NOTE: Our requirements may be more stringent than the California Department of Health Care Services Mental Health Services Division (DHCS-MHSD) requirements. DHCS-MHSD empowers us to set our requirements at or above the DHCS-MHSD requirements.

PROVIDER HANDBOOK

(Includes Higher-Level Placements)

Tehama County Health Services Agency
Mental Health Division
P.O. Box 400
1860 Walnut Street
Red Bluff, CA 96080
PH: (530) 527-5631

Revised May 2013

Table of Contents

Definitions 4
Important Numbers 6
Mission Statement and Values 7
Authorization to Deliver Specialty Mental Health Services 8
- Assessments 8
- Referrals to Providers 8
- Contract Monitoring Status Report 9
- Treatment (Service) Plans 9
- Requesting Additional/Different Services 10
- Therapeutic Behavioral Services (TBS) 10
- Timeliness of Services 10
- Discharge Summary 10
- Client Closure Notification Form 11
- Higher-Level Placements (level 10 or above) 11
  - Assessments 11
  - Referral to Higher-Level Placement 12
  - Contract Monitoring Status Report 12
  - Treatment (Service) Plans 12
  - Other 13
  - Discharge Summary 13
  - Client Closure Notification Form 14

Authorizations for Urgent and Emergency Conditions 15
Provider Responsibilities 16
Records 18
Beneficiary Problem Resolution Processes 19
- Beneficiary Rights 19
- Appeal 20
- Expedited Appeal 21
- Grievance 21

Provider Problem Resolution Processes 23
- Informal Process – Provider Services and Claims Payment 23
- Formal Process – Provider Services 23
- Formal Process – Claims Payment 24

Payment Policies and Procedures 25
- General Information 25
- Payment Procedures – Claim/Invoice Forms 25
- Payment Procedures – Itemized Invoice Instructions 26
- Payment Procedures – Monthly Invoice Summary Instructions 27
- Payment Procedures – Submission of Claims/Invoices 29
- Claims Processing – Retrospective Reviews (Audits) 30
- Claims Processing – Payment Policies 30

Program Integrity/Compliance 32

Code of Conduct 32
Exclusions for Federal Healthcare Programs 32
Other Requirements 33
Miscellaneous 34

Appendices

Assurance of Compliance and Letter of Transmittal A-1
Code of Conduct (2 pages)..... A-2
Documentation Standards for Client Records (4 pages) A-3
Assessments ..... Page 1
Treatment (Service) Plans ..... Page 2
Progress Notes ..... Page 3
Information Checklist A-4
Medical Necessity Determination Form A-5
Notice of Action – A A-6
Notice of Action – B A-7
Notice of Action – C A-8
Notice of Action – D A-9
Notice of Action – E (2 pages)..... A-10
Request for Change of Provider A-11
Treatment (Service) Plan – Adult A-12
Treatment (Service) Plan – Child/Adolescent A-13
Statement of Understanding and Compliance A-14
Written Appeal Form (English and Spanish)..... A-15
Written Grievance Form (English and Spanish) A-16
CSI Update Form A-17
Itemized Invoice A-18
Itemized Invoice – Sample A-19
Monthly Invoice Summary A-20
Monthly Invoice Summary – Sample A-21
Provider Information Change Form A-22
Client Closure Notification Form A-23
Therapeutic Behavioral Services (TBS) Protocol..... A-23

NOTE:

- As Department Health Care Services, Mental Health Services Division (DHCS-MHSD) requirements change, forms contained in the appendices may change.
- All forms contained in appendices are available in electronic form.

Definitions

Access Line: The Access Line (Local: **(530) 527-5637** or toll free: **1-800-240-3208**) is available to help Medi-Cal beneficiaries obtain mental health treatment. By calling these numbers, a beneficiary or provider is able to ask questions about current eligibility for mental health services, obtain referrals and/or authorization for mental health services, express a concern or complaint, or get immediate help for a crisis.

Beneficiary: Medi-Cal eligible individual who is a Tehama County resident (i.e., county code = 52) requesting mental health treatment. Parents or legal guardians may also call to request services.

Covered Individual: A Provider or Provider staff person with responsibilities pertaining to the ordering, provision, documentation, coding, or billing of services payable by a Federal Healthcare program. Providers request payment from the Mental Health Plan (MHP) and the MHP seeks reimbursement from Federal Healthcare programs. See section on Program Integrity/Compliance.

Emergency Psychiatric Condition: As a result of a mental disorder, the individual is a current danger to self or others, or is immediately unable to provide for or utilize food, shelter, or clothing, and therefore meets the Welfare and Institutions code section 5150 criteria.

Medi-Cal: California's version of the Federal Medicaid program. It is health insurance for low-income individuals and families that is funded by State and Federal money.

Medical Necessity: The justification for specialty mental health services. Medical necessity for access to the mental health system is determined by an initial assessment. Medical necessity for ongoing care is based upon the results of an evaluation by a clinician and/or a doctor. See Appendix for Medical Necessity Determination form.

Mental Health Plan (MHP): Refers to the Tehama County Mental Health Plan as described in the contract between Tehama County and the State Department of Health Care Services, Mental Health Services Division. It also refers to the Tehama County Health Services Agency – Mental Health Division.

Multi-Agency Treatment Team (MATT): An interdisciplinary team of professionals (i.e., social worker, probation officer, school counselor, drug/alcohol counselor, case manager, mental health counselor, family members, etc.) that meets regularly to develop coordinated care plans for high risk youth. This team is made up of Tehama County Departments and community providers.

Pre-Authorization/Authorization: All outpatient mental health services must be pre-authorized. A beneficiary or provider must call to obtain authorization **PRIOR** to

services beginning. Pre-authorization is obtained by calling the MHP locally: **(530) 527-5631** or toll-free: **1-800-240-3208**.

- **All planned inpatient admissions must be pre-authorized.**
- **All emergency in-patient admissions must be authorized within 10 calendar days of admission.** Please call the MHP at 530-527-5631 or 1-800-240-3208, 24 hours a day.

Providers: Licensed mental health specialists, agencies, and hospitals that have contracted with Tehama County to provide services to Medi-Cal beneficiaries.

Treatment/Service Plan: A plan for focus of treatment that is developed with the beneficiary and based on the beneficiary's desired results from mental health services. The plan must have specific, observable, and measurable goals that relate to the beneficiary's diagnosis and that address improvement in functioning.

Triage Team: An interdisciplinary team of Tehama County Mental Health Plan professionals (i.e., clinician, psychiatrist, nurse, case manager, drug/alcohol counselor, etc.) that meets regularly to review assessments and treatment/service plans, and approve mental health services for beneficiaries.

Urgent Condition: A situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.

Important Numbers

Tehama County Mental Health Plan
P.O. Box 400, 1860 Walnut Street
Red Bluff, CA 96080
(530) 527-5631
FAX: (530) 527-0232

24-hour Toll Free: 1-800-240-3208

Patient's Rights Advocates:
Gail Locke (530) 527-5290
Lynn Corda Chamblin (530) 527-4893
Shirley Fay (530) 824-5451 or (530) 585-2320

SERVICES MUST BE PRE-AUTHORIZED

The Tehama County Mental Health Plan is not responsible for payment for services that are not authorized. The ONLY exceptions are:

- Services for emergency psychiatric conditions (inpatient hospital admissions must be approved within 10 days of admission).
- Inpatient hospital services provided by a MD

Other Helpful Contacts - phone number is **530-527-8491** (extensions provided below):

Type of Information Needed	Person to Contact	Ext. #
Billing/Payments	Billing Supervisor	x3176
Clinical questions	Licensed Clinical Supervisor	x3003 x 3973
Contract compliance, privacy, confidentiality, and security	Compliance Officer	x3046
Contract negotiations	Mental Health Director	x3026
Contract processing and execution	Administrative Assistant	X3048
Cost report questions	Fiscal/Data Supervisor	x3060
Quality of care, quality assurance, client grievances or complaints, scheduling audits, audit questions	Quality Assurance Manager	x3139
Referrals, scheduling Triage Team treatment plan presentations, client financial and demographic information, CSI data (including outcome data)	Office Assistant III	x3097 x3098

Mission Statement and Values

Mission Statement

The mission of the Tehama County Mental Health Plan (MHP) is to provide each eligible beneficiary with access to a high quality, effective, cost-efficient system of mental health care that is community based, culturally competent, and consumer guided.

The MHP values Provider services as a component of its overall array of client services. Provider services offer a means to increase access, remove barriers to care, and provide more options for beneficiary services.

Values

Respect for each beneficiary is the central value of the MHP. This includes beneficiary choice, satisfaction, and confidentiality. The following principles are the basis for the process of improving cultural competency and age-appropriate services:

1. The MHP is committed to:
   - Hiring employees or contracting with providers who are proficient and skilled in serving multi-cultural populations.
   - Developing and maintaining a system of care for children, adults and older adults that is culturally competent and consumer guided.
   - Providing a comprehensive range of age appropriate services for each child, adult, and older adult beneficiary.
   - Providing language accessibility and cultural competence within the service system to the extent possible within our resources.
   - Providing timely ease of access to care.
2. Services are planned, designed, and delivered with respect for the diversity of each beneficiary.
3. The MHP strives through treatment and discharge planning to allow each beneficiary to maintain the least restrictive setting and most appropriate level of care, enhancing community linkages whenever possible.
6. The MHP recognizes that the family, as defined by each culture, is a primary system of support and should be incorporated into the service planning whenever possible.
10. The provision of high quality, cost-effective services is the overriding goal in the delivery of care and treatment to each beneficiary.
11. The MHP values prevention and early intervention as strategies to promote wellness, avert crises and maintain each beneficiary within his/her community whenever possible.
12. Staff recognizes and works with each beneficiary's own desired outcome(s) in the provision of care.
13. Positive outcomes are achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.

Authorization to Deliver Specialty Mental Health Services

All Providers, both in Tehama County and out-of-county, **MUST** call the MHP and obtain a written authorization **PRIOR** to providing a Medi-Cal reimbursable specialty mental health service. Services for emergency psychiatric conditions do not need prior authorization. Planned hospitalizations require pre-authorization.

Assessments

The MHP performs or coordinates **ALL** initial and updated assessments. An exception is any child eligible for Medi-Cal under Tehama County (code 52) who is located outside Tehama County. In this circumstance, a Provider needs to obtain pre-authorization prior to initiating the assessment.

In the unusual instance when an assessment is done by a Provider and not at a TCHSA site, the Provider will complete the Agency Admission Form that includes Client Intake & PFI as well as Client Demographics & Diagnosis (see Appendix).

Beneficiaries must have an assessment at least once a year. Assessments are available on a walk-in basis or by appointment. Call 530-527-5631 (local) or 1-800-240-3208 (toll free) to schedule an appointment or to find out the current walk-in hours.

The Triage Team reviews all assessments, determines if medical necessity criterion is met, and authorizes counseling services and treatment plan development. The authorization for counseling services is time-limited, identifies a specific number of authorized units, and requires successful submission of the treatment plan to the MHP within 60 days of the authorization date.

The Triage Team determines if the MHP or a Provider will best serve the beneficiary. This determination is based upon the beneficiary's individual needs, service availability, and clinical expertise. The Team verifies service availability prior to making its determination.

Providers may render reasonable, clinically necessary assessment activities for the purpose of gathering more historical information and evaluating new symptoms. Such additional assessment activities are to be documented appropriately within a progress note and do not replace the required updated assessment by the MHP.

Referrals to Providers

The following documents are faxed or mailed to the Provider:

- Completed Registration Form for the beneficiary (with the MHP client #)
- Completed beneficiary Assessment
- Beneficiary Medi-Cal verification

- Written verification of referral and authorization to render counseling services (number of units and length of authorization period are specified) and the requirement of successful submissions of a treatment plan within 60 days of the authorization date.

If, due to extenuating circumstances, the Provider cannot complete the treatment plan within 60 days from the authorization date, the Provider can make a written request for additional time that specifies the reasons for the extension request. The MHP will review the request and notify the Provider in writing of denial or authorization for a maximum of an additional 30 days.

Contract Monitoring Status Report

The Contract Monitoring Status Report provides information to the Provider about encumbered services (services authorized by the Triage Team) by client and the remaining contract availability. The MHP will periodically give a Contract Monitoring Status Report to the Provider as a tool for the Provider to verify their records. The Provider will notify the MHP Office Assistant III of any discrepancies within 30 days of receiving the report.

Treatment (Service) Plans

The beneficiary and/or their guardian(s) must be ACTIVELY involved in developing the treatment plan and must sign the treatment plan.

Providers may use one of our service plan forms (see Appendix) or may use their form if it contains all the same elements and has been approved by the MHP Quality Assurance Manager.

Treatment (service) plans are fluid and may change as treatment progresses. A revised treatment plan is completed whenever treatment or goals change. An updated treatment plan is required at least once every 6 months. All treatment plans go through the process described below.

The Provider mails the original signed treatment plan to a MHP Office Assistant III. If the Provider chooses to present the treatment plan in person, please call an Office Assistant III to schedule this. All required signatures must be on the plan before it is submitted to the MHP.

The Triage Team reviews the treatment plan and takes one of the following actions within one week of receipt of the plan:

- Defers approval. The Team notifies the Provider what is needed in the treatment plan in order to approve it.
- Denies approval. The Team notifies the Provider the reason for the denial (e.g., the client does not currently meet medical necessity criterion, the method of treatment is

inappropriate for the beneficiary, etc.). The MHP will then send the beneficiary a Notice of Action (See Appendix for copies of the different Notice of Action forms)

- Approves the treatment plan. The Team indicates approval of the treatment plan by signing the treatment plan authorization form and indicating the type, quantity, and duration of the services authorized. The authorized units/dollars of service immediately reduce the units/dollars available under the Provider contract with the MHP. An Office Assistant III faxes the signed treatment plan authorization form and other necessary documents to the Provider.

Requesting Additional/Different Services

The Provider may request additional/different (i.e., a change in the type, quantity or duration) services based upon the beneficiary's need for additional specialty mental health services. If requesting different services, the Provider completes a revised treatment plan (including beneficiary and/or guardian signature) and faxes/mails it to an Office Assistant III **PRIOR** to providing the different services. If requesting additional services, the Provider provides a written request explaining why the additional services are needed. The Triage Team may request additional documentation (e.g., progress notes) before authorizing the additional services, so please allow sufficient time for this. **NOTE:** Providers are to make these requests at least 10 days **PRIOR** to the last authorized visit to assure continuity of service and avoid the risk of non-reimbursement for services.

The Triage Team will review the treatment plan or written request (and requested information, if applicable) and take action (see above section) based upon the beneficiary's medical necessity and need for services.

NOTE: The Provider is responsible for verifying the beneficiary's eligibility for Medi-Cal services for **each month** a specialty mental health service is delivered. (We recommend that providers verify Medi-Cal eligibility during the delivery of each mental health service.)

Therapeutic Behavioral Services (TBS)

See TBS protocol in Appendix.

Timeliness of Services

Providers will schedule a beneficiary appointment within 10 working days of the receipt of an authorization from the Triage Team.

Discharge Summary

The Provider sends a discharge summary to the MHP when treatment is completed, the beneficiary drops out of treatment, or the beneficiary moves out of the area. This enables the MHP to enhance quality and continuity of care for all beneficiaries.

The discharge summary must include the following:

- Treatment summary
- Diagnosis when treatment ended (including GAF)
- Medications
- Beneficiary's current status, prognosis, and risk factors
- Beneficiary's progress towards treatment goals
- Reason for discharge
- Referrals/follow-up care recommended

The discharge summary (or a note containing all of the above elements) is faxed or mailed to the MHP within 30 days after treatment ends as follows:

Fax: 530-527-0232 Attention: OA III

Mail: Tehama County Health Services Agency – Mental Health Division
Attention: OA III
PO Box 400
Red Bluff, CA 96080-0400

Client Closure Notification Form

When treatment ends for any reason before all authorized services are rendered, the Provider notifies the MHP. This notification is done by submitting a completed Client Closure Notification Form (see Appendix) within 30 days after treatment ends.

This notification is for the benefit of the Provider. The MHP's receipt of a completed form activates the reinstatement of any encumbered (authorized but unused) services as available services under the Provider contract. Failure to submit this form means that any encumbered services remain unavailable to the Provider.

The Client Closure Notification Form, accompanied by a copy of the discharge summary, is faxed or mailed to the MHP as detailed in the previous section.

HIGHER-LEVEL PLACEMENTS (LEVEL 10 OR ABOVE)

The Multi-Agency Treatment Team (MATT) must authorize higher-level placements. Minors referred to organizations providing higher-level placements are typically eligible for Medi-Cal.

Assessments

Usually, the MHP performs the initial assessment. Beneficiaries must have an assessment at least once a year.

In the unusual instance when an assessment is done by a Provider and not at a TCHSA site, the Provider will complete the Agency Admission Form that includes Client Intake & PFI as well as Client Demographics & Diagnosis (see Appendix).

Treatment (service) plans are fluid and may change as treatment progresses. A revised treatment plan is completed whenever treatment or goals change. An updated treatment plan is required at least once every 6 months (3 months for day treatment – intensive services). All treatment plans go through the process described below.

The Provider faxes/mails the signed treatment plan to a MHP Office Assistant III. If the Provider chooses to present the treatment plan in person, please call an Office Assistant III to schedule this.

The Triage Team reviews the treatment plan and takes one of the following actions within one week of receipt of the plan:

- Defers approval. The Team notifies the Provider what is needed in the treatment plan in order to approve it.
- Denies approval. The Team notifies the Provider the reason for the denial (e.g., the client does not currently meet medical necessity criterion, the method of treatment is inappropriate for the beneficiary, etc.). The MHP will then send the beneficiary a Notice of Action (See Appendix for copies of the different Notice of Action forms)
- Approves the treatment plan. The Team indicates approval of the treatment plan by signing the treatment plan authorization form and indicating the type, quantity, and duration of the services authorized. The authorized units/dollars of service immediately reduce the units/dollars available under the Provider contract with the MHP. An Office Assistant III faxes the signed treatment plan authorization form and other necessary documents to the Provider.

Other

The Provider is responsible for verifying the beneficiary's eligibility for Medi-Cal services for **each month** a specialty mental health service is delivered (if applicable).

Discharge Summary

The Provider sends a discharge summary to the MHP when treatment is completed, the beneficiary drops out of treatment, or the beneficiary moves out of the area. This enables the MHP to enhance quality and continuity of care for all beneficiaries.

The discharge summary must include the following:

- Treatment summary
- Diagnosis when treatment ended (including GAF)
- Medications
- Beneficiary's current status, prognosis, and risk factors
- Beneficiary's progress towards treatment goals
- Reason for discharge
- Referrals/follow-up care recommended

Authorizations for Urgent and Emergency Conditions

Definition of Urgent Condition: A situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.

Definition of Emergency Psychiatric Condition: As a result of a mental disorder, the individual is a current danger to self or others, or is immediately unable to provide for or utilize food, shelter, or clothing, and therefore meets the Welfare and Institutions Code section 5150 criteria.

All planned inpatient admissions must be pre-authorized. All emergency inpatient admissions must be authorized within 10 days of admission. Please call 530-527-5637 or 1-800-240-3208, 24 hours a day.

Any beneficiary who is in Tehama County and needs **urgent** care is referred immediately to the MHP Community Crisis Response Unit (530-527-5637 or 1-800-240-3208) for a face-to-face assessment with a mental health professional.

Persons requiring hospitalization are assessed and referred to the hospital that best meets the beneficiary's need(s). Any beneficiary requiring **emergency** inpatient care is referred to an inpatient facility that best meets his/her unique needs using the current MHP protocol.

Authorization for payment for inpatient services will continue to occur through the Treatment Authorization Request (TAR) and concurrent review processes.

- The hospital discharge planner will be responsible for making appropriate pre-and post-discharge referrals including contacting MHP staff responsible to assure continuity of care and coordination with community services.
- The MHP staff assigned will keep in close contact with inpatient staff to check on beneficiary progress and assist with the aftercare plan.

If a **beneficiary is out-of-county** and requires **urgent** mental health services, the beneficiary and/or family can call the MHP for referral to appropriate services by calling 530-527-5637 or 1-800-240-3208.

Any **out-of-county beneficiary or Provider** requesting non-urgent care is referred to the MHP's Office Assistant III during regular clinic hours (M-F, 8-5) at (530) 527-5631.

Provider Responsibilities

1. Meet and maintain MHP contract requirements and report any changes as stipulated by their contract with Tehama County or State regulations and statutes.
2. Possess the necessary license to operate, if applicable, and any required certification.
3. Comply with all current State and Federal laws and regulations regarding confidentiality, privacy, and security of client healthcare information.
4. Report any confidentiality or privacy breaches and security incidents to the MHP Compliance Officer within one (1) business day of discovery.
5. Inform all inquiring beneficiaries of the requirement for the MHP to complete an assessment and authorize services prior to beginning a course of treatment.
6. Assist inquiring beneficiaries to communicate with the MHP (provide phone numbers, hours, etc.).
7. Have staffing adequate to claim federal financial participation for services.
8. Comply with the MHP's authorization process.
9. Complete the MHP Agency Admission Form that includes Client Intake & PFI as well as Client Demographics & Diagnosis (see Appendix) when doing an assessment.
10. Provide all requested information to the Triage Team in order to expedite requests for authorization of services.
11. Obtain authorization for services **PRIOR** to rendering services (or, if an emergency inpatient admission, notify the MHP within 10 days of admission). Only those services that are authorized by the MHP (or, if an emergency inpatient admission, services that are provided with the notification to the MHP within 10 days of admission) are reimbursed.
12. Schedule an initial visit with an authorized beneficiary within 10 working days of the receipt of an authorization from the Triage Team.
13. Consult with the Triage Team regarding a potential planned admission of a beneficiary into an inpatient hospital.
14. Verify a beneficiary's Medi-Cal eligibility for **each month** a mental health service is delivered. (We recommend that Providers verify Medi-Cal eligibility during the delivery of each mental health service.)
15. Provide services to beneficiaries in accordance with legal and ethical standards as prescribed by all relevant professional, federal, state, and/or local regulatory and statutory requirements.
16. Follow strict confidentiality guidelines to assure the beneficiary's privacy whenever referrals to other agencies and providers are necessary. Information regarding the beneficiary will not be provided without written permission of the beneficiary.
17. Comply with the Beneficiary Problem Resolution processes provided in this handbook.
18. Notify the MHP of a temporary inability to accept new referrals by calling an Office Assistant III at (530) 527-5631. This suspension of referrals will exist until the provider notifies the MHP that new referrals will be accepted.
19. Meet documentation standards as described in "Documentation Standards for Client Records" in the Appendix.

Records

Clinical records must be legible and kept in detail consistent with appropriate medical and professional practice in order to:

- Permit effective internal professional review and external medical audit process; and
- Facilitate an adequate system for follow-up of treatment.

The Provider must maintain clinical records for at least 7 years from the last date of service to the beneficiary. For minors, records must be maintained for the longer of 10 years or one year after the minor as reached the age of 18.

The Provider must also make the books and records that pertain to the services provided to beneficiaries under the contract provisions of the MHP, available for inspection, examination or copying:

- By the MHP, the State Department of Health Care Services, and the United States Department of Health and Human Services;
- At all reasonable times at the Provider's place of business or at another mutually agreeable location; and
- In a form maintained in accordance with the general standards applicable to such record keeping.

See the Appendix for Documentation Standards for Client Records.

Providers of specialty outpatient mental health services must use DSM-IVTR diagnostic codes (more recent versions of the DSM Manual require MHP written approval). ICD-9 codes are not acceptable, except for emergency psychiatric condition services.

Financial records must be retained for seven (7) years or until the fiscal year audit has been completed by the State Department of Health Care Services Mental Health Services Division, whichever is later.

Beneficiary Problem Resolution Processes

Beneficiaries may file an Appeal, Grievance, or request a State Fair Hearing without fear that it will result in any harm to them. The MHP and Providers will NOT reduce or withhold services or discriminate or retaliate IN ANY WAY in response to a beneficiary's complaint.

Notice of Action

A Notice of Action is a written notice from the MHP to a beneficiary when the MHP takes an action. An "action" is a decision made by the MHP with regard to one of the following:

- Denial or modification of authorization of a beneficiary requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Failure to provide services to a beneficiary in a timely manner as defined within the MHP program.
- Failure to act within stated timeframes for resolution of grievances or appeals.

The MHP is responsible for sending beneficiaries any required Notices of Action. The various notices are provided in the Appendix for your information. If a beneficiary has any questions about a Notice of Action, please have him/her call the MHP Quality Assurance Manager at (530) 527-8491 x3139.

Beneficiary Rights

A beneficiary has the right to:

- Be treated with dignity, privacy, and respect.
- Receive information on available treatment options and alternatives; and have them presented in a manner the beneficiary can easily understand.
- Participate in decisions regarding his/her mental health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, punishment or retaliation as specified in federal rules about the use of restraints and seclusion in facilities such as hospitals, nursing facilities and psychiatric residential treatment facilities where a beneficiary might stay overnight for treatment.
- Request and receive a copy of his/her medical records, and request that they be amended or corrected.
- Receive information in the Medi-Cal Mental Health Informing Materials Packet about services covered by the MHP, other obligations of the MHP and beneficiary rights as described here, and to receive the information in a manner the beneficiary can easily understand.
- Obtain information about the MHP Beneficiary Problem Resolution processes.

- Authorize another person to act on his/her behalf
- Have his/her legal representative use the Beneficiary Problem Resolution processes on the beneficiary's behalf.
- Have a staff person assist him/her with the problem resolution procedures at the beneficiary's request.
- Have his/her confidentiality respected and maintained throughout the Beneficiary Problem Resolution processes.
- Ensure that all complaint resolutions and all grievance resolutions undergo an appropriate review prior to final action.

Problem Resolution Processes

In accordance with Federal Regulations 42 CFR, Part 438, Subpart F, problems will fall under two categories, "appeal" or "grievance", depending on what the beneficiary's issue is. When a beneficiary lets a Provider or staff person know that the beneficiary has a problem, immediately contact the MHP. The MHP Quality Assurance Manager (QAM) is responsible for assisting with beneficiary problems. The beneficiary may contact the QAM, the Mental Health Director, the Tehama County Health Services Agency Executive Director or a Patient's Rights Advocate for help.

A beneficiary may request a State Fair Hearing if the MHP decides a beneficiary does not qualify for the services he/she wants. State Fair Hearings apply only to Medi-Cal beneficiaries unhappy with a decision made by the MHP.

- State Fair Hearing – 1-800-952-5253
- TDD – 1-800-952-8349
- California Department of Mental Health Ombudsman Program: 1-800-896-4042 (TDD 1-800-896-2512)

Appeal

An appeal is when a beneficiary disagrees with an "action" taken by the MHP. (See Notice of Action section on prior page for the definition of "action".) An appeal can be started after the MHP has made a decision regarding a beneficiary's service. The beneficiary has 90 days to file an appeal after the MHP has sent a Notice of Action. In addition to filing an appeal, the beneficiary may also request a State Fair Hearing.

The beneficiary (or his/her authorized representative) starts the Appeal process by telling any Provider or staff person the beneficiary disagrees with a MHP action. Alternatively, the beneficiary can file a written appeal. This can be written on a piece of paper or on the Written Appeal Form (see Appendix). Providers are responsible for assisting the beneficiary (or referring the beneficiary to the MHP QAM) if the beneficiary so desires.

The MHP QAM is responsible for ensuring the appeal is reviewed by a MHP staff person not involved in the beneficiary's care who has the same education and training related to the services requested.

The MHP QAM notifies the beneficiary in writing within 45 days as to the outcome of the appeal. If the MHP agrees with the appeal, the desired services will be provided to the beneficiary.

If the MHP disagrees with the appeal, the beneficiary may ask for a State Fair Hearing. The beneficiary has the right to request that services be provided while waiting for the State Fair Hearing process to occur. The beneficiary makes this request to the MHP QAM or any MHP supervisor. The MPH reviews the request and it may be granted if the MHP determines that not providing services would harm the beneficiary.

Expedited Appeal

The beneficiary may request an Expedited Appeal if he/she feels that the timeframe for the standard appeal (45 days) would result in jeopardy to the beneficiary's life, health, or ability to reach, maintain, or get back to his/her previous level of functioning. The MHP will grant the request for an Expedited Appeal if it is determined that the beneficiary's situation meets one or more of these criteria.

The Expedited Appeal is the same as the standard Appeal except that it does not have to be in writing and the MHP QAM notifies the beneficiary within 3 days (instead of 45 days).

If the MHP does not grant the request for an Expedited Appeal, then the process and timeframes for the standard Appeal will apply.

Grievance

A "Grievance" is anything the beneficiary is unhappy about that is not related to an "action" taken by the MHP (see Appeal section for the definition of an "action"). A Grievance may be related to:

- A beneficiary's treatment by staff (i.e., rudeness, etc.)
- Disagreements about medications
- Violations of beneficiary confidentiality
- Requests for another therapist, psychiatrist, case manager, etc.

The beneficiary (or his/her authorized representative) starts the Grievance process by telling any Provider or staff person the problem/complaint. Alternatively, the beneficiary (or his/her authorized representative) may write it down on the Written Grievance Form (see Appendix).

The MHP gives or mails a written statement to the beneficiary that the MHP has received the Grievance and is investigating it.

The MHP QAM or Compliance Officer investigates Grievances. The beneficiary may provide any written information he/she wants to be considered in the resolution process.

The MHP notifies the beneficiary within 60 days of possible solutions. This notification may be done in person, by phone, or by letter. If the beneficiary does not agree with the possible solutions, he/she is encouraged to contact the MHP. The MHP will make a concerted effort to resolve the issue to the mutual benefit and satisfaction of the beneficiary and the MHP.

Provider Problem Resolution Processes

Provider Problem Resolution Processes Statement

The focal point of the problem resolution process for Providers is the MHP. A Provider may access the MHP Informal or Formal Problem Resolution process anytime there is a payment authorization, claims processing problem, or any other problem area. Every effort will be made by the MHP to resolve problems at the informal level. If the problem cannot be resolved at the informal level, the Provider may appeal through the MHP Formal Problem Resolution Process. The MHP will work to resolve problems in a sensitive and timely manner.

MHP **Informal** Problem Resolution Process – Provider Services and Claims Payment

1. The Provider may address problems or suggestions to the MHP at any time. This may be accomplished verbally or in writing to the Mental Health Director or designee.
2. Resolution of problems may be reached through discussions between the Provider and the Mental Health Director and any other persons involved in the matter. Every effort will be made by MHP to resolve problems at this informal level.
3. The Mental Health Director or designee will respond to a Provider's problem within five (5) working days of receipt of specific problem information (two (2) business days for an inpatient provider).
4. All problems and resolutions will be documented in the Problem Resolution Log and reviewed monthly by the Quality Improvement Committee.

MHP **Formal** Problem Resolution Process - Provider Services:

1. Any Provider may appeal the denial of authorization for services to the MHP.
2. A Provider may file a written appeal concerning the denial for authorization of specialty mental health services directly to the Mental Health Director or designee.
3. The written appeal shall be submitted to the Mental Health Director or designee within 30 calendar days of the date of receipt of the denial of the request for authorization of services.
4. The Mental Health Director or designee and other qualified staff (as assigned by the Mental Health Director or designee) will review the appeal and make a decision. The MHP shall use personnel not involved in the initial denial decision to respond to the Provider's appeal.
5. The Mental Health Director or designee will complete an evaluation of the appeal within thirty (30) days of the appeal postmark or fax date (two (2) business days for an inpatient provider).
6. The Mental Health Director or designee notifies the Provider in writing if the appeal is upheld, there is a proposed resolution (partial authorization of services or payment), or no basis is found for altering the original decision.

MHP Formal Problem Resolution Process - Provider Claims Payment:

1. Any Provider may appeal the denial of claims payment.
2. Inpatient Providers who receive payment directly from a fiscal intermediary (e.g., EDS) may file a written appeal concerning the denial or delay of claims payment for specialty mental health services directly to the fiscal intermediary. The fiscal intermediary has thirty (30) days from the appeal postmark or fax date to respond in writing to the Provider.
3. Providers who receive payment directly from the MHP may file a written appeal concerning the denial or delay of claims payment directly to the Mental Health Director or designee.
4. The written appeal shall be submitted to the Mental Health Director or designee within thirty (30) calendar days of the date of receipt of the denial of the claims delay or payment.
5. The Mental Health Director or designee has ten (10) working days (two (2) business days for an inpatient provider) from the appeal postmark or fax date to complete an evaluation of the appeal.
6. The Mental Health Director or designee and other qualified staff (as assigned by the Mental Health Director or designee) will review the appeal and make a decision. The MHP shall use personnel not involved in the initial denial decision to respond to the Provider's appeal.
7. The Mental Health Director or designee notifies the Provider in writing if the appeal is upheld, there is a proposed resolution (i.e. partial payment), or no basis is found for altering the original decision.
8. If the Provider appeal is upheld or partial payment is approved, the MHP has fifteen (15) working days to process the claim for payment to the Provider.

The Mental Health Director or designee shall maintain a log of all MHP Formal Problem Resolution Requests and decisions (including disposition of the problems) and submitted them quarterly to the Quality Improvement Committee. The Formal Problem Resolution Log information shall include a method for identifying the provider, date of receipt, nature of the problem, time period allowed for resolution, party responsible for addressing the problem, date for resolution or disposition of the problem. These records will be open to review by the State Department of Mental Health, State Department of Health Services, and the Federal oversight agency. The Log shall document the resolution of the problem within 30 calendar days of its receipt, or the reason why it could not be resolved.

Payment Policies and Procedures

General Information

1. The rate(s) and the type(s) of authorized service are stated in the contract between the Provider and the Tehama County Health Services Agency – Mental Health Division.
2. Medi-Cal guidelines do not allow payment for sessions in which a Beneficiary fails to show.
3. Individual Providers: Treatment of any Medi-Cal Beneficiary must be performed by the practitioner to whom the referral was made. **You may not bill in your name for treatment provided by another practitioner or an assistant.**
4. All claims are processed on a line-by-line basis except for inpatient care claims. In-patient claims are processed on an entire-claim basis.
5. For questions or resolution of claims issues, contact our billing office at (530) 527-8491 extension 3176.
6. You may not in any case bill the Beneficiary for amounts above the rate outlined in your contract.
7. Service authorization does not guarantee Medi-Cal eligibility. It is the Provider's responsibility to assure that services are provided to eligible beneficiaries. Providers must verify a beneficiary's Medi-Cal eligibility for **each month** a mental health service is delivered. (We recommend that providers verify Medi-Cal eligibility during the delivery of each mental health service.)
8. If a Provider is billing for a group service, there must be a sign-in sheet for participating beneficiaries and the documentation for each beneficiary must include the number of participants and the total group time. The sign-in sheet should include the MHP client number for each beneficiary.
9. Units of services must be whole numbers (e.g., 42 minutes, 1 hour, 2 days, etc.).
10. **All services must be pre-authorized in order to receive reimbursement. The MHP is not responsible for payment for services that are not authorized.** The ONLY exceptions are:
    - Services for emergency psychiatric conditions (inpatient hospital admissions must be approved within 10 days of admission).
    - Inpatient hospital services provided by a MD

Payment Procedures

Claim/Invoice Forms

Individual Providers must submit a claim/invoice for payment using a CMS/HCFA-1500 form or a Monthly Invoice Summary accompanied by an Itemized Invoice. **Organizational Providers** must submit a Monthly Invoice Summary accompanied by an Itemized Invoice Form. Providers not using the CMS/HCFA-1500 form must use the Monthly Invoice Summary and Itemized Invoice forms that are provided in the Appendices.

NOTE: National Provider Identification numbers (NPI's) are required for all claims/invoices with dates of service after 12/31/06.

If a Provider renders a service to a beneficiary who has a payer other than Medi-Cal, the provider must bill the payer and receive an Explanation of Benefits (EOB) indicating payment or denial prior to billing the MHP. In these situations, the Provider must bill the MHP separately from the claims related to services to beneficiaries with only Medi-Cal. The Provider bills the MHP for these separate or supplemental services using the same forms described in this section (i.e., the Monthly Invoice Summary accompanied by an Itemized Invoice) and attaches a copy of the EOB.

NOTE: Most insurance payers will only pay for services provided by licensed staff. Provider is responsible for ensuring that provider staff providing services is appropriately and currently licensed at the level required for any payer source the beneficiary has.

See Submission of Claims/Invoices for time requirements.

Instructions for completing the Itemized Invoice

The letters below refer to the boxes as labeled in the Itemized Invoice – Sample (see Appendix A-19).

A. Provider Name and NPI (NPI for an Organizational provider would be the entity's NPI)
B. Provider Mailing Address
C. City, State, and Zip Code for mailing address
D. Telephone number
E. Date of Service – The date the service was provided to beneficiary (month, day, and year)
F. Billing Code – The billing code associated with the service provided. Acceptable Billing Codes include: 302, 310, 320, 325, 330, 335, 340, 345, 346, 371 and 375. Billing codes are identified in the Provider's contract.
G. # of Units – The number of units (usually minutes) spent providing the service using only whole numbers.
H. Client ID # - The MHP client number. It is included in the MHP Registration Form sent to the Provider when the client is referred. See the paragraph *Referrals to Provider* in the *Authorization to Deliver Specialty Mental Health Services* section of this Handbook.
I. Last Name – The last name of client as indicated on the Medi-Cal Eligibility website.
J. First Name – The first name of client as indicated on the Medi-Cal Eligibility website.
K. Total $ - The amount charged for services rendered on this date of service for this billing code.
L. Service Location/NPI – The location where the service was provided. If a Provider has multiple locations, the Provider may use a code for each location as long as the MHP has a legend for the location codes. If Provider is using a

separate NPI for this location, the NPI replaces the Provider's location code for service dates after 12/31/06.

M. Staff – The last name and first initial of the person who provided the service.
N. Staff NPI # - The NPI of the person who provided the service. Required for service dates after 12/31/06.
O. Total Units Billed – The total number of units (usually minutes) for all services provided for the month being billed. Page totals are not required.
P. Total Billed Amount – The total amount of the claim for all services provided during the month being billed. Page totals are not required.

Instructions for completing the Monthly Invoice Summary

The Monthly Invoice Summary is comprised of 3 sections: **General Information, Pending Insurance** and **Medi-Cal Service Classifications**. There are also shaded sections on the form indicating areas that the MHP will complete.

The letters or numbers below refer to the boxes as labeled in the Monthly Invoice Summary – Sample (see Appendix A-21).

General Information

A. Provider Name
B. Provider Mailing Address
C. City, State, and Zip Code for mailing address
D. Telephone number
E. Vendor # - the vendor number assigned by the County for payment purposes. This number is on the signature page of the Provider contract or may be obtained from the Billing Supervisor.
F. Contract # - the contract number assigned by the County for contract monitoring purposes. This number is on the Minute Order page (usually the last page) of the executed Provider contract or may be obtained from the Billing Supervisor.
G. Invoice # - assigned by Provider
H. Invoice date
I. Month of Service – The month of service being billed.

Pending Insurance

This section shows the services provided during the month to beneficiaries that have a payer **other than** Medi-Cal. This section will be blank for all supplemental invoices.

1. Client ID # - The MHP client number. It is included in the MHP Registration Form sent to the Provider when the client is referred. See the paragraph *Referrals to Provider* in the *Authorization to Deliver Specialty Mental Health Services* section of this Handbook.
2. DOS – The date the service was provided to beneficiary (month, day, and year)
3. Service Location/NPI – The location where the service was provided. If a Provider has multiple locations, the Provider may use a code for each location as

long as the MHP has a legend for the location codes. If Provider is using a separate NPI for this location, the NPI replaces the Provider's location code for service dates after 12/31/06.

4. Service Description – The description of the service as listed in the Provider contract (i.e., Collateral, Individual Therapy, etc.)
5. Billing Code – The billing code associated with the service provided. Acceptable Billing Codes include: 302, 310, 320, 325, 330, 335, 340, 345, 346, 371 and 375. Billing codes are identified in the Provider's contract.
6. # of Units - The number of units (usually minutes) spent providing the service using only whole numbers.
7. Rate - the rate per the contract with the MHP for the Billing Code indicated.
8. Total $ - the # of Units (box 6) times the Rate (box 7).
9. Total Pending - the total (in units and dollars) for services provided in the current month to beneficiaries with a payer other than Medi-Cal.

Medi-Cal Service Classifications

This section summarizes the Itemized Invoice by Billing Code.

10. Total Units - the total number of units provided to beneficiaries listed on the Itemized Invoice for the Billing Code indicated.
11. Rate – the rate per the contract with the MHP for the Billing Code indicated.
12. Total $ - the Total Units (box 10) times the Rate (box 11)
13. Total Invoice – the total (in units and dollars) being billed to the MHP before consideration of any insurance. If this is a supplemental invoice (i.e., for services to beneficiaries with a payer other than Medi-Cal for which an EOB has been received by Provider), boxes 14 and 15 must also be completed.
14. Total Insurance Payment – the total of all insurance payments received from the payer for the services listed in the Itemized Invoice. Note: This box is only completed for a supplemental invoice. Providers must attach the relevant EOB's. The brackets (<>) indicate these amounts will be deducted in arriving at the box 15 total.
15. Adjusted Invoice Total – the amount the Provider is billing the MHP after consideration of any insurance. This amount is equal to box 13 minus box 14.

The MHP Billing Supervisor is available upon request to provide orientation and instruction on these forms.

<u>Submission of Claims/Invoices</u>

1. Send claims/invoices to:
   Tehama County Health Services Agency (TCHSA)
   Billing – Mental Health
   P.O. Box 400

Red Bluff, CA 96080

2. Claims/invoices must be received by TCHSA by the thirtieth day following the last day of the month in which the services were delivered, except in the case of beneficiaries covered by both Medi-Cal and a third party payer. Medicare is considered a third party payer.
3. If a beneficiary is covered by both Medi-Cal and a third party payer, the Provider will bill the third party payer (and send a copy of the bill to TCHSA at the same time). The Provider will receive an Explanation of Benefits (EOB) from the third party payer indicating denial or payment for each service prior to billing the MHP. When there is a third party payer, claims/invoices must be received by TCHSA (1) no later than the thirtieth day following the last day of the month in which the Provider received an EOB for the billed service from the third party payer, and (2) no later than the 120th day following the last day of the month in which the services were delivered. If the Provider called the third party payer for pre-authorization and the service was denied, the Provider should request that the third party payer fax the denial to the Provider. This faxed document can be used in lieu of an EOB and will permit the Provider to bill the MHP sooner.
4. Organizational Providers must submit a separate Monthly Invoice Summary, accompanied by an Itemized Invoice for services to beneficiaries covered by both Medi-Cal and a third party payer. Copies of EOB's indicating denial or payment for every service on the Itemized Invoice must be attached.
5. **TIP for Organizational Providers:** If the Medi-Cal website eligibility page indicates a beneficiary has other insurance and the beneficiary says he/she doesn't have other insurance email wats@dhcs.ca.gov or fax (916) 440-5675. The insurance may require you to call for pre-authorization before providing the service.
6. The MHP is not obligated to pay for late claims/invoices.
7. Claims/invoices must be accompanied by all of the following:
   - Proof of MediCal eligibility (i.e., a copy of the MediCal website eligibility page) for each beneficiary for **each month** a mental health service is billed. These copies should be in the same beneficiary order as the claims/invoices.
   - Assurance of Compliance and Letter of Transmittal (see Appendix A-1). Note to Individual Providers: If you use the CMS/HCFA-1500 form, you may prepare a summary sheet listing and totaling all the forms submitted and prepare a single Assurance of Compliance and Letter of Transmittal for the summary sheet.
   - Explanation of Benefits (EOB) indicating denial or payment if beneficiary is covered by Medi-Cal and a third party payer (including Medicare).

Claims Processing

Retrospective Reviews (Audits)

1. All claims/invoices are subject to MHP retrospective review **prior** to payment.

2. The Mental Health Director or designee determines the range (0%-100%) of services that are audited.
3. Retrospective reviews are usually performed at the Provider's site. Exceptions may be made for Providers located a significant distance from Tehama County.
4. Retrospective reviews must be completed within 30 days of receipt of claim. Exceptions to this requirement require the Mental Health Director's written authorization.
5. Clinical records are reviewed to determine that documentation meets the MHP and Title 9 of the California Code of Regulations (CCR) standards. Payment is denied if documentation does not meet these standards. Payment will not be made on the basis of added, amended, or altered records presented after the date of the retrospective review.
6. Clinical records are also reviewed to determine that service standards established by the MHP and Title 9 of the California Code Regulations are met.
7. We want all Providers to be paid for all services they provide. Our Quality Assurance Manager will assist you if you have questions regarding whether or not your charting practices meet Medi-Cal standards. However, it is **your** responsibility to provide documentation that meets Medi-Cal standards for every service billed to the MHP.
8. The MHP will provide a document identifying the service date, beneficiary, time, amount, billing code, and reason for any denied payments.
9. The MHP will follow the Provider Problem Resolution Processes as described elsewhere in this handbook when a provider disputes denial of payment.

Payment Policies

Payment will be authorized for valid claims for specialty mental health services if **all** of the following occur within required timeframes:

1. The services were pre-authorized by the Triage Team (or, if an emergency inpatient admission, the MHP was notified within 10 days of admission).
2. Services were delivered by a contract Provider and were within the range of services specified in the Provider's contract.
3. The Provider submits a proper and timely claim/invoice.
4. The Provider submits proof of beneficiary Medi-Cal eligibility for the service dates. A copy of the Medi-Cal website eligibility page for the beneficiary is considered proof. Organizational Providers are expected to access the Medi-Cal website eligibility page. Individual Providers may call an Office Assistant III to verify eligibility and request that a copy of the page be faxed to them.
5. The Provider submits an Explanation of Benefits (EOB) from a third party payer that indicates denial or payment for each service provided to a beneficiary who is covered by Medi-Cal and a third party payer.
6. The Provider submits an Assurance of Compliance and Letter of Transmittal (see Appendix A-1)

7. The Provider has submitted a signed Code of Conduct and Provider Information Change Form (see Program Integrity/Compliance section) for every service provider listed on the bill/invoice.
8. The rates are as contracted.
9. The amount of services encumbered has not reached the contract dollar limit.
10. Documentation meets Medi-Cal standards.
11. All required CSI and outcome performance data and client financial, insurance, and share of cost information (if applicable) have been received from the Provider.

The MHP will pay the Provider within thirty (30) days of the date the services were approved for payment following the completion of the MHP retrospective review.

Program Integrity/Compliance

Code of Conduct

The MHP is committed to complying with state and federal laws and regulations, as evidenced by the Tehama County Health Services Agency (TCHSA) Code of Conduct (see Appendix). Providers and Provider staff are required to certify that they have read, understood, and agree to comply with the Code of Conduct. Providers and Provider staff are required to submit signed certifications to Compliance Officer within thirty (30) days of executing the provider contract and within thirty (30) days after the start date of any newly-hired employees.

Exclusions from Federal Healthcare Programs

The MHP pays Providers and then seeks reimbursement from Federal Healthcare programs. Thus, Providers are rendering services payable by a Federal Healthcare program.

> **Definition of Covered Individual:** A Provider or Provider staff person with responsibilities pertaining to the ordering, provision, documentation, coding, or billing of services payable by a Federal Healthcare program.

Organizational Providers will not employ any covered individual who is, or at any time has been, excluded from participation in any federally funded healthcare program including, without limitation, Medicare or Medi-Cal. Provider will search the lists indicated below and verify every covered individual employed or contracted by Provider does not appear on these lists. Such verification will occur prior to hiring or contracting a covered individual and then at least annually thereafter. The lists to be searched are:

- U.S. Department of Health and Human Services, Office of Inspector General (OIG) List of Excluded Individuals/Entities (located at: http://exclusions.oig.hhs.gov)
- State of California, Medi-Cal Suspended and Ineligible List (located at: www.medi-cal.ca.gov and click on S & I Provider List on left side of page)

Organizational Providers will immediately (within one (1) business day) notify the MHP Compliance Officer if a covered individual working for an organizational Provider becomes suspended, excluded, or ineligible to participate in any federally funded healthcare program.

The MHP Compliance Officer will verify that individual Providers do not appear on these lists prior to contracting with the individual Provider and then at least annually thereafter. Individual Providers will immediately (within one (1) business day) notify the MHP Compliance Officer if an individual Provider becomes suspended, excluded, or ineligible to participate in any federally funded healthcare program.

Other Program Integrity/Compliance Requirements

- Each service Provider is required to sign a Statement of Understanding and Compliance (see Appendix A-14) for every day he/she provides a service to a beneficiary. The Statement shall be attached to or printed on the Provider's daily time sheet, service activity log, or billing record. Providers will make this available to the MHP upon request.

- A signed Assurance of Compliance and Letter of Transmittal (see Appendix A-1) must accompany a claim for payment. See item 7 under Submission of Claims/Invoices.

- Providers are required to report to the MHP Compliance Officer any confidentiality, privacy, or security breach within one (1) business day of discovery.

- The "Provider Information Change Form" (A-22) provides the information necessary for the MHP to bill federal healthcare programs. This form is required for each "covered individual". It is also required whenever there is a change in status (i.e., termination, re-hire) for a "covered individual". "Covered Individuals" are defined as the employees or independent contractors of the Provider with responsibilities pertaining to the ordering, provision, documentation, coding, or billing of services for which County seeks reimbursement from the Federal Healthcare programs (e.g. Medicare, Medi-Cal). Individual providers who contract directly with the MHP are also required to complete this form.

Miscellaneous

1. Provider is required to complete and provide to the MHP CSI and performance outcome data that is required by the State of California Department of Health Care Services, Mental Health Services Division (DHCS-MHSD). See the Appendix for the CSI Update Form. This form is completed by the Provider or Provider staff whenever they are aware that there has been a change in any of the elements listed on the form.

2. Provider is required to participate in consumer surveys and provider satisfaction surveys as requested by the MHP and required by the California State Department of Health Care Services, Mental Health Services Division..

3. Organizational Providers must submit their annual cost reports to the MHP in Short-Doyle State format by September 30th of each year for the prior State fiscal year (July 1 – June 30).

4. The MHP will conduct Provider site certifications and re-certifications according to the DHCS-MHSD requirements. The MHP will send the site certification protocol to the Provider at least 2 weeks prior to the site certification or recertification. Sites located in other counties may be certified by the other county. The Provider must provide the MHP with a copy of the other county's certification within 14 days of receipt. The Provider must have documentation (and supply the MHP with such documentation if the MHP did not generate the documentation) of a current valid certification when rendering any services to beneficiaries. The Provider must notify the MHP at least 30 days before providing a service at a new location.