high school or bachelors degree, documentation of program monitor/COTR waiver, etc). This documentation is used to verify scope of practice.
- Program is responsible to insure that current copy of qualifications such as license, registration, etc. is kept of file. Expired documents are to be maintained as they demonstrate qualifications for a given timeframe.
- Signature entries and copies of qualifications of staff that are no longer employed by the program are to be maintained, as they documented in the medical record.

N. DATA REQUIREMENTS

Data Collection and Retention
All programs shall maintain an outcome data entry system (DES) for all clients. DES entry shall be completed promptly upon collection of data at designated intervals, including intake, UR/authorization cycle and discharge. Records shall be kept up to date and data shall be entered into the CMHS MIS within one business day of service delivery.

Outcome Tools and Requirements
Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CMHS treatment providers. Specialized program may have individual program outcomes either in addition to or in lieu of standard outcomes measured by all programs.

- Child/Adolescent Measurement System – Youth (CAMS-Y) – 11years of age or older
- Child/Adolescent Measurement System - Parent/Caregiver (CAMS-P) – all ages
- Child/Adolescent Measurement System -Clinician (CAMS-C) – when acting as caregiver
- Family Centered Behavior Scale (FCBS) – all ages
- Client Functioning Quadrant (Quadrant) – all ages
- Youth Services Survey – Youth (YSS-Y) – 13 years of age or older
- Youth Services Survey – Family (YSS-F) – caregivers of youth up to age 18

Ongoing client progress objectives:

- For 80% of clients whose episode lasts 6 months or longer, the CAMS-P total score shall show improvement between intake and the most recent CAMS-P collected.
- For 80% of clients whose episode lasts 6 months or longer, CAMS-Y total score shall show improvement between intake and the most recent CAMS-Y collected.
- For 80% of clients whose episode lasts 6 months or longer, the most recent Quadrant shall be at least one level higher (improvement) in one or more domains, compared to Intake.
-

Discharge outcomes objective:

- For 80% of discharged clients whose episode lasted 2 months or longer, the CAMS-P total score shall show improvement between intake and the last CAMS collected.
- For 80% of discharged clients whose episode lasted 2 months or longer, the CAMS-Y total score shall show improvement between intake and the last CAMS collected.
- For 80% of discharged clients whose episode lasted 2 months or longer, the Quadrant shall be at least one level higher (improvement) at discharge than at admission in at least in one domain.

- For 80% of those clients who remain in the program for 2 months or longer, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the Quadrants rating for substance use.

Satisfaction outcomes:

- Submission rate of YSS-Y and YSS-F shall meet or exceed the 80% standard established by the County of San Diego Children's Mental Health.
- Aggregated scores on the YSS-Y and the YSS-F shall show an average of 80% or more respondents responding in the two most favorable categories (e.g., 25% Agree plus 55% Strongly Agree) for at least 75% of the individual survey items.
- Scores on the FCBS shall average 80% or higher across questions/test items.

Additional Data Information:

Additional data may be required in your specific contract or program. This may involve additional tools for specific parts of the system, such as wraparound and residential programs. Your contract may also require manual collection of certain outcomes from charts, such as number of hospitalizations, arrests, or changes in level of placement/living situation. The data so collected should be submitted on your MSR or as directed by the County.

1. Symptoms/Functioning:

Child and Adolescent Measurement System (CAMS)

a) Youth aged 11 and over shall be administered the CAMS modules at intake, UR/Authorization cycle, and at discharge from the Contractor's program.
b) Do not administer measure if it has been less than 2 months since the last administration of the measure by the provider. When client discharges from program during this interval, remember to enter the discharge information into DES; consider using the Cover Sheet form.
c) CAMS scores should be considered during Utilization Review/Authorization as evidence of medical necessity and clinical effectiveness.
d) Parents/Caregivers of all youth shall be administered the parent modules of the CAMS on the same cycle. When no guardian is available, staff may be in the role of caregiver (often in a residential program) and complete this measure, notating it was completed by clinician/staff. Or, a notation on the Cover Sheet that is entered in to the DES is made to reflect that no guardian is available.
e) All responses shall be recorded by Contractor's staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
f) Data recorded in the database shall be supplied to CASRC via mailing a disk or direct upload, as directed.

Client Functioning Quadrants

a) All CMHS clients shall be assessed at intake in accordance with the Client Functioning Quadrants on the Behavioral Health Assessment, the Behavioral Health Update, or the Initial/Annual Client Functioning Form(for TBS cases). The Quadrants must also be completed annually and at discharge and are embedded in the Behavioral Health Update, UR/Authorization forms, the Annual Client Functioning Form (for TBS & medication only cases) and the Discharge Summary. Quadrant scores should be used as evidence of medical necessity and clinical effectiveness.
b) All responses shall be recorded by Contractor's staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
c) Data recorded in the database shall be supplied to CASRC via mailing a disk or direct upload, as directed.

CRAFFT

a) All CMHS clients shall be assessed for substance use at intake and the CRAFFT must be administered. The CRAFFT measure is included in the Behavioral Health Assessment and the Behavioral Health Update.
b) Intake CRAFFT responses shall be recorded by Contractor's staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. Note that although the CRAFFT must be completed at intake and annually, only the intake responses must be entered into the database. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
c) Data recorded in the database shall be supplied to CASRC via mailing a disk or direct upload, as directed.

2. Client Satisfaction: Currently administered twice a year to all clients and families who receive services during a two week interval specified by the State of California (excluding detention programs, inpatient and crisis services).

Youth Services Survey (YSS)

a) Youth aged 13 and over complete the Youth Services Survey with attached comments page.
b) Parents/caregivers of children and youth up to age 18 complete the Youth Services Survey-Family.
c) Surveys are to be administered in a manner that ensures full confidentiality and as directed by the Child and Adolescent Services Research Center (CASRC).
d) Surveys shall be delivered by hand or mailed to CASRC within 7 days after the completion of each survey interval.
e) Effective September 2006, medication only cases are excluded from the YSS measure.

Family Centered Behavior Scale (FCBS)

a) Parent / Guardians of clients shall be administered the Family Centered Behavior Scale (FCBS) at each UR / Authorization cycle, and additionally at discharge, along with the other assessment tools.
b) When no measure is obtained (caregiver refuses / not available), enter that information into DES.

Research Projects Involving Children's Mental Health Clients

Some providers may develop research projects or test additional outcome tools with methods that utilize MHP clients. All such projects must be reviewed by the MHP's Research Committee as well as the organization's Internal Review Board, if any. Approval is required prior to implementation of the project.

Medi-Cal Administrative Activity Recording (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities that are necessary for the proper and efficient administration of a State's Medicaid (Medi-Cal) plan. These MAA activities are focused on assisting individuals to access the Medi-Cal program and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities and other designated activities.

Organizational providers may be permitted to provide and claim for MAA activities. The MHP requires that each organizational provider have an approved MAA Claiming Plan prior to claiming MAA activities, and that each provider complies with all applicable State and Federal regulations. MAA activities in mental health are governed by a set of procedures, which are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health.

To assist providers, CMHS offers technical assistance and training on MAA through the MAA Coordinator. The MAA Coordinator can provide assistance with claiming and procedural questions or provide a MAA training to staff.

Included in the attachments to this Handbook is a description of Medi-Cal Administrative Activities Procedures (*Appendix N. N.2*) for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes.

MHSA Full Service Partnerships

A number of providers will be participating in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self sufficiency and stability. These providers are required to participate in

a State data collection program which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

Additional Outcome Measures

Additional data may be required in your specific contract. This may involve additional tools for specific parts of the system. Your contract may also require manual collection of certain outcomes from charts, such as number of hospitalizations, readmissions, arrests, or changes in level of placement/living situation. The data collected should be submitted on your MSR or as directed by your Program Monitor/COTR

O. TRAINING

The increasing focus on cultural sensitivity, outcomes measures, practice guidelines and evidence based practice necessitates the need for ongoing training. Many providers have a contractual obligation to participate in trainings such as:

- Cultural Competency Training – Minimum of four hours annual requirement for all staff. When an in service is conducted, program shall keep on file a sign in sheet for all those in attendance, as well as a training agenda. For outside trainings, certificate of completion shall be kept on file at the program. Contractor shall maintain and submit a Cultural Competence Training Log annually.
- System of Care and Wraparound Training – Every four years all direct service staff must attend. These classes are available through the System of Care Training Academy (619-563-2769) and through Families Forward (619 297-8111). Maintain certificates of completion at provider sites.
- Training in Disaster Response -- as directed by County.
- Contractor shall require clinical staff to meet their licensing Continuing Education Units (CEUs). Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year.
- Contractor shall require clerical staff to complete MIS training on topics such as data entry, reporting, and billing. It is recommended that Program Manager's attend trainings as well.
- Contractor shall attend trainings as specified in the Behavioral Health Plan.
- Contractor shall schedule with CASRC the training and orientation for DEC.

QI Unit Training

The Quality Improvement Unit provides training and technical assistance on topics related to the provision of services in the Mental Health System of Care. Training covers topics such as Documentation and Uniform Clinical Record Manual Training. For information on training schedules, or regarding any other training issue, please contact the Quality Improvement Unit at 619 584-5026.

P. MENTAL HEALTH SERVICES ACT - MHSA

After California voters passed Proposition 63 in November 2004, the Mental Health Services Act (MHSA), became effective January 1, 2005. The purpose of the act was to expand mental health service funding to create a comprehensive community based mental health system for persons of all ages with serious and persistent mental health problems. The MHP has completed its initial extensive community program planning process and has secured a state approved Community Services and Supports Plan. The next phases of enactment of the MHSA will include funding for prevention/early intervention, innovations, capital facilities and technology, and education and training.

MHSA System Transformation

Under the MHSA, community based services and treatment options in San Diego County are to be improved, expanded, and transformed by:

1. Increasing Client and Family Participation
2. Serving More Clients
3. Improving Outcomes for Clients
4. Decreasing Stigmatization
5. Minimizing Barriers to Services
6. Increasing Planning and Use of Data
7. Increasing Prevention Programming
8. Including Primary Care in the Continuum of Care
9. Using of Proven, Innovative, Values-Driven and Evidence-Based Programs

As a result of expanded funding, the MHSA will hold counties accountable for a number of outcomes. The outcomes include decreases in racial disparities, hospitalizations, incarcerations, out-of-home placements and homelessness while increasing timely access to care. Other outcomes may be required as the State and County evaluate the start-up of MHSA services. Contractors receiving MHSA funding will be responsible for complying with any new MHSA requirements.

MHSA Full Service Partnerships

A number of providers will be participating in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self sufficiency and stability. These providers are required to participate in a State data collection program which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

MENTAL HEALTH SERVICES ACT - MHSA

For current information on MHSA, visit www.sandiego.networkofcare.org/mh. For current State level and general MHSA information, visit www.dmh.cahwnet.gov/MHSA or call (800) 972-6472.

Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only
(Contractor Instructions)

Q. Payment Schedule Budget Guidelines for Cost Reimbursement

This document includes additional instructions (*in italics*) to help clarify the intent of the requirements and guidelines.
Contractors prepare program budgets for County review and approval. The approved budgets for each fiscal year serve as objectives and guidelines for contract performance and allowable expenditures. The budget guidelines allow for flexibility within specified limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget.
The clauses expanded upon below are only those that have been subject to inquiry or that have been recently modified or updated.

Budget Guidelines

Contractor must obtain written approval from the County prior to exceeding any fiscal year's budgeted amounts except as noted in Clauses 0 through . Unexpended budgeted amounts may not be applied to subsequent fiscal years expenditures unless authorized by an Agreement Amendment. An Agreement Amendment is required prior to exceeding any fiscal year's budgeted maximum Agreement amount.
If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services and are subject to subsequent review and approval. Any expenditures requiring written approval must be requested in advance via an Administrative Adjustment or Contract Amendment. Approval is not effective, and contractor should not incur any requested expense, until notified that the Administrative Adjustment or Contract Amendment has been executed.

Total Direct Labor Cost.
Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost, as evidenced by Schedule I – Agreement Budget, that is attached hereto and by reference made a term and condition hereof. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and Benefits category plus any allowable unexpended Operating Expenses (as defined in Clause) without the prior written approval of the Local Mental Health Director or his/her designated representative.
In addition to the stated limitations on the total Salaries and Benefits amount, additional guidelines for changes that require prior written approval are listed below.

- Unexpended Salaries and Benefits, up to 10% of total budgeted amounts, may be applied to Operating Expenses.

  Example 1: The total Salaries and Benefits amount for a program budget equals $500,000, and contractor expects to spend less than $430,000. Of the $70,000 in projected savings for this category, up to $50,000 (10% of the $500,000 Total Budget), may be applied to Operating Expenses without requiring prior approval or change to the budget.

  Example 2: The total Salaries and Benefits amount for a program budget equals $600,000, and contractor expects to spend less than $570,000. The entire $30,000 in projected savings for this category, which is less than the limit of $60,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.

- Unexpended Salaries and Benefits that may be applied to Operating Expenses may only be from temporary vacancies of budgeted staff.
  Contractor may not purposefully keep positions vacant for the purpose of accruing savings to be applied to Operating Expense. When staffing levels are reduced due to reduced work loads, then it would be expected that operating expenses would be similarly under-expended. The intent is to fill all budgeted positions. Savings due to other reasonable variables can be applied to Operating Expense.
  - Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior approval as long as costs do not exceed amounts budgeted for these positions.
    Temporary and/or replacement staff should be listed in the Salaries and Benefits category, and are not subject to prior approval as long as total of Salaries does not exceed the budgeted amount plus 10% for this category.
  - All staffing changes, including addition or deletion of budgeted staff, and unbudgeted salary increases require prior approval from the County.
    Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs) or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, and individual salaries may fluctuate within the range as budgeted, as long as the overall 10% rule is heeded.

Total Other Direct Cost.
Reimbursable operating costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such expenses, as evidenced by Schedule I – Agreement Budget, that is attached hereto and by reference made a term and condition hereof. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits (as defined in

Clause 0) without the prior written approval of the Local Mental Health Director or his/her designated representative.

- Unexpended Operating Expenses, up to 10% of total budgeted amounts, may be applied to Salaries and Benefits.
  Example: If the total Operating Expenses for a program budget equals $300,000, any unexpended amount for the year, up to a maximum of $30,000 (10% of the total budget for this category), may be applied to Salaries and Benefits without requiring prior approval or change to the budget.
  - The budgeted amounts for Operating Expenses line items may be exceeded as long as the total of all items does not exceed the total budgeted Operating Expenses (including any allowable unexpended Salaries and Benefits as defined in Clause 0), except for Leasehold Improvements, Consultants, Interest Expense, and Depreciation.
    Example: If $1,000 is budgeted for Office Supplies and the expenses to date equals $1,500, no prior approval or change to the budget is needed unless the total Operating Expenses amount is exceeded beyond allowable limits; however, all expenses must be reasonable and appropriate for the contracted services and are subject to subsequent review and approval.
  - Consulting expenses are budgeted on Schedule II of the Agreement Budget and may not be exceeded without prior approval, with the exception of temporary staffing as per Clause . All other consulting services not previously budgeted require prior written County approval.
  - Budgeted amounts for Leasehold Improvements, Interest Expense, and Depreciation may not be exceeded without prior written County approval.
  - No expense will be allowed for any line item that does not have an amount currently budgeted.
    Any expense within a line item that has no currently budgeted amount requires prior approval. It is assumed that the approved budget includes most expected expenditures, and unbudgeted items were deliberately omitted; therefore, prior approval is required if an unbudgeted expense is subsequently considered necessary.

Fixed Assets.
All fixed asset expenses must be budgeted and itemized on Schedule II, and no line item budget may be exceeded without prior written County approval. Purchase of fixed assets not currently budgeted and itemized requires prior written County approval. Fixed assets include all non-expendable property with a value of $5,000 or more and a normal life expectancy of more than one year.
Purchase of fixed assets that are budgeted on the itemized Schedule ll and any assets not currently budgeted require written notification to the COTR who will complete HHSA

Agency Asset AUD form and forward to the HHSA Agency asset coordinator as outlined in HHSA-G-4.19.

Total Indirect Cost.
Reimbursable indirect costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost, as evidenced by Schedule III – Indirect Cost Statement, attached hereto and by reference made a term and condition hereof. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the Local Mental Health Director or his/her designated representative. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost.
If the total budget is under-expended, it is expected that Indirect Costs would decrease proportionately.

- Budgeted Units of Service may not be changed without prior written County approval.

Units of Service are the most critical element of the program budget and the budgeted units of service may not be changed without prior written approval. Delivery of service below budgeted levels may be a performance issue and subject to notice of required corrective action.

R. QUICK REFERENCE

PHONE DIRECTORY

Access And Crisis Line	**1-800-479-3339**
County Of San Diego MHP Administration	**619-563-2700**
Children's Mental Health Administration	619-563-2750
Chief, TBS and Outpatient Services	619-584-5004
Chief, Juvenile Forensic Services	858-694-4695
Chief, Critical Care and Outpatient Services	619-421-6900
Chief, Special Education Services	619-758-6226
Quality Improvement Supervisor	619-584-5021
Quality Improvement FAX	619-584-5018
Contract Administration Unit Manager	619-563-2733
Claim Submission FAX	619-563-2730
Interpreters Unlimited	**858-451-7490**
Deaf Community Services	**1-800-290-6098**
United Behavioral Health, Administrative Services Organization for San Diego MHP	
Provider Line	**1-800-798-2254**
UBH Administrative Services for MHP	**619-641-6800**
Director, Compliance and Provider Services	619-641-6806
MIS Help Desk	619-641-6928
MIS FAX	619-641-6975
Clinical	619-641-6802
Provider Services & Quality Improvement	619-641-6979

Problem Resolution

Consumer Center for Health Education and Advocacy (CCHEA)	877-734-3258
USD Patient Advocacy	800-479-2233

Appendix A
Systems of Care

Appendix B
Compliance and Confidentiality

Loc Codes: 1=Office; 2=Field; 3=Phone; 4=Home; 5=School; 6=Satellite; 7=Crisis Field; 8=Jail; 9=Inpatient

Staff Masks: 2=Psychiatrist; 4=Psych Tech; 8=Nurse; 16=Psychologist; 32=LCSW; Intern=8192

SD County Outpatient Master Code Map

Effective 3/15/2004

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
90801		Psychiatric diagnostic interview examination (previously 330)										
	H2015		801		PSYCH DX INTERVIEW EXAM	90801	30	1, 9	HE	All	2, 8, 16, 32	2
	H2015			701	PSYCH DX INTERVIEW EXAM AB2726	90801-2726	30	1, 9	HE	All	2, 8, 16, 32	2
90802		Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (previously 330)										
	H2015		802		INTERACT PSYCH INTERVIEW EXAM	90802	30	1, 9	HE	All	2, 8	2
	H2015			702	INTER PSYCH INT EXAM - AB2726	90802-2726	30	1, 9	HE	All	2, 8	2
90804		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient (previously 340/341)										
	H2015		804		INDIVIDUAL PSYCH 20-30 MINS	90804	40	1	HE	All	2, 8, 16, 32	2
	H2015			704	INDIV PSYCH 20-30 MINS-AB2726	90804-2726	40	1	HE	All	2, 8, 16, 32	2

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
90806		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient										
	H2015	(previously 340/341)	806		INDIVIDUAL PSYCH 45-50 MINS	90806	40	1	HE	All	2, 8, 16, 32	2
	H2015			706	INDIV PSYCH 45-5O MINS-AB2726	90805-2726	40	1	HE	All	2, 8, 16, 32	2
90808		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient										
	H2015	(previously 340/341)	808		INDIVIDUAL PSYCH 75-80 MINS	90808	40	1	HE	All	2, 8, 16, 32	2
	H2015			708	INDIV PSYCH 75-80 MINS-AB2726	90808-2726	40	1	HE	All	2, 8, 16, 32	2
90810		Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the										
	H2015	patient (previously 340/341)	810		INTER INDIV PSYCH 20-30 MINS	90810	40	1	HE	All	2, 8, 16, 32	2
	H2015			710	INT IND PSY 20-30 MINS AB2726	90810-2726	40	1	HE	All	2, 8, 16, 32	2
90812		Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the										
	H2015	patient (previously 340/341)	812		INTER INDIV PSYCH 45-50 MINS	90812	40	1	HE	All	2, 8, 16, 32	2
	H2015			712	INT IND PSY 45-50 MINS AB2726	90812-2726	40	1	HE	All	2, 8, 16, 32	2

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
90814												
	H2015	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient (previously 340/341)	814		INTER INDIV PSYCH 75-80 MINS	90814	40	1	HE	All	2, 8, 16, 32	2
	H2015			714	INT IND PSY 75-80 MINS AB2726	90814-2726	40	1	HE	All	2, 8, 16, 32	2
90846												
	H2015	Family psychotherapy (without the patient present) (previously 310/311)	846		FAMILY PSYCH W/O PATIENT	90846	10	1, 9	HE	All	2, 8, 16, 32	2
	H2015			746	FAMILY PSYCH W/O PT - AB2726	90846-2726	10	1, 9	HE	All	2, 8, 16, 32	2
90847	H2015	Family psychotherapy (conjoint psychotherapy)(with patient present) (previously 340/341)	847		FAM PSYCH CONJOIN W/ PATIENT	90847	40	1, 9	HE	All	2, 8, 16, 32	2
	H2015			747	FAM PSY CONJOIN W/ PT -AB2726	90847-2726	40	1, 9	HE	All	2, 8, 16, 32	2
90849	H2015	Multiple-family group psychotherapy (previously 350/351)	849		MULTI-FAMILY GROUP PSYCH	90849	50	1, 9	HE	All	2, 8, 16, 32	2
	H2015			749	MULTI FAM GRP PSYCH - AB2726	90849-2726	50	1, 9	HE	All	2, 8, 16, 32	2
90853	H2015	Group psychotherapy (other than of a multiple-family group) (previously 350/351)	853		GROUP PSYCH(NOT FAMILY)	90853	50	1, 9	HE	All	2, 8, 16, 32	2
	H2015			753	GRP PSYCH(NOT FAMILY) - AB2726	90853-2726	50	1, 9	HE	All	2, 8, 16, 32	2
90857	H2015	Interactive group psychotherapy (previously 350/351)	857		INTERACT GROUP PSYCHOTHERAPY	90857	50	1, 9	HE	All	2, 8, 16, 32	2
	H2015			757	INTERACT GRP PSYCH - AB2726	90857-2726	50	1, 9	HE	All	2, 8, 16, 32	2

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
90862												
	H2010	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy (previously 360/361)	862		PHARMACOLOGICAL MANAGEMENT	90862	60	1, 9	HE	2	2	2
	H2010			762	PHARMOCOLOGICAL MGMT - AB2726	90862-2726	60	1, 9	HE	2	2	2
M0064												
	H2010	Brief office visit for the sole purpose of monitoring or changing drug prescriptions (previously 360/361)	864		BRIEF OFFICE VISIT	M0064	60	1, 9	HE	2	2	2
	H2010			764	BRIEF OFFICE VISIT - AB2726	M0064-2726	60	1, 9	HE	2	2	2
None												
	H2010	Other Medication Related Service, including participation in team meeting where meds are discussed or considered for named client, review of records, etc.	860		Other Med. Service	OTHER MED	60	1, 9	HE	2		
	H2010			760	Other Med. Service	OTHER MED	60	1, 9	HE	2		
99078												
	H2010	Physician educational services rendered to patients in a group setting.	878		PHYSICIAN EDUCATIONAL SERVICES	99078	60	1, 9	HE	2, 8	2, 8	2
	H2010			778	PHYSICAN EDUC SVCS - AB2726	99078-2726	60	1, 9	HE	2, 8	2, 8	2
90885												
	H2015	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes (previously 310/311)	885		PSYCH EVAL OF REPORTS	90885	30	1, 9	HE	All	2, 16, 32	
	H2015			785	PSYCH EVAL OF REPORTS - AB2726	90885-2726	30	1, 9	HE	All	2, 16, 32	
90887												
	H2015	Interpretation or explanation of result of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (previously 310/311)	887		INTERPRET OF PSYCH PROCEDURES	90887	40	1, 9	HE	All	2, 16, 32	

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
	H2015			787	INTERPRET PSYCH PROC - AB2726	90887-2726	40	1, 9	HE	All	2, 16, 32	
90889												
	H2015	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers (previously 310/311)	889		CLIENT REPORT PREPARATION	90889	40	1, 9	HE	All	2, 8, 16, 32	
	H2015			789	CLIENT RPT PREP - AB2726	90889-2726	40	1, 9	HE	All	2, 8, 16, 32	
96100		Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour.										
	H2015	(previously 330)	835		PSYCHOLOGICAL TESTING	96100	30	1, 9	HE	16, 8192	16	
	H2015			735	PSYCHOLOGICAL TESTING-AB2726	96100-2726	30	1, 9	HE	16, 8192	16	
96105		Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.										
	H2015	(previously 330)	836		ASSESSMENT OF APHASIA	96105	30	1, 9	HE	16, 8192	16	
	H2015			736	ASSESSMENT OF APHASIA-AB2726	96105-2726	30	1, 9	HE	16, 8192	16	
96110		Developmental testing; limited (eg., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report.										
	H2015	(previously 330)	837		DEVELOPMENTAL TESTING-LIMITED	96110	30	1, 9	HE	16, 8192	16	
	H2015			737	DEV TESTING-LIMITED-AB2726	96110-2726	30	1, 9	HE	16, 8192	16	

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
96111												
		96110…extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg., Bayley Scales of Infant Development) with interpretation and report, per										
	H2015	hour. (previously 330)	838		DEVELOPMENTAL TESTING-EXTENDED	96111	30	1, 9	HE	16, 8192	16	
	H2015			738	DEV TESTING-EXTENDED-AB2726	96111-2726	30	1, 9	HE	16, 8192	16	
96115												
		Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and										
	H2015	report, per hour (previously 330)	839		NEUROBEHAVIORAL STATUS EXAM	96115	30	1, 9	HE	16, 8192	16	
	H2015			739	NEURO STATUS EXAM-AB2726	96115-2726	30	1, 9	HE	16, 8192	16	
96117		Neuropsychological testing battery (eg., Halstead-Reitain, Luria, WAIS-R) with interpretation and report, per										
	H2015	hour. (previously 330)	840		NEUROPSYCHOLOGICAL TESTING BAT	96117	30	1, 9	HE	16, 8192	16	
	H2015			740	NEURO TEST BATTERY-AB2726	96117-2726	30	1, 9	HE	16, 8192	16	

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
None	H2015	A service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.	535	N/A	Rehabilitation Service	Rehab	40	1, 9	HE	All		
None	H2019	Therapeutic Behavioral Service	313	N/A	THERAPEUTIC BEHAVIORAL SVCS	TBS	58		HE	All		
None	T1017	Case Management Brokerage	501		CASE MGMT/BROKERAGE	CASE MG/BR	01		HE	All		
	T1017			512	CASE MGMT/BROKERAGE(AB2726)	CASE MG/BR	01		HE	All		
None	H2015	Other Collateral Incl. Case Conf.	310		OTHER COLLATERAL	COLLATERAL	10		HE	All		
	H2015			311	OTHER COLLATERAL AB2726	COLLATERAL	10		HE	All		
None	H2011	Medi-Cal Only – Crisis Intervention	370		CRISIS INTERVENTION	CRISIS INT	75		HE	All		
	H2011			371	CRISIS INTERVENTION (AB2726)	CRIS 2726	75		HE	All		
None	H2010	Comprehensive Med Services (Non-MD)	362		MEDICATION NON MD	MED NON MD	60		HE	4,8		
	H2010			388	MEDICATION NON MD AB2726	MED NON MD	60		HE	4,8		
None	Do not claim	Unlisted psychiatric service or procedure/ Non-billable	899		UNLISTED PSYCHIATRIC SERVICE	90899	40			All		
	Do not claim			799	UNLISTED PSYC SERVICE - AB2726	90899-2726	40			All		
None	No bill	Medication Visit - Non Billable	214		Med Service-Non Billable	NOBILL MED	60			2,8		

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
	No bill			215	Med Service-Non Billable AB2736	NOBILL MED	60			2,8		

CPT Code	Medi-Cal HCPC Code	CPT or Short/Doyle Procedure Definition (2001 Standard Edition)	3-Digit InSyst Code	3-Digit InSyst AB2726 Code	Long InSyst Name	Short InSyst Name	SFC	Location Code for Mcare	Default Medi-Cal Modifier	InSyst Staff Mask (Service Entry)	InSyst Staff Mask (Medicare)	Medicare Staff InSyst Staff Mask County Operated Programs
None	No bill	Case Mgmt - Non-Billable	560		Case Mgmt - Non-Bill	NO BILL CM	01			All		
	No bill			515	CM NO BILL AB2726	NO BILL CM	01			All		
None	No bill	Crisis Intervention - Non Billable	218		Crisis Interv.-Non Billing	NO BILL CI	75			All		
	No bill			216	CI Non Billing - AB2726	NO BILL CI	75			All		
None	No bill	No Show	299		NO SHOW	NO SHOW	00			All		

Documentation Requirements	Asst	Asst inter	Individ	Individ	Individ	Individ inter-active	Individ inter-active	Individ inter-active	Fam Ther	Fam with Individ	Multi-family	Group	Group inter-active	Other Med Service	Pharm Mngmt	Med monitor; drug change	MD Educ	Nurse med service	Rehab	TBS	Inter-pret Data to Others	Rec Review	Crisis Interv'n	Collateral	Case Mgmt
	90801	90802	90804	90806	90808	90810	90812	90814	90846	90847	90849	90853	90857	H2010	90862	M0064	99078	H2010	H2015	H2019	90887	90885	H2011	H2015	T1017
	801	802	804	806	808	810	812	814	846	847	849	853	857	860	862	864	878	362	535	313	878	885	370	310	501
	701	702	704	706	708	710	712	714	746	747	749	753	757	760	762	764	778	388	Rehab	TBS	778	785	371	311	512
Date of service	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Name of Client	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Procedure Code	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Diagnosis Code	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Emotional Symptoms/Complaints	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●		☺	●	●			●		☺
Face-to-face time	●	●	20-44	45-74	=75>	20-44	45-74	=75>	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Location	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
History																									
History of Present Illness	●	●							☺	☺	☺			☺	☺	☺		☺				☺	☺	☺	☺
PFSH (Past, Family, Social)	●	●							☺	☺	☺			☺	☺	☺		☺				☺	☺	☺	
Historical Response to Treatment	●	●							☺	☺	☺			☺	☺	☺		☺				☺	☺	☺	☺
Client Appearance	●	●	●	●	●	●	●	●		●	●	●	●	☺	●	●	☺	☺	●	●			●		☺
Precipitators/Environmental Attributes	●	●	●	●	●	●	●	●	☺	●	●	●	●	☺	☺	☺	☺	☺	●	☺			●	☺	☺
Level of Cognitive Capacity	●	●	●	●	●	●	●	●		●	●	●	●	☺	●	●	☺	☺	●	☺			●	☺	☺
Potential for harm/Disposition/Tendencies	●	●	●	●	●	●	●	●		●	●	●	●	☺	●	●	☺	☺	●	☺			●	☺	☺
Medical Evaluations/Impressions	●	●																				●	●		
Medical Examination/ROS	●	●																					☺		
Medical Tests Review	●	●																				☺	☺		
Progress/Response to Treatment			●	●	●	●	●	●	●	●	●	●	●	☺	●	●	●	☺	●	●		☺	●		☺
Interactive activities		●				●	●	●	☺	☺	☺	☺	●	☺	☺	☺	☺	☺	☺	☺	☺		☺	☺	☺
Immediate service intervention required	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺		☺	☺			●		☺
Counseling/therapy/interventions provided	●	●	●	●	●	●	●	●	●	●	●	●	●	☺	●	☺	●	☺	●	●	●		●	●	●
Plan of Care/Changes to Plan of Care	●	●	●	●	●	●	●	●	●	●	●	●	●	☺	●	●	☺	☺	●	●	☺	●	●	●	●
Other resources of information	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	●	☺	●	●	☺
Medications	●	●							☺	☺				●	●	●	☺	☺					☺		
Effects of Medications														●	●	●	☺	☺					☺		
Side-effects experienced														●	●	●		☺					☺		
Medication Education Administered														☺	●	●	●	☺			☺		☺		
Referrals	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Date Documentation Written	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Signature of Provider of Service	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

● Required element
☺ Recommended, if applicable
Blank Not a required element

Appendix C
Accessing Services

Children's Mental Health Services

PROVIDER:
Month/Year:

Request for Services Log

Title 9, Section 1810.405

Contractual Requirements
May use for wait time calculations

Inquiry date	Name	Indicate Y or N			Referring Party / District	Res-ponse code	Dispo code	Appointment Date (reason for no appt. or unusual delays)
		M/C	AB 2726	MHSA				

Response Codes
E = Emergent - access within the same day
U = Urgent - access within 72 hours
H = Patient D/C'ed from inpatient program (72 hr rapid response assessmer
R = Routine - within 5 days
I = Request for Information/referra

Disposition Codes
1) Made appt **6)** No appt or referral made
2) Referred out for Routine services
3) Provided client with County health insurance referral informatio
4) Referred out for non-Mental Health service
5) Referred out for Urgent services

County of San Diego
Health and Human Services Agency (HHSA)
Mental Health Services

SERVICE AUTHORIZATION FORM
Interpreter Services for Clients – Access and Authorization

A. To Be Completed BEFORE Services Have Been Provided:

Circle one: Interpreter's Unlimited OR
Deaf Community Services (DCS) OR
Network Interpreting Services

The County of San Diego, HHSA – Mental Health Services has authorized the following interpreting services:

Client/Family Member's Name:	Language Requested:	Date of Service Requested:	Time of Service Requested:	Requested By:

Clinical Need Type: ____ Urgent (within 48 hours)
____ Routine (by appointment)

Approved By: _____ _____
(Signature of Manager or designee) (Date)

Printed Name: _____
Phone: ( ) _____ Fax: ( ) _____

Agency/Program Name: _____
Address: _____

B. To Be Completed AFTER Services Have Been Provided:

I verify that the above service was provided on _____ for_____hours.
(Date) (Total hours)

By: _____
(Name of Interpreter)

Verified by: _____ _____
(Clinician requesting service) (Date)

C. PLEASE FAX THIS COMPLETED SERVICE AUTHORIZATION FORM TO:

Interpreter's Unlimited……Fax Number : (800) 726-9822
Deaf Community Services……Fax Number: (619) 398-2490
Network Interpreting Services……...Fax Number: (815) 425-9244

NOTE: IT IS A HIPAA VIOLATION TO EMAIL ANY DOCUMENT CONTAINING PROTECTED HEALTH INFORMATION (PHI).

This form should be used to request authorization of payment for **Specialty Mental Health Services.**	**County of San Diego Mental Health Plan** **Specialty Mental Health Services DPR** RECEIVED by UBH:	**Form must be submitted to UBH by client's Day Program provider. UBH cannot accept this form if submitted by Specialty Mental Health Services Provider**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client InSyst #:	Date of Birth

DAY PROGRAM INFORMATION

Day Program Name: *Please print clearly*

_____Phone: :_____ Day Program RU# _____

SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION

Specialty Mental Health Program Name: *Please print clearly*

_____Phone: :_____ Program RU# _____

REQUEST FOR AUTHORIZATION of Specialty Mental Health Services delivered by Organizational County Contracted providers on the same day as Day Program Services.

*** Treatment must include coordination with the other professionals treating client. Authorization is required only for ancillary services delivered on the same day client receives Day Program Services. Ancillary Services delivered to client in an Intensive Day Program require continued authorization within 3 months. Ancillary Services delivered to client in a Day Rehab program require continued authorization within 6 months. Medication Management, Case Management, TBS, and Crisis Intervention Services do not require authorization. ***

Complete the request by writing the # of visits requested per week (or month) and the # of weeks (or months) within which the visits will occur.

Service(s)	Frequency	Service(s)	Frequency
☐ Individual Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months	☐ Group Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months
☐ Collateral Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months	☐ Collateral Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months
☐ Other Mental Health Services (describe)_____	__ visit(s) per _____week _____month for_____weeks_____months	☐ Other Mental Health Services (describe)_____	___ visit(s) per _____week _____month for_____weeks_____months

Community services/self help do not require authorization but must be coordinated comprehensively with all mental health and psychosocial rehab services.

Community services/self help (please list) _____

ADULT/OLDER ADULT Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ The client is unable to receive these services while attending the Day Rehabilitation program due to client's specific clinical needs or family/caregiver needs. (Describe needs)

_____

_____

☐ Client transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and length of interval)

_____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

_____

CHILD and YOUTH Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ Requested service(s) is not available through the day program. (Describe why service is not available through day program) _____

_____

☐ Continuity or transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and time interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

_____

_

CURRENT FUNCTIONING (enter highest level of severity in past 2 months):

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Actively _____	☐Suicidal ☐ Fire Setting ☐Homicidal ☐Psychotic			☐None
School _____	☐Expelled ☐Increased Placement Level ☐Chronic Truancy ☐Threats to Staff or Students ☐Major Property Damage	☐Failure ☐ Significant Decline ☐ Frequent Truancy/Non-Excused Absences ☐ Frequently Disruptive	☐Declining Grades ☐ Poor Attention ☐ Periodic Behavior Problems ☐ Producing Less Than Expected Level	☐Regular Attendance ☐Minimal Behavior Problems
Home _____	☐ Threats to Family Members ☐ AWOL/Running Away ☐ Severe Property Damage] Serious and Repeated Violations of Rules/Laws	☐Overnight Running Away ☐Moderate Property Damage ☐Persistent Failure to Comply with Reasonable Rules	☐Episodic Property Damage ☐Frequent Disobedience and/or Resistance	☐Occasional Disobedience
Thinking _____	☐Active Thought Disorder ☐Dissociation ☐Disorientation	☐Disorganized Communication ☐Distortion of Thinking ☐Occasional Reality Impairment (Suspicions/Obsessions)	☐Odd Beliefs ☐Unusual Perceptions ☐Eccentric	☐No disturbance in Thinking ☐Normal Concerns
Substance _____	☐Dependence, ☐Frequently Intoxicated or High (More than twice per week)	☐Abuse with Interference of Functioning	☐Recurrent Use with Minimal Interference of Functioning	☐Occasional ☐No Use ☐Full Remission
Mood _____	☐Persistent and Incapacitating	☐Intense and Abrupt Episodes ☐Marked Mood Changes ☐Blunt Affect ☐ Significantly Withdrawn / Isolative	☐Anxious ☐ Self Critical ☐ Fearful/Sad with Overt sx ☐ Low Self Esteem ☐ Easily Distressed ☐ Restricted Affect	☐Normal Reactions to Life Events ☐Expresses Emotions Appropriately
Self Harm _____	☐Active Clear Plan ☐Serious Self Harm	☐Superficial Cuts ☐Suicidal Ideation without Immediate Danger	☐Fleeting Suicidal Ideation ☐Pinching/Scratching Self	☐None
Behavior Toward Others _____	☐Serious Intent to Cause Harm ☐Seriously Assaultive ☐Serious Repeated Criminal Activity	☐Threats to others ☐Some Aggressive Behaviors ☐Inappropriate Sexual Behavior ☐ Police Involvement	☐Argumentative ☐ Occasional Tantrums ☐ Ignored/Rejected by Peers ☐ Poor Social Skills ☐ Assault History	☐Age Appropriate Behavior
Other				

End date of previous authorization: ____/_____ Start date of this authorization: _____/_____ End date of this authorization: _____/_____
MM/YYYY MM/YYYY MM/YYYY

Name of Ancillary Services

Clinician requesting authorization: (print)_____**Phone:**_____ **Date:**_____

Countersignature by Licensed Clinician:_____ **Phone:**_____ **Date:**_____

County of San Diego
Health and Human Services Agency (HHSA)
Mental Health Services

SERVICE AUTHORIZATION FORM INSTRUCTIONS

The form accompanying these Instructions and dated 3/1/07 replaces all Service Authorization Forms previously in use to request Interpretation Services for clients/family members in Mental Health programs only.

It is an expectation that all programs will make every effort to recruit and deploy bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client's preferred language; and interpreter services will be utilized more efficiently by everyone.

Note that any services not cancelled 24 hours in advance will still be billed to the County. Please share this information with all clients/family members and ask them to contact your program in a timely manner when they must cancel an appointment utilizing interpreter services.

This form serves several purposes:

- Requesting scheduled interpreting services (Section A)
- Authorizing scheduled interpreting services (Section A)
- Verifying that scheduled interpreting services were provided (Section B) **OR**
- Verifying that scheduled interpreting services were cancelled and when they were cancelled (Section B)
- Providing FAX numbers to send forms (Section C)

Section A:

- One form shall be completed for EACH service requested.
- Please provide all information in this section as directed and print legibly.
- The requestor usually will be the clinician or support staff asked to arrange the service.
- The manager or designee is asked to authorize the services requested. Any questions about the delivered services, cancellations, etc. will be directed to the authorizing manager/designee.
- It is essential to identify your program name and address so that it can be identified as a Mental Health program authorized to use these county wide contracted interpreting services.
- **FAX the form with Section A completed to the selected provider.**
- (DO NOT EMAIL the form with client information entered on it.)

Section B:

- Please provide all information in this section as directed and print legibly.
- For billing purposes, the total number of hours the service was provided is required. The clock starts ticking from the time the interpreter (if present!) was scheduled- not when the client arrives or the service begins.
- NOTE that a new line in this form provides a space to fill in when services that were ordered in Section A are cancelled.
- **FAX the form with Section B completed to the selected provider after the services have either been completed or cancelled.**
- You may also provide the interpreter with a completed copy if they request it.

TRANSITIONAL YOUTH REFERRAL FORM

To be completed and submitted with referral packet

The following youth has been served by _____program and will be transitioning to Adult Mental Health services by_____(Date).

I have referred this client to Adult Mental Health Services and have been unable to obtain services due to the following:_____
_____

Name of Youth:_____
Birthdate: _____Date of this referral:_____
Currently Residing :_____
Address:_____Phone Number:_____
Services currently receiving: _____
_____
Insurance Status:_____
Name of provider referring this youth: _____
Address: _____ Phone Number:_____

Mental health needs/services required by this client:
_____
_____
_____

Program client referred to:_____
When:_____Staff member contacted:_____
Results:_____
_____
Program client referred to:_____
When:_____Staff member contacted:_____
Results:_____
_____
Program client referred to:_____
When:_____Staff member contacted:_____
Results:_____
_____
_____

Other Issues/Concerns:

Appendix D
Authorization of Reimbursement for Services

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego 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 specialty 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 (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

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 (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of USD Patient Advocacy Program at (800) 479-2233, 5998 Alcala Park, UOP 304, San Diego, CA 92110. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. Or you can follow the directions in the information pamphlet 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, for inpatient/residential services, you may call and talk to or write a representative of USD Patient Advocacy Program at (800) 479-2233, 5998 Alcala Park, UOP 304, San Diego, CA 92110. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair 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 this 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 San Diego 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: (_____)_____

NOA-BACK (DMH revised 6/1/05. SD update 8/1/05.)

County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of 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:_____
_____

<u>If you don't agree with the plan's decision, you may</u>:

1. 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 (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; 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 (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

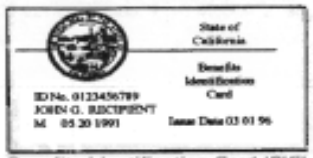
Appendix E
Interface with Physical Health Care Provider

HEALTHY SAN DIEGO

Plan Partner Identification for Pharmacies†

Step 1 - State

If patient has this (BIC) CARD:



Benefits Identification Card (BIC)

Step 1, please inquire if the patient has one of the other Plan Partner cards.
Step 2, if not, use your Point of Service (POS) Swipe Card Box for Plan Partner, Provider identification, and Member eligibility verification,
or call AEVS at 800-456-2387 or 800-786-4346. Your PIN# [ ]

Note: To obtain a POS device, please contact your pharmacy affiliation (Chain, PSAO).

Drug Carve-Out List

The drugs listed below should be submitted to Electronic Data System (EDS) Medi-Cal Fee-For-Service (FFS).

HIV/AIDS Drugs:

Abacavir Sulfate
Amprenavir
Atazanavir
Delavirdine Mesylate
Efavirenz
Emtricitabine
Indinavir Sulfate
Lamivudine
Lexiva
Lopinavir
Lopinavir/Ritonavir
Nelfinavir Mesylate
Nevirapine
Ritonavir
Saquinavir
Saquinavir Mesylate
Stavudine
Tenofovir Disoproxil Fumarate
Zidovudine/Lamivudine
Zidovudine/Lamivudine/Abacavir

Anti-Psychotic Drugs:

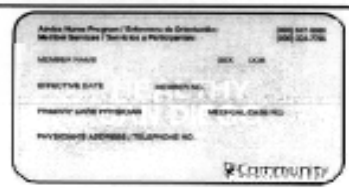
Amantadine HCL
Aripiprazole
Benztropine Mesylate
*Biperiden HCL
*Biperiden Lactate
Chlorpromazine HCL
Chlorprothixene
Clozapine
Fluphenazine Decanoate
Fluphenazine Enanthate
Fluphenazine HCL
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
*Isocarboxazid
Lithium Carbonate Caps
Lithium Carbonate Tabs/CR
Lithium Citrate Syrup
*Loxapine HCL
*Loxapine Succinate
Mesoridazine Mesylate
Molindone HCL
Olanzapine
Perphenazine
*Phenelzine Sulfate
*Pimozide
Proclyclidine HCL
*Promazine HCL
Quetiapine
Risperidone
Thioridazine HCL
Thiothixene
Thiothixene HCL
*Tranylcypromine Sulfate
Trifluoperazine HCL
*Triflupromazine HCL
Trihexyphenidyl
Ziprasidone
Ziprasidone Mesylate

*Indicates medications which require a TAR (treatment authorization request)

† *Document adapted courtesy the L.A. Care Health Plan*

Step 2 - Plan Information

PBM:Wellpoint 800-700-2541
Eligibility: 800-962-7378
Prior Auth. Fax: 888-831-2243
CCU: 800-407-4627
Member ID: Client Identification # (CIN)

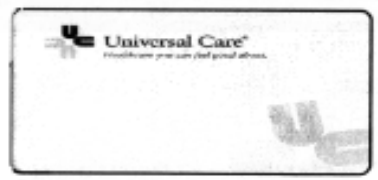


PBM:MedImpact: 800-788-2949
Eligibility: 800-854-0208
Prior Auth. Phone: 800-788-2949
Prior Auth. Fax: 800-578-9732
Member ID: Social Security #

PBM:HNPS
(Health Net Pharmaceutical Services)
Eligibility: 800-554-1444 #1
Prior Auth. Phone: 800-867-6564
Prior Auth. Fax: 800-977-8226
Member ID: Social Security #

PBM: Kaiser Pharmacy Services 800-464-4000
Eligibility: 800-464-4000
Medi-Cal Program: 619-528-5282
Member ID: Medical Record #

PBM:RxAmerica 800-770-8014
Eligibility: 800-359-2002
Prior Auth. Phone: 619-228-2400
Prior Auth. Fax: 619-228-2448
Member ID: Social Security #



PBM:MedImpact 800-788-2949
Eligibility: 800-673-4666
Prior Auth. Phone: 800-673-4666
Prior Auth. Fax: 562-981-5808
Member ID: Social Security#

SAN DIEGO REGIONAL CENTER FOR THE DEVELOPMENTALLY DISABLED

CALIFORNIA EARLY START PROGRAM

Eligibility:

- Birth to age 3 years
- Residence in San Diego or Imperial County
- No financial qualifications
- High risk for developmental disability:
  (Two or more factors that require early intervention services)
  - Small for gestational age
  - Seizures in the first week of life
  - Less than 32 weeks gestation or 1500 grams
  - Lack of oxygen at birth
  - Assisted ventilation for 48 hours or more
  - Failure to thrive

OR

Established risk for developmental disability:
- Conditions known to cause delays in development
  (e.g. Down syndrome, Prader-Willi, Spina-Bifida)
- Need not be demonstrating delays at time of referral

OR

Developmental delay in one or more of the following areas:

Cognitive	Physical
Communication	Social or Emotional
Adaptive	

Services:

Evaluation of all areas of development to determine eligibility.
Development of an Individualized Family Service Plan (IFSP).
Coordination of early intervention services which may include:

Assistive Technology	Audiology
Health Services	Medical Services (for evaluation)
Nursing Services	Nutrition Services
Occupational Therapy	Physical Therapy
Psychological Services	Service Coordination
Social Work	Special Instruction
Speech & Language Services	Transportation
Vision Services	Transition Plan at age 3 yrs
Respite	Counseling
Family Training	Home Visits

TO REFER

San Diego County (858) 496-4318 Imperial County (760) 355-8383

SAN DIEGO REGIONAL CENTER (SDRC)

Eligibility:

- Age 3 years or older
- Residence in San Diego or Imperial County
- No financial qualifications
- Developmental Disability:
  - Mental Retardation
  - Cerebral Palsy
  - Epilepsy
  - Autism
  - Other conditions similar to mental retardation

AND

- Originated prior to age 18 years

AND

- Is likely to continue indefinitely

AND

- Constitutes a substantial disability in 3 or more of the following areas:

Communication	Economic Self-Sufficiency
Learning	Self Care
Self-Direction	Mobility
Capacity for Independent Living	

Services:

Evaluation to determine eligibility
Assessment to assist with program planning
Development of the Individual Program Plan (IPP)
Case Management/Service Coordination
Coordination of developmental disability services which may include:

Residential Services	Respite
Work Program	Behavior Intervention
Transportation	Physical Therapy
Psychological Services	Medical Services
Nursing Services	

(In order to process intake, SDRC must be contacted by the parent or legal guardian of a minor, the conservator, or the unconserved adult.)

TO REFER

San Diego County (858) 576-2938 Imperial County (760) 355-8383

Programs of San Diego Imperial Counties Developmental Services, Inc.

COORDINATION OF CARE

BETWEEN PHYSICAL & BEHAVIORAL HEALTH PRACTITIONERS

SECTION A. CLIENT INFORMATION			
Name Last First Middle Initial		AKA	☐ Male ☐ Female
Street Address		Date of Birth	
City		Telephone #	
Zip		Alternate Telephone #	

SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION		
Name		
Organization OR Medical Group		
Street Address	City, State, Zip	
Telephone #	Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis
Current Symptoms		
Current Medications		
Summary of Patient Evaluation	Current Treatment Plan	

SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION		
Name		
Organization OR Medical Group		
Street Address	City, State, Zip	
Telephone #	Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis
Current Symptoms		
Current Medications		
Summary of Patient Evaluation	Current Treatment Plan	

To Reach a Plan Representative

Blue Cross Of California (800) 407-4627	Health Net (800) 675-6110	Universal Care (800) 635-6668
Community Health Group (800) 404-3332	Kaiser Permanente (800) 464-4000	United Behavioral Health (800) 479-3339
	Sharp Health Plan (800) 359-2002	

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

FOR OFFICE USE	ID VALIDATION
SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

o Information Contained on this form o Current Medication & Treatment Plan o Substance Dependence Assessments o Assessment /Evaluation Report	o Discharge Reports/Summaries o Laboratory/Diagnostics Test Results o Medical History o Other _____
To Reach A Health Plan Representative Call: Blue Cross Of California (800) 407-4627 Community Health Group (800) 404-3332 Health Net (800) 675-6110 Kaiser Permanente (800) 464-4000 Sharp Health Plan (800) 359-2002 Universal Care (800) 635-6668 United Behavioral Health (800) 479-3339	**Client Name { *Please type or print clearly*}** *(Last)* _____ *(First)* _____

I would like a copy of this authorization.

☐ Yes ☐ No Initials ☐

PLACE A COPY OF THIS FORM
IN THE CLIENT'S MEDICAL RECORD

Appendix F
Beneficiary Rights and Issue Resolution

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

1) Grievance process
2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)
3) Expedited Appeal process (available in certain limited circumstances)
4) State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5,

Section 1850.205 and 42 CFR Subpart F, Part 438.400. **The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document.** By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.

2. To protect the rights of consumers receiving mental health services, including the right to:

- Be treated with dignity and respect,
- Be treated with due consideration for his or her privacy,
- Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
- Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
- Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
- Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
- Freely exercise these rights without adverse effects in the way providers treat him or her.

3. To protect the rights of consumers during grievance and appeal processes.

4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.

5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.

6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.

2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.

3. Consumers shall be informed of their right to contact the University of San Diego (USD) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.

4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the USD Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages, and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.

5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.

6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.

7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.

8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.

9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

   - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
   - Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision whether or not the client received a Notice of Action (NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)
   - Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
   - Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact USD Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from USD or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through USD Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and

Advocacy (for outpatient and all other mental health services.)

IV. GRIEVANCE PROCEDURES:

At any time the consumer chooses, the consumer may contact CCHEA or USD Patient Advocacy, as appropriate. CCHEA or USD Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts USD Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).
   NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition). not a grievance. See "Appeal Process" in Section V below for procedure.

2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include:

   - the client name or other identifier,
   - date the grievance was received,
   - the date it was logged, the nature of the grievance,
   - the provider name,
   - whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.

4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.

5. CCHEA or Patient Advocacy Program investigates the grievance.

   - CCHEA or USD shall ensure that the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.
   - In cases where the CCHEA or USD staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.
   - The client's confidentiality shall be safeguarded per all applicable laws.

6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's

condition.

7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or USD and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If a case should arise in which CCHEA or USD and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or USD shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or USD may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.

8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
   - the date
   - the resolution

   A copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.

9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or USD will contact the client to discuss an extension, clearly document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or USD staff must give the client written notice of the reason for the delay. If CCHEA or USD staff is unable to meet the timeframe described herein, the staff person shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or USD Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason

there has not been a final disposition of the grievance.

11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or USD. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

Grievance Plan of Correction
Quality Improvement Unit
P.O. Box 85524, Mail Stop P531G
Camino Del Rio South
San Diego, CA 92186-5524

The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or USD's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing Date
2	Grievance Logged	1 Working Day from Grievance Filing
3	Written Acknowledgement to client	3 Working Days from Grievance Filing
4	Provider Contact	Within 3 Working Days from Client's Written Permission to Represent
5	Clinical Consultant review, if applicable	Within 60 day total timeframe
6	Grievance Disposition	60 Days from Filing Date
7	Disposition Extension (if needed)	14 Calendar Days from the 60th day
8	Provider Plan of Correction (if needed)	10 Working Days from Disposition Date
9	Request for Administrative Review	10 Working Days from receipt of the Grievance Disposition

V. APPEAL PROCESS—available to Medi-Cal Beneficiaries only

The appeal procedure begins when a Medi-Cal beneficiary contacts USD Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOA was mailed, or
- within 10 days of the date the NOA was personally given to the beneficiary, or
- before the effective date of the service change, <u>whichever is later</u>.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, <u>whichever is earliest</u>.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be

provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.

2. CCHEA or USD Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.

3. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the:

   - client name or other identifier,
   - date the appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - the provider involved,
   - and whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. If the client requests to see the log, CCHEA or USD will summarize in writing the content pertaining to the client.

4. CCHEA or USD shall acknowledge, in writing, receipt of the appeal within three working days.

5. CCHEA or USD shall contact the provider as soon as possible and within three working days of receipt of the client's written authorization to represent the client.

6. CCHEA or USD Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.

7. CCHEA or USD evaluates the appeal and:

   - Ensures that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - Safeguards the client's confidentiality per all applicable laws.

     In cases where the CCHEA or USD staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the

client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or USD staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or USD, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or USD denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or USD believes that there is sufficient merit to grant an appeal regarding an action that:

- denied or limited authorization of a requested service, including the type or level of service,
- reduced, suspended or terminated a previously authorized service, or
- denied, in whole or in part, payment for a service, CCHEA or USD shall do the following within 30 calendar days of the date the appeal was filed:

  a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
  b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.

12. CCHEA or USD shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:
    - the date,
    - the resolution,
    - and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
      - the right to request a State Fair Hearing within 90 days of notice of the decision,
      - how to request a State Fair Hearing, and
      - the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
      - A copy of the appeal resolution letter will be sent to the provider and the Quality Improvement (QI) Unit at the time the letter is sent to the client.

13. Appeals must be resolved within 45 calendar days from the date of receipt of the appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of appeal

resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.

14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.

15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOA-D to Medi-Cal beneficiaries only. A copy shall be sent to the QI Unit. CCHEA or USD Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.

16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

STEP	ACTION	TIMELINE
1	Appeal Filed by client	File Date
2	Appeal Logged	1 Working Day from Appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	3 Working Days from Receipt of Appeal
5	Provider Contact	3 Working Days from Client's Written Permission to Represent
6	Clinical consultant review, if applicable	As soon as possible
7	Notify QI Unit	3 Working Days of Appeal Filing
8	Advocacy Organization recommends denying appeal	See #10 for timelines
9	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation	Within 30 calendar days from date appeal was filed
10	MHP Director makes decision on the appeal	Within 10 calendar days from receipt of appeal.
11	**Appeal Resolution**	**45 Calendar Days from Receipt of Appeal**
12	Appeal Extension (if needed)	14 Calendar Days from Extension Filing Date

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or USD Patient Advocacy program staff, jeopardize the client's life, health or ability to

attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:
   - client name or other identifier,
   - date appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - provider involved,
   - and whether the issue concerns a child.
4. The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
6. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two working days.
7. The client or his or her representative may present evidence in person or in writing.
8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
   - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - The client's confidentiality shall be safeguarded per all applicable laws.
9. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
10. If, in the opinion of CCHEA or Patient Advocacy Program, the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
    - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.
    - Transfer the appeal to the timeframe for standard appeal resolution (above), and
    - Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a

written notice. A copy of the letter shall be sent to QI.

11. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or USD staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or USD, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If CCHEA or USD denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14.*

12. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two working days of the date the appeal was filed:
        - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
        - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.

13. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.

14. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:
    - the date,
    - the resolution,
    - and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
    - information regarding the right to request an expedited State Fair Hearing
    - information on how to request continued services (aid paid pending) while the hearing is pending.

    A copy of the appeal resolution letter will be sent to the provider and the QI Unit

at the same time the letter is sent to the client.

15. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or USD staff determines that there is a need for more information AND that the delay is in the client's best interest.

16. If the timeframe extension was not requested by the client, CCHEA or USD Patient Advocacy staff must give the client written notice of the reason for the delay.

17. If CCHEA or USD staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.

18. CCHEA or USD Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

19. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

EXPEDITED APPEAL PROCESS

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in 2 calendar days in writing
3	Expedited Appeal Logged	1 Working Day from Appeal receipt
4	Written Acknowledgement of appeal to client	2 Working Days from Receipt of Appeal
5	Provider Contact	2 Working Days from Client's Written Permission to Represent
6	Notify QI Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines
8	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation.	Within 2 working days from date appeal was filed
9	MHP Director makes decision on the appeal	Within 1 working day from receipt of notification from the Advocacy Organization
10	Appeal Resolution	3 Working Days from Receipt of Appeal
11	Disposition Extension (if needed)	14 Calendar Days from 3rd working day.

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or USD Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QI Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QI Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:
    - within 10 days of the date the NOA was mailed, or
    - within 10 days of the date the NOA was personally given to the beneficiary, or
    - before the effective date of the service change, <u>whichever is later</u>.
5. The beneficiary must have:
    - an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or

- been receiving specialty mental health services under an 'exempt pattern of care' (see Section XII. Definitions).

6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

7. After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case is not resolved in the MHP's favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Action (NOA) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QI Unit shall review the files of CCHEA and USD Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.

2. On a monthly basis, by the 20th of the following month, USD Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:

   - client name or other identifier
   - date the grievance or appeal was filed,
   - date logged
   - nature of the grievance or appeal
   - provider involved,
   - and whether the issue concerns a child.

3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

4. The MHP QI Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track

outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and USD Patient Advocacy shall report to the QI Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QI Unit also.

2. The QI Unit will investigate all such complaint clusters.

3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of 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 or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Appeal: A request for review of an action (as action is defined above).

Beneficiary: A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

Client:	Any individual currently receiving mental health services from the County MHS system, regardless of funding source.
Consumer Center for Health Education and Advocacy (CCHEA):	CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.
Consumer:	Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)
Grievance:	An expression of dissatisfaction about any matter other than an action (as action is defined).
Grievance and Appeal Process:	A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.
Mental Health Plan (MHP):	County of San Diego, Health & Human Services Agency, Mental Health Services.

Notice of Action (NOA):

A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.

NOA-B: (Denial of Services) Denial or modification of provider's request for Medi-cal services requiring pre-authorization. The denial is sent from the point of authorization to both provider and beneficiary, when the beneficiary did not receive the service.

NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.

NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.

NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.

Patients' Rights Advocate:

The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

USD Patient Advocacy Program staff currently serve as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serve as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Improvement (QI) Program:

The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

State Fair Hearing:	A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.
University of San Diego (USD) Patient Advocacy Program:	The University of San Diego Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.

Appendix G
Quality Improvement Program

CALIFORNIA DEPARTMENT OF
Mental Health

REASONS FOR RECOUPMENT
IN FY'06-07
NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1830.205(b)(1)(A-R).

   CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   CCR Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C) and 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C)—(see below):

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope MC beneficiaries under the age of 21 years, a condition, as a result of the mental disorder, that specialty mental health services can correct or ameliorate

   NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT-eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

   CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(A)

REASONS FOR RECOUPMENT
IN FY'06-07

MEDICAL NECESSITY (con't):

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:

   - Significantly diminish the impairment
   - Prevent significant deterioration in an important area of life functioning
   - Allow the child to progress developmentally as individually appropriate
   - For full-scope M/C beneficiaries under the age of 21 years, correct or ameliorate the condition

   CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(B)(1),(2), and (3)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in MHP's documentation guidelines, or, lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

   MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in MHP's documentation guidelines.

   MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

   MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving TBS, no documentation of a plan for TBS.

   DMH Letter No. 99-03, pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

   CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

    CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT
IN FY'06-07

PROGRESS NOTES (con't):

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for FFP, e.g., Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per Title 9, Chapter 11.

    CCR, Title 9, Chapter 11, Sections 1840.312(g)&(h) and 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for MC. (Dependent minor is MC eligible. Delinquent minor is only MC eligible after adjudication for release into community.)

    CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

    CCR, Title 9, Chapter 11, Section 1840.312(a),(b),(c), and (d)

14. The claim for a group activity was not properly apportioned to all clients present.

    CCR, Title 9, Chapter 11, Section 1840.316)b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

    CCR, Title 9, Chapter 11, Sections 1810.355(a)(1)(B), 1840.312(f), and 1810.247, and 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

    CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

    CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

19. No service provided: Missed appointment per DMH Letter No. 02-07.

    DMH Letter No. 02-07

REASONS FOR RECOUPMENT
IN FY'06-07

PROGRESS NOTES (con't):

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

    a) For the convenience of the family, caregivers, physician, or teacher
    b) To provide supervision or to ensure compliance with terms and conditions of probation
    c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
    d) To address conditions that are not a part of the child's/youth's mental health condition

    DMH Letter No. 99-03, page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

    DMH Letter No. 99-03, page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

    CCR, Title 9, Chapter 11, Section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
    - Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital

REASONS FOR RECOUPMENT
IN FY'06-07

MEDICAL NECESSITY (con't):

- Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, Title 9, Chapter 11, Sections 1820.205(a)(2)(B) 1 a-d, 1820.205(a)(2)(B) 2 a-c, and 1820.205(b)(1-4)

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity criteria for acute psychiatric inpatient hospital service during the current hospital stay.

    CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following: a) The status of the placement option(s), b) the dates of the contacts, and c) the signature of the person making each contact.

CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

    Code of Federal Regulations (CFR), Title 42, Subchapter C, Subpart D, Sections 456.180; *CCR, Title 9, Chapter 11,* Section 1820.210

27. The client plan was not signed by a physician.

    CFR, Title 42, Subchapter C, Subpart D, Sections 456.180; *CCR, Title 9, Chapter 11,* Section 1820.210

OTHER:

28. A claim for a day when the beneficiary was not admitted to the hospital.

    CCR, Title 9, Chapter 11, Sections 1810.238, 1820.205, and 1840.110(a)
    (b)(2)(A),(B),(C) and 1830.210(a)(3)

APPEAL PROCESS
Medi-Cal QI Recoupment Report
County of San Diego Children's Mental Health Services

The Quality Improvement Unit's 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision is as follows:

1. QI Specialist will mail the provider a formal written report outlining the results of their medical record review within 14 days of review completion.

2. Provider has 14 days from date of the cover letter attached to the written report to request a first level appeal.

3. First level appeal must be in writing, specify which recoupment(s) is being appealed, reason why, and include any supporting documentation from the medical record. Appeal should be marked "confidential" and mailed to Victoria Hilton, QI Program Manager.

4. First level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

5. Should provider disagree with first level decision, provider has 7 working days from receipt of written decision to request a second level appeal. Second level appeal must be in writing, specify which recoupment(s) is being appealed from first level decision, and reason why. Appeal should be marked "confidential" and mailed to Candace Milow, Chief, Quality Improvement.

6. Second level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

Mailing address for Children's Quality Improvement:
County of San Diego
Children's Mental Health Services
P.O. Box 85524 Mailstop: P-531Q
San Diego, CA 92186-5524

Any questions regarding this procedure may be directed to Kathleen Sorahan at (619) 584-5021.

Actions For Reasons for Recoupment
as of 01-01-06

Reason	*Adjustment to Cost Report*	*Service Deletion*	*Provider Re-enter Service*
Medical Necessity:			
1.Documentation does not establish an included diagnosis	X		*No re-entry for this reason.*
2. Documentation does not establish impairment criteria	X		*No re-entry for this reason.*
3. Documentation does not establish proposed intervention to address the impairment	X		*No re-entry for this reason.*
4. Documentation does not extablish expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	X		*No re-entry for this reason.*
Client/Service Plan:			
5. Initial plan not completed within time period	X		*No re-entry for this reason.*
6. Not updated within time period	X		*No re-entry for this reason.*
7. No documentation of client participation/agreement	X		*No re-entry for this reason.*
Progress Notes:			
8. No note for service claimed		X	*No re-entry for this reason.*
9. Time claimed greater than time documented		X	*Re-enter corrected time.*
10. Service provided were ineligible for FFP(Federal Finiancial Participation) or in setting subject to lockouts (i.e. service provided while client was in an IMD, Jail, Juvenile Hall, etc…)		X	*Re-enter as non-billable.*
11. TBS provided in juvenile hall		X	*Re-enter as non-billable.*
12. Service provided was solely academic, vocational, recreation, socialization		X	*Re-enter as non-billable.*
13. Claim for group activity was not properly apportioned		X	*Re-enter corrected time.*
14. Does not contain a signature	X		*No re-entry for this reason.*
15. Service provided was solely transportation		X	*Re-enter as non-billable.*
16. Service provided was solely clerical		X	*Re-enter as non-billable.*
17. Service provided was solely payee related		X	*Re-enter as non-billable.*
18. "No Show" billed (over zero minutes) when no treatemt service provided		X	*Re-enter as non-billable.*
19. Entry 14 days (plus) after service date (as of 7-1-06)		X	*Re-enter as non-billable.*

QUALITY IMPROVEMENT – HHSA-CHILDREN'S MHS
MEDICATION MONITORING SCREENING TOOL

Please complete all boxes on this form with legible writing or type.

Program:	**Review Date:**
Client (first name only):	**InSyst #:**
Treating Psychiatrist:	
Reviewer:	

PLEASE NOTE: ALL "NO" ANSWERS REQUIRE A MCFLOOP FORM.

	CRITERIA	COMPLIANCE Yes	No	NA	COMMENTS
1.	Were medication rationale and dosage consistent with standard of care in Child and Adolescent Psychiatric community?	☐	☐		
2.	If Labs were indicated, were they ordered, obtained, & acted upon?	☐	☐	☐	
3.	Were physical health conditions and treatment considered when prescribing psychiatric medication?	☐	☐	☐	
4.	For each class of meds below please indicate whether there was clearly documented rationale for prescribing <u>more</u> than 1 medication in each category:				"No" answer means that the rationale was not clearly documented <u>and</u> client is on more than 1 med. in that class. Put N/A if client doesn't take this medication.
	a. Stimulants	☐	☐	☐	
	b. Mood Stabilizer	☐	☐	☐	
	c. Antidepressants	☐	☐	☐	
	d. Antipsychotics	☐	☐	☐	
	e. Antiparkinsonian	☐	☐	☐	
5	Were Adverse Drug Reactions and/or Side Effects treated and managed effectively?	☐	☐	☐	
6.	Was informed consent obtained, as evidenced by a signed consent form or ex-parte order?	☐	☐	☐	
7.	Was the diagnosis in concordance with prescribed medication?	☐	☐	☐	
8.	Did treating M.D. document:				
	a. client's response to medication therapy?	☐	☐	☐	
	b. the presence/absence of side effects?	☐	☐	☐	
	c. the extent of client's compliance with the prescribed medication regime and relevant interventions?	☐	☐	☐	
	d. measures taken to educate client/parent in regard to medication management?	☐	☐	☐	

Medication Monitoring Committee Minutes

PROGRAM:_____

PLEASE LIST ALL RU NUMBERS COVERED BY THIS REPORT: _____
(If this report covers more than one program, please identify the programs on the screening tools)

Committee Members		**Discipline**	**√ Present**
Chairperson	_____	_____	☐
Members	_____	_____	☐
	_____	_____	☐
	_____	_____	☐
	_____	_____	☐
	_____	_____	☐
	_____	_____	☐

Meeting

Date: _____

Time: _____**to** _____

Place_____

Reporting Period
Year:_____

☐ **Jul 1 – Sep 30**
☐ **Oct 1 – Dec 31**
☐ **Jan 1 – Mar 31**
☐ **Apr 1 – Jun 30**

Description of Activities

Old Business

_____ Number outstanding variances from last MM Committee Meeting (see McFloop form)

_____ Number of variances requiring follow-up

New Business

_____ Number of records screened this meeting by ☐ County Pharmacy
Or by ☐ MM Committee

_____ Number of variances identified and requiring follow-up

_____No medication monitoring done at this site(s)

_____ _____
Signature Date
Medication Monitoring Chairperson or Designee

Revised 2/9/02

McFloop Form

PROGRAM:

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____
Patient Name _____
InSyst # _____

Summary of Recommendations/Requests for Action:

_____

Physician Reviewer Signature & Discipline **Date**

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

_____

Physician Signature & Discipline **Date**

Verification of Physician Response

( ) Approved

( ) Disapproved (Forwarded to PTSOC)

_____

Physician Reviewer Signature & Discipline **Date**

Perpetual Inventory Medication Log					
Program Name:					Month:
Client Name:					
Date	Medication Name and Doseage	# of Tablets Received	# of Tablets Adm. by Client	Staff Signature	Client Signature

Medication Disposal Log					
Program Name:					
Date	Client	Medication/Dosage	# of Tablets	Witness Signature #1	Witness Signature #2

County of San Diego
Health and Human Services Agency
Children's Mental Health Services
UNUSUAL OCCURRENCES REPORT

Client's Name:_____ DOB:_____ Program:_____
Address of occurrence: _____
Date/Time of Occurrence: _____ Location/Setting: _____
Staff Involved: _____
Type(s) of Occurrence: (check all that apply)

_____Suicide attempt	_____Self injury	_____Property destruction
_____Alleged child abuse	_____Physical abuse	_____Epidemic outbreak
_____Medication error	_____AWOL	_____Adverse drug reaction
_____Police involvement	_____Fire setting	_____Injurious assault by client
_____Inappropriate sexual behavior	_____Poisoning	_____Injurious assault on client
_____Death	_____Major accident	_____ Physical injury

Other_____

Describe Incident: (description of client physical condition, what happened, to whom, where, what methods of intervention, who was present)_____
_____
_____
_____
_____
_____
_____
_____(cont. on back if needed)

Physical and/or medical concerns; also include current prescribed medication and dosage: _____
_____
_____

Staff response/Planned follow-up (conclusion): _____
_____
_____
_____

Staff Signature:_____Title:_____
Print Name: _____Date/Time: _____Phone:_____

Supervisor Remarks: _____
_____(cont. on back if needed)
Supervisor Signature: _____Title:_____ Date/Time:_____

OCCURRENCE REPORTED TO:	**DATE:**
Parent/Guardian: (name & phone number)	☐ Verbal ☐ Written
Program Monitor:	☐ Faxed to Program Monitor
Case Managers: (names and phone number)	☐ Verbal ☐ Written
Children's Services Worker/Probation Officer: (name and phone number)	☐ Verbal ☐ Written

County of San Diego
Health and Human Services Agency
Children's Mental Health Services

MAJOR UNUSUAL OCCURRENCES REVIEW SUMMARY

Client Name: _____ **Client Number:**_____ **D.O.B.:**_____

Program Name: _____ **Program Phone Number**: _____

Incident Reviewed (please check one):

_____ Physical injury resulting in a client experiencing severe (serious or grievous) physical damage or loss of consciousness, respiratory or circulatory collapse

_____ Death

_____ Other:

Date of incident: _____ **Time of incident**: _____ **Location:** _____

Admitting Diagnosis/Problems: _____

Instructions: Please record case information, discussion, conclusions, recommendations and action of each serious incident reviewed.

DATE OF COMMITTEE REVIEW: _____

REASON FOR REVIEW:

SUMMARY OF FINDINGS:

CONCLUSIONS: (Include quality of medical record and clinical pertinence)

RECOMMENDATIONS: (Include what corrective action is recommended)

ACTIONS TAKEN/RESPONSE:

Committee Members with credentials:

_____ _____

_____ _____

Committee Chair/Designee

_____ _____

Signature Date Signed

Please fax to:
Designated County Program Monitor,
Chief, Special Education Services (fax) 619-758-6255 **or**
Chief, Juvenile Forensics (fax) 858-694-4492 **or**
Chief, Critical Care and Outpatient Services (fax) 619-421-7186 **or**
Chief, EPSDT and Outpatient Services (fax) 619-584-5009 **or**
Chief, Residential Services (fax) 619-688-4605
Quality Improvement (fax) 618-584-5018 **and in all cases to**
Mental Health Director, Children's Mental Health Services (fax) 619-563-2775

6-11-03

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. SERVICE AND BILLING UNITS:

SERVICE FUNCTIONS	Service Units					Billing Units				
	Annual Budget	Prior Month YTD	Report Month Actual	YTD Actual	% of Objective Complete	Annual Budget	Prior Month YTD	Report Month Actual	YTD Actual	% of Objective Complete
MHS										
MED SUPPORT										
CRISIS INTERVENTION										
CM BROKERAGE										
REHABILITATION										
TOTAL	0	0	0	0	0%	0	0	0	0	0%
REP PAYEE										
MAA										
FIRST TIME CALLS										
REPEAT CALLS										
TRANSFER TO ACL										
IMD LONG TERM										
OTHER (SPECIFY)										
TOTAL	0	0	0	0	0%	0	0	0	0	0%
COMMENTS										

3. STATISTICAL INFORMATION:

Report Item	Report Month	Year to Date
Admissions - *Total number as of last day of report month.*		
Discharges - *Total number as of last day of report month.*		
Active cases - *Total active cases as of last day of report month.*		
Unduplicated clients - *Total unique served during report month.*		
Serious Incident Report - *Total for the report month.*		
Budgeted FTE Direct Service Staff - *Total number,* ***(excluding consultants).***		
Actual FTE Direct Service Staff - *Total number as of the last day of the report month.*		
Average Caseload per Actual Direct Service Staff FTE - *#active cases/#direct service.*		

ITEMS 4 AND 5 BELOW APPLY TO CHILDREN'S PROGRAM ONLY.

4. WAIT LIST REPORT:

Total Number on Waiting List	Waiting Time (WT) in Days	WT for Initial MD Evaluation in Days	Total Number of AB2726 Waiting

Comments:

5. FAMILIES PARTICIPATING IN FACE-TO-FACE THERAPY AT LEAST TWO TIMES PER MONTH:

Total Number of Families	Total Number of Participating Families	Percent of Participation

Comments:

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-OUTCOMES

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. MHRTS (MENTAL HEALTH RECOVERY TREATMENT SCALE)

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

3. SATS-R (SUBSTANCE ABUSE TREATMENT SCALE - REVISED)

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

4. RESIDENTIAL STATUS OUTCOME

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

5. EMPLOYMENT STATUS OUTCOME

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

5. EDUCATION STATUS OUTCOME

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

County of San Diego - Health and Human Services Agency

Mental Health Services

MONTHLY STATUS REPORT-SUGGESTION & TRANSFER

due the 15th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

For instructions please click on the RED Markers located at the upper right corner of each heading.

1. General Information

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. Suggestion and Transfer Data

Date Received or Initiated **mm/dd/yy**	Indicate if this is Client **(S)** Suggestion or **(T)** Transfer Request	Client Suggestion Code **1-15**	Transfer Request Code **1-11**	Indicate if Client Transfer Request is **(O)** Out of Program or **(N)** To New Provider within the Program	Description of Client Suggestion or Transfer Request	Date of Resolution **mm/dd/yy**	Describe Resolution or Action Taken

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-MEDICARE PART "D"

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. MEDICARE PART "D" DATA:

Data Elements		Comments
What is the current caseload for:		
Dual eligibles (Medi-Medi)		
Medicare only		
Total		
Has the program been affected by Medicare Part D?		
YES		
NO		
If YES, mark all issues that apply by an "X":		
Medication not on Formulary		
Difficulty with payment (copay, premium, etc)		
Difficulty with enrolling/changing plans		
Access to physical medications		
Increase in Hospital or START program admissions		
Increase in serious incidents		
Other:		

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. STAFFING UPDATES

3. PERSONNEL LISTING

Position	Name	Credential	Position Type Code	Budgeted FTE	Actual FTE	Ethnicity Code	Language Prof Code	Read & Write Prof	Specialty Code	Hire Date	Terminate Date	CC Training Attended	CC Trng Course Attended

County of San Diego - Health and Human Services Agency

TRAINING REPORT

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. TRAINING REPORT

Training Course Designation	Course Topic or Description	Training Provided by **(C)** County or **(N)** NonCounty	Course Length (number of hours) **0.5** to **40.0**	Course Date Enter Actual Course Start Date **mm/dd/yy**	Number of Attendees by Function				Type of Training
					Administration or Management	Direct Services	Support Services	Volunteer or Student Workers	

Appendix H
Cultural Competence

Appendix I
Management Information System

Appendix J
Provider Contracting

County of San Diego - Health and Human Services Agency
Mental Health Services
PROVIDER SELF-REPORT DISALLOWANCE CLAIM FORM
Forward form electronically to: MHS-COTR.HHSA@sdcounty.ca.gov
For instructions please refer to attached worksheet Disallowance Instructions

1. GENERAL INFORMATION:

Organization Name		Email Address	
Program Name		Review Period	
Contract Number		Review Date	
RU Number		Contact Phone	
Approved & Submitted By		County Tracking Number	

2. CERTIFICATION:

By submitting this form, the organization hereby certifies that all entries are correct and accurate, a thorough review was conducted, and a full understanding that submitted disallowance amounts will be deducted from the organizational account. Organization further certifies that it fully understands and has reviewed the County of San Diego, Health and Humna Services Agency, Mental Health Services Organizational Handbook specifically dealing with Billing Disallowances-Provider Self Report.

3. DISALLOWANCE DESCRIPTION:

InSyst Number (Unique Client ID)	**Procedure Code** (3-Digit InSyst Service Procedure Code)	**Service Date** (MM/DD/YY)	**Therapist** (4-Digit Provider ID Number)	**Service Time** (HH:MM)	**Service Cost** ($ Amount)	**Service Deletion** (X)	**Re-Entered Procedure Code** (3-Digit InSyst Service Procedure Code)	**Reason for Disallowance** (Select from drop-down menu 1 – 20)	**DCS Status** (County Use Only)	**DCS Final Status** (County Use Only)
999999999	999	01/01/07	9999	01:15	$ 125.00	X	222	4-Documentation does not establish expectation interventior	NB	NB

Reason	Disallow Billing	Delete Service	Provider Re-enter Service
Medical Necessity:			
1.Documentation does not establish an included diagnosis	X		No re-entry for this reason.
2. Documentation does not establish impairment criteria	X		No re-entry for this reason.
3. Documentation does not establish proposed intervention to address the impairment	X		No re-entry for this reason.
4. Documentation does not extablish expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	X		No re-entry for this reason.
Client/Service Plan:			
5. Initial plan not completed within time period	X		No re-entry for this reason.
6. Not updated within time period	X		No re-entry for this reason.
7. No documentation of client participation/agreement	X		No re-entry for this reason.
Progress Notes:			
8. No note for service claimed	X	X	No re-entry for this reason.
9. Time claimed greater than time documented	X	X	Re-enter corrected time.
10. Service provided were ineligible for FFP (Federal Financial Participation) or in setting subject to lockouts (i.e. service provided while client was in an IMD, Jail, Juvenile Hall, etc…)	X	X	Re-enter as non-billable.
11. TBS provided in juvenile hall	X	X	Re-enter as non-billable.
12. Service provided was solely academic, vocational, recreation, socialization	X	X	Re-enter as non-billable.
13. Claim for group activity was not properly apportioned	X	X	Re-enter corrected time.
14. Does not contain a signature	X		No re-entry for this reason.
15. Service provided was solely transportation	X	X	Re-enter as non-billable.
16. Service provided was solely clerical	X	X	Re-enter as non-billable.
17. Service provided was solely payee related	X	X	Re-enter as non-billable.
18. "No Show" billed (over zero minutes) when no treatment service provided	X	X	Re-enter as non-billable.
Data Entry:			
19. Data entry error	X	X	Re-enter corrected service.
20. Documentation done 14 days after date of service	X	X	Re-enter as non-billable.

Instructions: For each reason, follow the corresponding action identified and document that on the Provider Self Reported Disallowance Claim Form. If the action indicates "delete service" please mark an "X" in the Service Deletion field. All services identified on the Disallowance Claim Form will be disallowed from the California State Department of Mental Health Claims Database.

Appendix K
Provider Issue Resolution

FORMAL COMPLAINT BY PROVIDER

Provider's Name	
Program Manager	
Agency	
Address	
Phone	
Fax	

FORMAL COMPLAINT BY PROVIDER **Forward Copy to QI Unit**
Date:
To:
From:
Summary and date on which issue(s) was attempted to be resolved informally (if applicable):
Outline of formal complaint/concern including all relevant data and comments, which support issue(s).
Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issues(s) informally. Attach any applicable document(s).

FORMAL RESPONSE TO COMPLAINT	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern, which includes a statement of the reason(s) for the decision that addresses each issue, raised by the provider, and any action required by the provider to implement the decision.	
Program Monitor/Chief shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision.	

FORMAL APPEAL BY PROVIDER	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Formal Provider Appeal may be submitted to the Mental Health Contracts Manager at any time.	
Outline summary of issue(s) and support for appeal with any needed attachment(s).	
When a formal complaint process was utilized, appeal shall be submitted to the Mental Health Contracts Manager within 30 calendar days of formal complaint response.	

FORMAL APPEAL RESPONSE	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern which includes a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.	
Mental Health Contracts Manager shall have 60 calendar days from the receipt of the written appeal to inform the provider in writing of the decision.	

Appendix L
Practice Guidelines

QUARTERLY PROGRESS MENTAL HEALTH IEP REPORT

Program: _____

Address: _____

Telephone: _____

Patient Name:	**DOB:**
Therapist:	
Reporting Period: **to**	

Progress Rating:
1-Goal not met; symptoms stayed the same or got worse
2-Goal not met completely, but some progress made (1-50% of goal achieved)
3-Goal not met completely, but substantial progress made (51-99% of goal achieved)
4-Goal met or exceeded (100% of goal achieved)

GOAL # 1:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 2:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 3:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

Scheduled Frequency of Sessions: **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐

Concerns with Attendance: No ☐ Yes ☐

Date of Contacts with School:

_____ _____

Therapist Signature **Date**

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
SAN DIEGO MENTAL HEALTH SERVICES

MENTAL HEALTH TREATMENT PLAN

Date: **Student:** **Type of Service:** **Start Date: ASAP** **Duration: 6 months**

Area of Need:

Present Level

Measurable Long-Term Goal:

Parents will be informed of progress	Periodic Review Dates	Progress Toward Goal	Sufficient Progress to Meet Goal
☒ Quarterly ☐ Trimester	1.	1.	☐Yes ☐No
☐ Semester ☐ Other:	2.	2.	☐Yes ☐No
How ?	3.	3.	☐Yes ☐No
☐ Annotated Goals/Objectives	4.	4.	☐Yes ☐No
☒ Other: teacher, therapist			

Benchmark/Short-Term Objective: Within 2 months:
1.

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Benchmark/Short-Term Objective: Within 4 months:
1.

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Area of Need

Present Level:

Measurable Long-Term Goal:

Parents will be informed of progress	Periodic Review Dates	Progress Toward Goal	Sufficient Progress to Meet Goal
☒ Quarterly ☐ Trimester	1.	1.	☐Yes ☐No
☐ Semester ☐ Other:	2.	2.	☐Yes ☐No
How ?	3.	3.	☐Yes ☐No
☐ Annotated Goals/Objectives	4.	4.	☐Yes ☐No
☒ Other: teacher, therapist			

Benchmark/Short-Term Objective: Within 2 months:

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Benchmark/Short-Term Objective: Within 4 months:

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Student Signature *Date* *Signature of Parent* *Date*

Signature of Mental Health Service Representative *Date*

MHTXPLN.tmp 09/28/99

COUNTY OF SAN DIEGO
DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES

NEED FOR IEP REVIEW

TO: _____DATE:_____

FROM: _____ TELEPHONE _____

RE: _____ DOB: _____

A. We are unable to continue our delivery of mental health assessment services to your pupil _____, for the following reason:

_____1. Parent has not signed a mental health assessment plan.

_____2. Parent has failed to come in for scheduled assessment visits.

_____3. Parent has withdrawn permission for the mental health assessment.

_____4. Other/comments _____
_____
_____
_____

B. This is to notify you of a substantial change to the IEP/Treatment Plan because:

_____1. Client has completed treatment.

_____2. Client is in need of change in mental health services level of care.

_____3. Child is not benefiting from his mental health services.

_____4. Parent no longer wishes to have treatment services identified on the IEP for the child through Short-Doyle/MHS.

_____5. Parent has had difficulty following through with the treatment plan.

_____6. Parent has moved to another district/SELPA

Other/comments_____
_____
_____
_____

cc: Chart

Appendix M
Staff Qualifications

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 11/03)

(Please fill-in all boxes below. See reverse side for completion instructions.)

APPLICANT'S FULL NAME, (Include aliases and maiden names):	
TYPE OF WAIVER REQUEST **(Please check appropriate box)**	
PSYCHOLOGIST: (5 years maximum) ☐	OUT-OF-STATE/LICENSE READY: (3 years maximum) PSYCHOLOGIST ☐ LCSW ☐ MFT ☐
DATE OF DEGREE OR DATE ALL DEGREE REQUIREMENTS MET:	EMPLOYMENT START DATE (in the position requiring the waiver):
REQUEST SUBMITTED BY: (SIGNATURE-MENTAL HEALTH DIRECTOR/DESIGNEE)	
DATE:	COUNTY:

DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

DATE WAIVER EXPIRES:	DATE COMPLETE WAIVER APPLICATION RECEIVED:
COMMENTS: (if denied, reason for denial)	
Approved by: ☐ Frank Salmon, Chief Medi-Cal Oversight-North/ Cathy Bishop, Designee ☐ Tom Burke, LCSW, Chief Medi-Cal Oversight-South/ Kathy Schramm, Ph.D. Designee	
Signature of Chief/Designee:	Date:

This waiver is effective the date a complete waiver application was received in the Medi-Cal Oversight regional office or the date of employment, whichever is later. It is not retroactive to the date of hire.

This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period.

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 11/03)

PROFESSIONAL LICENSING WAIVER REQUEST

Instructions for completing this form:

1) *Applicant's Full Name, Include Aliases and Maiden Names:* DMH staff need this information, when applicable, to accurately track the applicant's waiver history. At the option of the county, a waiver granted in one county is valid in another county for the life of the waiver. Rather than requesting a new waiver, when applicable, a county can obtain a copy of the previous waiver.

2) *Type of Waiver Request*: Clearly indicate the type of waiver request. The applicant will receive the maximum waiver period, unless requested otherwise by the county—five years Psychologists who are gaining experience for licensure or three years for individuals who were recruited from outside of California. (To be eligible for the Out-of-State/License-ready category, an applicant must be both license-ready and recruited from out-of-state.)

3) *Date of Degree or Date all Degree Requirements Were Met:* Attach a copy of the applicant's degree or a letter from the applicant's alma mater specifying the date the applicant met all the requirements for the doctorate degree. This is important in determining the commencement of the waiver period. A waiver cannot be granted prior to the degree date or the date the applicant met all the requirements for the doctorate degree.

4) *Employment Start Date (In the Position Requiring the Waiver):* Specify the date the applicant started or will start employment in the position requiring a waiver. The waiver time period (three or five years) will commence on this date unless the applicant had been previously employed in a local mental health program (county or contract) in a position that required a license. If the applicant has been so previously employed, the waiver time period will commence on the date of the previous employment.

   In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, it is necessary to attach a copy of the applicant's post-degree employment history. This can take the form of a current, complete resume or recent employment application. In addition, the DMH will check for a previously issued waiver.

   While the waiver period commences as explained above, the waiver is not effective until a complete waiver application is received in the Medi-Cal Oversight regional office or the date of employment, whichever is later.

   Normally, the maximum period of time for a waiver is either three or five years, whichever is applicable. However, the Department will consider a request for an additional period of time when documentation supports the presence of extenuating circumstances that have resulted in a significant amount of time away from work.

5) *Request Submitted by (Local Mental Health Director/Designee Signatue, County and Date):* All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No. 02-09.

Appendix N
Data Requirements

This procedure applies only to providers approved for MAA Claiming.

Medi-Cal Administrative Activities (MAA) Procedures

MAA activities in mental health are governed by a set of procedures. These procedures are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health, and are summarized below.

The Claiming Plan

In order to participate in MAA, the County must submit a Claiming Plan to the State for approval by the last day of the quarter in which the first invoice will be submitted. Using a standardized format developed cooperatively by the State and Federal Medicaid agencies, the MAA Claiming Plan must describe in detail each of the MAA activities for which claims will be submitted, by job class. The standardized format can be found in the California Department of Mental Health MAA instruction manual.

The Claiming Plan also describes the units that will be participating in MAA, the type of supporting documentation that will be maintained, and the development and documentation of costs relating to MAA. It indicates which activities will be focused entirely on the Medi-Cal population. If the activities will be focused on a larger population, the Claiming Plan must describe the methodology that will be used to discount the claim by the percentage of Medi-Cal eligibles in the population.

The State Department of Mental Health has established procedures for amending the MAA Claiming Plan. It has also developed a Claiming Plan checklist and a checklist to use when submitting amendments to the Claiming Plan. Copies of these documents, along with a copy of the most recently approved version of the plan, are on file in the Mental Health Plan administrative offices. Claiming plans and any amendments will remain in effect from year to year. A Claiming Plan will not need to be amended, unless the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a Claiming Plan must be amended when a new outreach campaign or program is instituted, or a new claiming unit performing MAA is created.

Claiming Procedures

Claims for MAA reimbursement are submitted quarterly to the State Department of Mental Health (DMH) by HHSA. A detailed quarterly invoice is prepared for each mental health unit participating in MAA, as identified in the claiming plan. County-operated programs are one unit; each participating contractor is a separate unit. A summary invoice is also prepared that aggregates all invoices submitted by mental health. An approved claiming plan covering the period of the claim must be in place before an invoice may be paid.

The County is required to provide DMH with complete invoice and expenditure information no later than December 31, following the fiscal year for which a claim is submitted. Invoice and expenditure information must be submitted to DMH prior to or with the County's cost report for the current fiscal year. DMH may approve the claim, return it for correction and/or revision, or deny the claim. The County may request reconsideration of a denied claim in writing within 30 days of receiving the denial.

The detailed quarterly invoice captures the time spent on MAA, the Medi-Cal percentage, expenditure and revenue information on a single spreadsheet.

MAA Training

All staff participating in MAA, and completing MAA activity logs, will attend MAA training sessions on at least an annual basis. Sign-in sheets will serve as a record of the individual's attendance. Training will be scheduled and provided at the direction of Mental Health Administration.

Reporting MAA Activities

MAA activities are reported to InSyst. The reporting requirements are somewhat different than what is required for direct services. For MAA, staff must report the following each time an MAA activity is performed:

- the day the activity occurred;
- the activity code (as a proxy for the name of the activity);
- the number of minutes spent on the activity;
- the name of the employee performing the activity.

A standardized MAA Activity Log has been developed; however, programs can develop their own as long as it contains the essential MAA reporting information. When programs develop their own form, they should forward it to the MAA Coordinator to ensure it covers the basic elements. The standardized forms are included as Attachments 1 and 2. Each activity log is to be signed by the employee before he/she gives it to the clerical staff responsible for entering data into InSyst Mental Health MIS. Activity logs may cover multiple days. Completed logs should be signed by the employee, and turned in to the person responsible for entering the information into InSyst on a timely basis, but no later than the fifth working day after the end of each month.

Document Retention

The County of San Diego has adopted a record retention policy that requires these records to be retained for seven (7) years. Program managers are responsible for storing signed, original versions of all MAA activity logs, outreach materials, and all documentation that supports the MAA claimed by their staff.

Becoming an InSyst User

Information on the amount and type of MAA activity performed by individual staff is entered into InSyst. Anyone who performs MAA activities needs an InSyst User ID so these activities may be entered into InSyst. Staff who provides direct services have InSyst identification numbers. Administrative and clerical staff who perform MAA activities will need an InSyst ID number as well. These ID numbers may be secured by calling UBH.

Quality Assurance; Monitoring

The quality of the MAA program will be monitored through quarterly reports from InSyst. The Mental Health Services MAA Coordinator will disseminate these reports to program managers, notifying them of any identifiable discrepancies found. These reports will provide managers with summaries of the amount of time reported to all MAA activities, by staff name. Program managers are expected to use the monitoring reports to:

- ensure that staff is reporting their MAA time accurately, using the correct activity codes;
- ensure that all staff that should be reporting MAA is doing so;
- ensure that MAA time is being reported consistently among staff in same classification.

Managers are required to ensure that corrective action is taken on any discrepancies they find or that have been identified by the MAA coordinator. Random reviews will take place to ensure that staff is reporting MAA correctly.

The MAA Audit File

An MAA audit file will be maintained at Mental Health Administration, and includes the following:

- a copy of the most recently approved MAA claiming plan for the County and for each participating contract agency;
- copies of current SPMP forms, and verification that each SPMP's license, where applicable, is current;
- job descriptions and/or duty statements for all staff participating in MAA;
- electronic or hard copies of the raw data used to calculate each quarterly percentage of MAA activity;
- electronic or hard copies of the reports used to establish the Medi-Cal percentage for each quarterly MAA claim;
- locations (with addresses) where MAA activity logs are kept on file, and where copies of information used in outreach or eligibility assistance activities are kept;
- copies of annual training schedules, training rosters, and materials used in training.

Who Can Claim MAA: An Overview

Clinical staff

- MAA may be used for client-based activities that are not part of a direct service or that are provided to an individual who does not have an open case anywhere within the system. MAA also includes outreach activities to inform individuals or groups about the availability of Medi-Cal and mental health services.

Administrators

- MAA includes program planning and contract administration.
- MAA includes outreach activities to inform individuals or groups about the availability of mental health services.

Clerical staff, Human Service Specialist and all other staff

- MAA includes activities that assist individuals, regardless of their case status, to apply for Medi-Cal or to access services covered by Medi-Cal.
- MAA activities include the administrative support clerical staff provide around outreach, contract administration, program planning, and crisis situations.

The MAA Activity Codes

A set of MAA activity codes has been developed for local mental health programs. The activities include:

Activity Code	
401	Medi-Cal Outreach
457	Mental Health Outreach
404	Facilitating Medi-Cal Eligibility Determinations
481	Case Management of Non-Open Cases
451	Referral in Crisis Situations – Non-Open Cases
409	MAA Coordination and Claims Administration

MAA Activity Code Definitions

401 Medi-Cal Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing Medi-Cal eligibles or potential Medi-Cal eligibles about Medi-Cal services, including Short-Doyle/Medi-Cal services;

- assisting at-risk Medi-Cal eligibles or potential Medi-Cal eligibles to understand the need for mental health services covered by Medi-Cal;
- actively encouraging reluctant and difficult Medi-Cal eligibles and potential Medi-Cal eligibles to accept needed health or mental health services;
- performing information and referral activity that involves referring Medi-Cal beneficiaries;
- referring Medi-Cal eligibles to Medi-Cal eligibility workers.

457 Mental Health Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services;
- providing telephone, walk-in or drop-in services for referring persons to Medi-Cal and non-Medi-Cal mental health programs.

404 Facilitating Medi-Cal Eligibility Determinations – This code may be used by all staff in county and contract programs. Includes the following:

- screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

481 Case Management of Non-Open Cases – May be used by all staff in county and contract agencies. Includes the following:

- gathering information about an individual's health and mental health needs.
- assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up and arranging transportation to health care.

451 Referral in Crisis Situations - Non-Open Cases – May be used by all staff in county and contract programs. Includes the following:

- intervening in a crisis situation by referring to mental health services.

409 MAA Coordination and Claims Administration – This code may be used by all staff in county and contract programs. Includes the following:

- MAA Training

Appendix O
Training

Appendix P
Mental Health Services Act

Appendix Q
Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only *(Contractor Instructions)*

Appendix R
QUICK REFERENCE