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

PROVIDER HANDBOOK

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

Revised May 2024

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Definitions

Access Line: The Access Line (toll free: **1-800-240-3208**) is available to help Medi-Cal beneficiaries obtain mental health treatment. By calling this number, a member or provider can 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.

Member: 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.

Interagency Child and Family Services Collaborative (ICFSC): An interdisciplinary team of professionals that meet regularly to develop coordinated care plans for high-risk youth. This team is made up of Tehama County Departments and community providers.

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.

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 (DHCS). It also refers to the Tehama County Health Services Agency – Mental Health Division.

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 member and based on the member's desired results from mental health services. The

plan must have specific, observable, and measurable goals that relate to the member'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 meet regularly to review assessments and treatment/service plans and approve mental health services for beneficiaries.

Urgent Condition: As defined in BHIN 23-041, an urgent condition is when the member's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

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 Advocate:
(530) 527-8491 x3014

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	x3002 x 3973 x3319 x3011
Contract compliance, privacy, confidentiality, and security	Compliance Officer	x3046
Contract negotiations	Mental Health Director Mental Health Assistant Director	x3026 x3096
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	x3014
Referrals, scheduling Triage Team treatment plan presentations, client financial and demographic information, CSI data (including outcome data)	Office Assistant III	x3097 x3017

Forms

To access all Tehama County Mental Health forms, all providers must be issued an account login. The link to request access is available on the Tehama County Health Services website under the Provider Resources tab - Provider Resources - Tehama County Health Services (tehamacohealthservices.net). Instructions on utilizing the electronic platform will be issued at time of account registration.

Mission Statement and Values

Mission Statement

The mission of the Tehama County Mental Health Plan (MHP) is to provide each eligible member 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 member services.

Values

Respect for each member is the central value of the MHP. This includes member 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 member.
    - 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 member.
3. The MHP strives through treatment and discharge planning to allow each member to maintain the least restrictive setting and most appropriate level of care, enhancing community linkages whenever possible.
4. 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.
5. The provision of high quality, cost-effective services is the overriding goal in the delivery of care and treatment to each member.
6. The MHP values prevention and early intervention as strategies to promote wellness, avert crises and maintain each member within his/her community whenever possible.
7. Staff recognizes and works with each member's own desired outcome(s) in the provision of care.
8. Positive outcomes are achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.

Access to Specialty Mental Health Services

In collaboration with the County, Contractor will work to ensure that individuals to whom the Contractor provides SMHS meet access criteria, as per DHCS guidance specified in BHIN 21-073. Specifically, the Contractor will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as specified below.

A. For enrolled clients under 21 years of age, Contractor shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled clients who meet <u>either</u> of the following criteria, (I) or (II) below. If a client under age 21 meets the criteria as described in (I) below, the member meets criteria to access SMHS; it is not necessary to establish that the member also meets the criteria in (II) below.
    I. The client has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.
    II. The client has at least one of the following:
        a. A significant impairment
        b. A reasonable probability of significant deterioration in an important area of life functioning
        c. A reasonable probability of not progressing developmentally as appropriate.
        d. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal Managed Care Plan (MCP) is required to provide.

        <u>AND</u> the client's condition as described in subparagraph (II a-d) above is due to one of the following:
            - A diagnosed mental health disorder, according to the criteria in the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases and Related Health Problems (ICD).
            - A suspected mental health disorder that has not yet been diagnosed.
            - Significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

B. For clients 21 years of age or older, Contractor shall provide covered SMHS for clients who meet <u>both</u> of the following criteria, (I) and (II) below:
    I. The client has one or both of the following:
        a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

II. The client's condition as described in paragraph (I) is due to either of the following:
   a. A diagnosed mental health disorder, according to the criteria in the current editions of the DSM and ICD.
   b. A suspected mental disorder that has not yet been diagnosed.

C. Criteria

I. A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service listed within Exhibit A of this Agreement can be provided and submitted to the County for reimbursement under any of the following circumstances:
   a. The services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process;
   b. The service was not included in an individual treatment plan; or
   c. The client had a co-occurring substance use disorder.

D. Diagnosis Not a Prerequisite

I. Per BHIN 21-073, a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a current Centers for Medicare & Medicaid Services (CMS) approved ICD diagnosis code.

Medical Necessity

- Contractor will ensure that services provided are medically necessary in compliance with BHIN 21-073 and pursuant to Welfare and Institutions Code section 14184.402(a). Services provided to a client must be medically necessary and clinically appropriate to address the client's presenting condition. Documentation in each client's chart as a whole will demonstrate medical necessity as defined below, based on the client's age at the time of service provision.
- For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.
- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

Coordination of Care

- Contractor shall ensure that all care, treatment and services provided pursuant to this Agreement are coordinated among all providers who are serving the client, including all other SMHS providers, as well as providers of Non-Specialty Mental Health Services (NSMHS), substance use disorder treatment services, physical health

services, dental services, regional center services and all other services as applicable to ensure a client-centered and whole-person approach to services.

- Contractor shall ensure that care coordination activities support the monitoring and treatment of comorbid substance use disorder and/or health conditions.
- Contractor shall include in care coordination activities efforts to connect, refer and link clients to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
- Contractor shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
- To facilitate care coordination, Contractor will request a HIPAA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state and federal privacy laws and regulations.

Co-Occurring Treatment and No Wrong Door

- Per BHIN 22-011, Specialty and Non-Specialty Mental Health Services can be provided concurrently, if those services are clinically appropriate, coordinated, and not duplicative. When a client meets criteria for both NSMHS and SMHS, the client should receive services based on individual clinical need and established therapeutic relationships. Clinically appropriate and covered SMHS can also be provided when the client has a co-occurring mental health condition and substance use disorder.
- Under this Agreement, Contractor will ensure that clients receive timely mental health services without delay. Services are reimbursable to Contractor by County even when:
    a. Services are provided prior to determination of a diagnosis, during the assessment or prior to determination of whether SMHS access criteria are met, even if the assessment ultimately indicates the client does not meet criteria for SMHS.
    b. If Contractor is serving a client receiving both SMHS and NSMHS, Contractor holds responsibility for documenting coordination of care and ensuring that services are non-duplicative.

Prior Authorization or TCHSA Referral for Outpatient SMHS:

Per BHIN 22-016 TCHSA shall not require prior authorization for the following services/service activities:

1. Crisis Intervention;
2. Crisis Stabilization;
3. Mental Health Services, including initial assessment;
4. Targeted Case Management;
5. Intensive Care Coordination;
6. Peer Support Services; and
7. Medication Support Services.

As a regular practice, assessments are conducted by the TCHSA's clinical staff. TCHSA shall not require prior authorization in the event that an organizational provider conducts an assessment, however, prior to the commencement of services, TCHSA's Quality Assurance Manager (QAM) or designee shall review and approve the beneficiaries' completed assessment and Client Plan. Assessments and Client Treatment Plans completed by organizational providers will be securely sent to TCHSA via a mutually agreed upon electronic system.

Per BHIN 22-016 TCHSA requires prior authorization or referral for the following services:

1. Intensive Home-Based Services
2. Day Treatment Intensive
3. Day Rehabilitation
4. Therapeutic Behavioral Services
5. Therapeutic Foster Care

The authorization for these services shall specify the amount, scope and duration of the treatment TCHSA has authorized. Prior to the expiration of the initial referral, TCHSA requires organizational providers to request payment authorization for the continuation of services at the following intervals:

1. Every month
    a. Day Treatment Intensive
    b. Therapeutic Behavioral Services
    c. Therapeutic Foster Care

2. Every six (6) months
    a. Intensive Home Based Services
    b. Day Rehabilitation

If TCHSA denies or modifies an authorization request, notification will be given to the member, in writing, of the adverse benefit determination prior to services being discontinued. Notification of adverse benefit decisions shall follow guidelines outlined in BHIN 18-010E.

Outpatient Authorization Timeframe:

- Contractor will collaborate with County to complete authorization requests in line with County and DHCS policy.
- Contractor shall have in place, and follow, written policies and procedures for completing requests for initial and continuing authorizations of services, as required by County guidance.
- Contractor shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
- County shall provide Contractor with written notice of authorization determinations within the timeframes set forth in BHINs 22-016 and 22-017, or any subsequent DHCS notices.

- Contractor shall alert County when an expedited authorization decision (no later than 72 hours) is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function.

Retrospective Authorization Requirements:

TCHSA's QAM or designee conducts retrospective authorization of inpatient and outpatient SMHS under the following circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Member's failure to identify payer (e.g., for inpatient psychiatric hospital services).

TCHSA communicates retrospective authorization decisions to the individual who received the services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make the determination in a manner consistent with state requirements.

Referrals to Providers

Documents are securely sent to the Provider via a mutually agreed upon electronic system.

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 and Care Plans

Contractor is required to complete treatment or care plans for clients under this Agreement, as specified in BHIN 22-019 and additional guidance from DHCS that may follow execution of this Agreement.

Documentation Provisions

- Contractor will follow all documentation requirements as specified in the Provider Handbook in compliance with federal, state and County requirements.
- All Contractor documentation shall be accurate, complete, and legible, shall list each date of service, and include the face-to-face time for each service.

Contractor shall document travel and documentation time for each service separately from face-to-face time and provide this information to County upon request. Services must be identified as provided in-person, by telephone, or by telehealth.

- All services shall be documented utilizing County-approved templates and contain all required elements. Contractor agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this Provider Handbook require corrective action plans.

Assessment

- Contractor shall ensure that all client medical records include an assessment of each client's need for mental health services.
- Contractor will utilize the seven uniform assessment domains and include other required elements as identified in BHIN 22-019 and document the assessment in the client's medical record.
- For clients aged 6 through 20, the Child and Adolescent Needs and Strengths (CANS), and for clients aged 3 through 18, the Pediatric Symptom Checklist-35 (PSC-35) tools are required at intake, every six months during treatment, and at discharge, as specified in DHCS MHSUDS INs 17-052 and 18-048.
- The time period for providers to complete an initial assessment and subsequent assessments for SMHS are up to clinical discretion of County; however, Contractor's providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

ICD-10

- Contractor shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
- Once a DSM diagnosis is determined, the Contractor shall determine the corresponding mental health diagnosis in the current edition of ICD. Contractor shall use the ICD diagnosis code(s) to submit a claim for SMHS to receive reimbursement from County.
- The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by CMS.

Problem List

- Contractor will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

- Contractor must document a problem list that adheres to industry standards utilizing at minimum current SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) and ICD-10-CM.
- A problem identified during a service encounter may be addressed by the service provider during that service encounter and subsequently added to the problem list.
- The problem list shall include, but is not limited to, all elements specified in BHIN 22-019.
- County requires the problem list to be updated annually, at a minimum, and Contractor shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

Treatment and Care Plans

Contractor is required to complete treatment or care plans for clients under this Agreement, as specified in BHIN 22-019 and additional guidance from DHCS that may follow after execution of this Agreement.

Progress Notes

- Contractor shall create progress notes for the provision of all SMHS services provided under this Agreement.
- Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
- Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or a group service.
- Contractor shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
- Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services, if applicable.

Transition of Care Tool

- Contractor shall use a Transition of Care Tool for any clients whose existing services will be transferred from Contractor to an Medi-Cal Managed Care Plan (MCP) provider or when NSMHS will be added to the existing mental health treatment provided by Contractor, as specified in BHIN 22-065, in order to ensure continuity of care.
- Determinations to transition care or add services from an MCP shall be made in alignment with County policies and via a client-centered, shared decision-making process.
- Contractor may directly use the DHCS-provided Transition of Care Tool, found at https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx, or obtain a copy of that tool provided by the County. Contractor may create the Transition of Care Tool in its Electronic

Health Record (EHR). However, the contents of the Transition of Care Tool, including the specific wording and order of fields, shall remain identical to the DHCS provided form. The only exception to this requirement is when the tool is translated into languages other than English.

Telehealth

- Contractor may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
- All telehealth equipment and service locations must ensure that client confidentiality is maintained.
- Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.
- Medical records for clients served by Contractor under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Contractor. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.
- County may at any time audit Contractor's telehealth practices, and Contractor must allow access to all materials needed to adequately monitor Contractor's adherence to telehealth standards and requirements.

NOTE: The Provider is responsible for verifying the member'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)

Per Department of Mental Health (DMH) Information Notice 08-38 dated December 22, 2008, Therapeutic Behavioral Services (TBS) are a one-to-one behavioral mental health service available to children/youth with serious emotional challenges who are under age 21 and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal). TBS can help children/youth and parents/caregivers, foster parents, group home staff, and school staff learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kids of behavior that will allow children/youth to be successful in their current environment.

TBS are designed to help children/youth and parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the needs of the

child/youth and family. TBS are never a stand-alone therapeutic intervention. It is used in conjunction with another mental health service.

On October 21, 2004 DMH issued DMH Letter 04-11 which clarified that TBS services are available to full scope Medi-Cal beneficiaries under age 21 who are at risk of admission to a hospital for acute psychiatric inpatient hospital services or to a psychiatric health facility for acute care as a result of behaviors that may benefit from TBS interventions.

The process for authorizing TBS is separate and different from the process for authorizing specialty mental health services. The process for authorizing TBS is more involved and requires:

- Monthly reviews
- Approval from a team (which may have participants from different organizations and agencies), and
- Different and/or additional forms not provided in this handbook

To initiate the process for authorizing TBS services, please contact a Licensed Clinical Supervisor (current phone numbers are on page 6 of this handbook).

Timeliness of Services

Providers will schedule a member 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 member drops out of treatment, or the member 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
- Medications
- Member's current status, prognosis, and risk factors
- Member'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) will be securely sent to the Provider via a mutually agreed upon electronic system.

Client Closure Notification Form

When treatment ends for any reason, 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 to ensure accuracy against contract maximum liability limits.

The Client Closure Notification Form, accompanied by a copy of the discharge summary, is securely sent to the MHP via a mutually agreed upon electronic system.

Placements in an STRTP

The Interagency Child and Family Services Collaborative (ICFSC)) must authorize placements in a Short-Term Residential Treatment Program (STRTP). Minors referred to organizations providing STRTP placements are typically eligible for Medi-Cal. ICFSC referrals are managed and facilitated by Victor Community Supports and referral forms can be obtained by contacting their office at 530.840.2013.

Authorizations for Urgent and Emergency Conditions

Definition of Urgent Condition: As defined in BHIN 23-041, an urgent condition is when the member's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

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 concurrently, and notification given to the MHP within 24 hours. Please call 530-527-5637 or 1-800-240-3208.

Any member who is in Tehama County and needs **urgent** care is referred immediately to the MHP Mobile Crisis Team at 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 member's need(s). Any member requiring **emergency** inpatient care is referred to an inpatient facility that best meets their 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 member progress and assist with the aftercare plan.

If a **member is out-of-county** and requires **urgent** mental health services, the member 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 member 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.

Concurrent Review for Psychiatric Inpatient Hospital/Psychiatric Health Facility (PHF) Services:

TCHSA shall conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services per BHIN 22-017 requirements or any subsequent DHCS notices. Authorization procedures will be based on medical necessity and consistent with current evidence-based clinical practice guidelines, principles, and processes. Concurrent review of treatment authorizations shall be conducted no later than 72-hours after receipt of the request for services. TCHSA may elect to authorize multiple days, however, each day of treatment must meet medical necessity and/or continued stay criteria.

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services:

TCHSA shall conduct concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS) per BHIN 22-016 requirements or any subsequent DHCS notices.

TCHSA does not require prior authorization for Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Authorization for CRTS and ARTS must be by referral and/or concurrent review.

If TCHSA does not initiate the referral for CRTS or ARTS, the TCHSA shall conduct concurrent review of treatment authorizations following the first day of admission to the facility through discharge. The TCHSA may elect to authorize multiple days as long as the services are medically necessary.

If TCHSA refers a member to a facility for CRTS or ARTS, the referring LPHA will complete the Crisis Residential Treatment Services Authorization Form or the Adult Residential Treatment Services Authorization Form and specify the number of days authorized. TCHSA shall then reauthorize medically necessary CRTS and ARTS services, as appropriate, using the concurrent review process outlined above.

Notification of decisions to approve, modify, or deny requests for authorization of CRTS or ARTS shall follow the notification procedure outlined in BHIN 22-016 or any subsequent DHCS notices.

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 problem list prior to beginning a course of treatment.
6. Assist inquiring beneficiaries to communicate with the MHP (provide phone numbers, hours, etc.).
7. Have adequate staffing 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 when doing an assessment.
10. Provide all requested information to the Triage Team in order to expedite requests for services requiring authorization.
11. Obtain authorization for services requiring prior authorization **PRIOR** to rendering services (or, if an emergency inpatient admission, notify the MHP within 24 hours of admission).
12. Schedule an initial visit with an assigned member within 10 working days of the determination of medical necessity. Consult with the Triage Team regarding a potential planned admission of a member into an inpatient hospital.
13. Verify a member'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.)
14. 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.
15. Follow strict confidentiality guidelines to assure the member's privacy whenever referrals to other agencies and providers are necessary. Information regarding the member will not be provided without written permission of the member.
16. Comply with the Member Grievance and Appeal processes provided in this handbook.
17. 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.
18. Post notices explaining grievance and appeal process and procedures in all Provider sites sufficient to ensure that the information is readily available to beneficiaries and provider staff.
19. Give beneficiaries notice of their rights as contained in the Tehama County Beneficiary Handbook (available upon request from the MHP in electronic or paper form).

20. Provide information on Advance Directives to any Medicare client who has not been assessed by MHP staff.
21. Complete the CANS 50 for beneficiaries between the ages of 6-20 at admission, every 6 months, and at discharge.
22. Complete the PSC35 for beneficiaries between the ages of 3-18 at admission, every 6 months, and at discharge.
23. Complete the PQ16 for beneficiaries between the ages of 15-30 at admission and annually thereafter.

Records

Maintenance of Records

Contractor shall maintain proper clinical and fiscal records relating to clients served under the terms of this Agreement, as required by the Director, DHCS, and all applicable state and federal statutes and regulations. Client records shall include but not be limited to admission records, diagnostic studies and evaluations, client interviews and progress notes, and records of services provided. All such records shall be maintained in sufficient detail to permit evaluation of the services provided and to meet claiming requirements.

Access to Records

Contractor shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Contractor shall allow County, CMS, the Office of the Inspector General, the Controller General of the United States, and any other authorized federal and state agencies to evaluate performance under this Agreement, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor pertaining to such services at any time and as otherwise required under this Agreement.

Federal, State, and County Audits

In accordance with the California Code of Regulations, Title 9, Chapter 11, Section 1810.380(a), County will conduct monitoring and oversight activities to review Contractor's SMHS programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to SMHS as established in BHIN 21-073, in compliance with the applicable state and federal laws and regulations, and/or the terms of the Agreement between Contractor and County, and future BHINs which may spell out other specific requirements.

Internal Auditing

- Contractors of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet SMHS definitions and be documented accurately.
- Contractor shall provide County with notification and a summary of any internal audit exceptions, and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Contractor's internal audit process. Contractor shall provide this notification and summary to County in a timely manner.

Confidentiality in Audit Process

- Contractor and County mutually agree to maintain the confidentiality of Contractor's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA and California Welfare and Institutions Code, Section 5328. Contractor shall inform all of its officers, employees, and agents of the confidentiality provisions of all applicable statutes.
- Contractor's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.
- Contractor's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the County. All statistical data or information requested by the Director shall be provided by the Contractor in a complete and timely manner.

Reasons for Recoupment

- County will conduct periodic audits of Contractor files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.
- Such audits may result in requirements for Contractor to reimburse County for services previously paid in the following circumstances:
    I. Identification of Fraud, Waste or Abuse as defined in federal regulation
        a. Fraud and abuse are defined in C.F.R. Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d).
        b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulation-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf
    II. Overpayment of Contractor by County due to errors in claiming or documentation.
    III. Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.
- Contractor shall reimburse County for all overpayments identified by Contractor, County, and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

Cooperation with Audits

- Contractor shall cooperate with County in any review and/or audit initiated by County, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite program, fiscal, or chart reviews and/or audits.
- In addition, Contractor shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.

- Contractor shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.
- Contractor shall allow inspection, evaluation and audit of its records, documents and facilities for ten years from the term end date of this Agreement or in the event Contractor has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R.§§ 438.3(h) and 438.230I(3)(i-iii).

Member Problem Resolution Processes

Member Rights

Beneficiaries have a right to receive information regarding services covered by the MHP, other obligations of the MHP and member rights to receive that information in a manner the member can easily understand. For a full detail of these rights, please refer to the most recent version of the Tehama County Mental Health Plan Beneficiary Handbook located on the Tehama County Health Services Agency website https://www.tehamacohealthservices.net/.

Grievances, Appeals, Expedited Appeals, and State Fair Hearings

In accordance with Federal Regulations 42 CFR, Part 438, Subpart F, problems will fall under two categories, "appeal" or "grievance", depending on what the member's issue is. A grievance is anything the member is unhappy about that is not related to an action taken by the MHP on a NOABD. An appeal is when a member disagrees with an action taken by the MHP as communicated on a NOABD. The member may request an Expedited Appeal if he/she feels that the timeframe for the standard appeal (45 days) would result in jeopardy to the member's life, health, or ability to reach, maintain, or get back to his/her previous level of functioning. If the MHP disagrees with the appeal, the member may ask for a State Fair Hearing. The member has the right to request that services be provided while waiting for the State Fair Hearing process to occur. For full details on definitions and explanations for each of these processes, please refer to the most recent version of the Tehama County Mental Health Plan Beneficiary Handbook located on the Tehama County Health Services Agency website https://www.tehamacohealthservices.net/.

Problem Resolution Processes

When a member lets a Provider or staff person know that the member has a problem, immediately contact the MHP. The MHP Quality Assurance Manager (QAM) is responsible for assisting with member problems. The member 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 member may request a State Fair Hearing if the MHP decides a member 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)

Beneficiaries may file a Grievance, Appeal, 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 member's complaint.

Grievances, Appeals and Notices of Adverse Benefit Determination

- All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Contractor must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
- Contractor shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
- Aligned with MHSUDS IN 18-010E and 42 C.F.R. §438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Contractor within the specified timeframes using the template provided by the County.
- NOABDs must be issued to clients anytime the Contractor has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Contractor must inform the County immediately after issuing a NOABD. If a member has any questions about a NOABD, that the Contractor is unable to adequately answer please have them call the MHP Quality Assurance Manager at (530) 527-8491 x3139.
- Procedures and timeframes for responding to grievances, issuing and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
- Contractor must provide clients any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
- Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

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:

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 ten (10) working days of receipt of specific problem information (two (2) business days for an inpatient provider).
4. Problems and resolutions that are appropriate for group discussion will be reviewed quarterly by the Quality Improvement Committee.

MHP *Formal* Problem Resolution Process - Provider Services:

1. Any Provider may appeal the denial of services that require prior authorization to the MHP.
2. The appeal must be in writing and provided to the Mental Health Director or designee within thirty (30) calendar days of the date of receipt of the denial.
3. 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.
4. 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).
5. 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.

Site Certifications

The MHP will conduct Provider site certifications and re-certifications according to DHCS requirements.

For sites located in Tehama County:

- The MHP will send the site certification protocol to the Provider at least 2 weeks prior to the site certification or recertification due date.
- The Provider shall return the completed protocol, with all supporting documentation, to the MHP prior to the scheduled on-site visit date.
- Following the on-site visit, the MHP will send the Provider written notification of results, and a written plan of corrective action if deficiencies were identified. This written plan of corrective action will have a specified due date. Once any deficiencies are corrected, another written notification of results will be sent to the Provider.

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 Tehama County 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 any service at a new location.

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 Member fails to show.
3. Individual Providers: Treatment of any Medi-Cal Member 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 Member 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 member'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 member must include the number of participants and the total group time. The sign-in sheet should include the MHP client number for each member.
9. Units of services must be whole numbers (e.g., 42 minutes, 1 hour, 2 days, etc.).
10. All services requiring pre-authorization must be pre-authorized in order to receive reimbursement. The MHP is not responsible for payment of these services if they were not pre-authorized.

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 member 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.
companied 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 member 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 member (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 member (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: 301, 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. s must attach the relevant EOB's. The brackets (<>) indicate these amounts will be deducted in arriving at the box 15 total.
16. 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.

Submission of Claims/Invoices

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 member 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 member has other insurance and the member 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 member for **each month** a mental health service is billed. These copies should be in the same member 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 member 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, member, 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 assessment and treatment plan was reviewed by the quality assurance manager or designee.
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 member Medi-Cal eligibility for the service dates. A copy of the Medi-Cal website eligibility page for the member 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 member who is covered by Medi-Cal and a third party payer.
6. ach service provided to a member who is covered by Medi-Cal and a third party payer.
7. The Provider submits an Assurance of Compliance and Letter of Transmittal (see Appendix A-1)
8. 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.

9. The rates are as contracted.
10. The amount of services encumbered has not reached the contract dollar limit.
11. Documentation meets Medi-Cal standards.
12. 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.

FROM THE CALMHSA BOILERPLATE CONTRACT:

FINANCIAL TERMS

1. CLAIMING
   A. Contractor shall enter claims data into the County's billing and transactional database system within the timeframes established by County. Contractor shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, as from time to time amended.
   B. Claims shall be complete and accurate and must include all required information regarding the claimed services.
   C. Contractor shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all eligible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.
2. INVOICING
   A. Contractor shall invoice County for services monthly, in arrears, in the format directed by County. Invoices shall be based on claims entered into the County's billing and transactional database system for the prior month.
   B. Invoices shall be provided to County within 15 days after the close of the month in which services were rendered. Following receipt and provisional approval of a monthly invoice, County shall make payment within 30 days.
   C. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the service rates in Exhibit B-2.

D. County's payments to Contractor for performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities. County's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this Agreement or the reasons for recoupment set forth in Article 5, Section 6.

4. ADDITIONAL FINANCIAL REQUIREMENTS

A. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.

B. Contractor must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the United States Department of Health and Human Services may specify.

C. Contractor agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.

D. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud [42 U.S.C. section 1396b(i)(2)].

5. CONTRACTOR PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS [IF APPLICABLE]

A. Contractor may not redirect or transfer funds from one funded program to another funded program under which Contractor provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.

B. Contractor may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.

Quality Improvement Program

- Contractor shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
    - Contractor shall collaborate with County to create a QAPI Work Plan with documented annual evaluations and documented revisions as needed. The QAPI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.
- Contractor shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Contractor shall measure, monitor, and annually report to the County its performance.
- Contractor shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Contractor shall assess client/family satisfaction by:
    - Surveying client/family satisfaction with the Contractor's services at least annually, as required by Department of Healthcare Services, or more frequently as requested by the MHP.
    - Evaluating client grievances, appeals and State Hearings at least annually.
    - Evaluating requests to change persons providing services at least annually.
    - Informing the County and clients of the results of client/family satisfaction activities.
- Contractor, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.
- Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually and shared with the County.
- Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.
- Contractor shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Contractor shall ensure that there is active participation by the Contractor's practitioners and providers in the QIC.
- Contractor shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under

this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

Network Adequacy

- The Contractor shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206 (a), (c)).
- Contractor shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information and timely access to services information to the County, utilizing a provided template or other designated format.
- Contractor shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services.
- To the extent possible and appropriately consistent with CCR, Title 9, §1830.225 and 42 C.F.R. §438.3 (l), the Contractor shall provide a client the ability to choose the person providing services to them.

Provider Directory

- Contractor must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.
- Contractor must make available to clients, in paper form upon request and electronic form, specified information about the county provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).
- Any changes to information published in the provider directory must be reported to the County within two weeks of the change.
- Contractor will only need to report changes/updates to the provider directory for licensed, waivered, or registered mental health providers.

Alternative Formats

- Contractor shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. § 438.10(c)(1)) Contractor shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Contractor shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.
- Contractor shall provide the required information in this section to each client receiving SMHS under this Agreement and upon request. (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26., attachments 3, 4; Cal. Code Regs., tit. 9, § 1810.360(e).)
- Contractor shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all requirements regarding the same set forth 42 C.F.R. § 438.10.
- Contractor shall use DHCS/County developed Beneficiary Handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3))
- Client information required in this section may only be provided electronically by the Contractor if <u>all</u> of the following conditions are met:
    - The format is readily accessible;
    - The information is placed in a location on the Contractor's website that is prominent and readily accessible;
    - The information is provided in an electronic form which can be electronically retained and printed;
    - The information is consistent with the content and language requirements of this agreement;
    - The client is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days. (42 C.F.R. § 438.10(c)(6).)

<u>Language and Format</u>

- Contractor shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 C.F.R. 438.10(d)(6)(ii))
- Contractor shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.
- Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Contractor's mental health education materials, available in the prevalent non-English languages in the county. (42 C.F.R. § 438.10(d)(3))
    - Contractor shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how

to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Inst. Code § 14727(a)(1); Cal. Code Regs. tit. 9 § 1810.410, subd. (e), para. (4))

- Contractor shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)- (4))
- Contractor shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).
- Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

Member Informing Materials

- Each client must receive and have access to the member informing materials upon request by the client and when first receiving SMHS from Contractor. Member informing materials include but are not limited to:
    - Guide to Medi-Cal Mental Health Services
    - County Beneficiary Handbook (BHIN 22-060)
    - Provider Directory
    - Advance Health Care Directive Form (required for adult clients only)
    - Notice of Language Assistance Services available upon request at no cost to the client
    - Language Taglines
    - Grievance/Appeal Process and Form
    - Notice of Privacy Practices
    - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) poster (if serving clients under the age of 21)
- Contractor shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.
- Contractor shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.
- Required informing materials must be electronically available on Contractor's website and must be physically available at the Contractor agency facility lobby for clients' access.
- Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.
- Informing materials will be considered provided to the client if Contractor does one or more of the following:
    - Mails a printed copy of the information to the client's mailing address before the client first receives a specialty mental health service;
    - Mails a printed copy of the information upon the client's request to the client's mailing address;

- Provides the information by email after obtaining the client's agreement to receive the information by email;
- Posts the information on the Contractor's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
- Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If Contractor provides informing materials in person, when the client first receives specialty mental health services, the date and method of delivery shall be documented in the client's file.

Miscellaneous

1. 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).