YOLO COUNTY

Alcohol, Drug, And Mental Health Department

Provider Manual

January 2009

Table of Contents

QUICK REFERENCE

Contact Information

Yolo County Alcohol, Drug, and Mental Health
137 N. Cottonwood Street
Woodland, CA 95695

24-Hour Screening and Referral	888-965-6647
Administration	530-666-8630
TDD	800-735-2929
FAX	530-666-8294

Regular Clinic Hours: Monday through Friday, 8:00 am to 5:00 pm

ALL PLANNED SERVICES MUST BE PREAUTHORIZED BY:

Yolo County Alcohol, Drug, and Mental Health Department
Quality Management Unit
530-666-8787

PATIENT'S RIGHTS ADVOCATE

1-877-YOLO-PRA (1-877-965-6772)

Definitions

ADMH: The Yolo County Alcohol, Drug and Mental Health Department is referred to as ADMH throughout this document.

Beneficiary: This is a Medi-Cal-eligible individual who is a Yolo County resident requesting mental health treatment services. Parents or legal guardians also may call to request services on behalf of a minor beneficiary (under the age of 18).

Contract Provider: This is a licensed mental health professional, organization, or hospital that has contracted with the Yolo County Alcohol, Drug and Mental Health Department to provide evaluation and treatment to Medi-Cal beneficiaries.

Emergency Condition: The criterion for emergency status is that the individual is a danger to self or others, or is gravely disabled.

Intake Process: Support staff with basic intake skills training will receive calls from beneficiaries and providers. Support staff will ask questions regarding the general nature of the call. Support staff are required to obtain basic information to complete a state-mandated Access Log.

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

Medical Necessity: Medical necessity is required to justify payment for specialty mental health services. See the later section titled "Medical Necessity."

MHP – Yolo County Mental Health Plan: MHP is the contract vehicle between the Yolo County Alcohol, Drug and Mental Health Department and the California State Department of Mental Health for Yolo County to provide specialty mental health services to Medi-Cal beneficiaries. The Yolo County Mental Health Plan is referred to as YCMHP in this document.

Pre-Authorization: All planned specialty mental health services require pre-authorization. This can be arranged by contacting the Quality Management Team and completing the intake process.

Screening and Referral Line: This is ADMH's primary line, which is available to help Medi-Cal beneficiaries obtain mental health treatment. Callers may ask questions about eligibility for mental health services, and can obtain referrals and/or authorization for mental health services. They also may express a concern or complaint, or get immediate help for a crisis. (Note: The hearing impaired may call the TDD number: 1-800-735-2929.)

Specialty Mental Health Services: Client, family, and group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. Mental Health Services are interventions consistent with the requirements for learning, development, independent living, and enhanced self-sufficiency. Service activities may include, but are not limited to: assessment, evaluation, collateral, individual and group therapy, rehabilitation, and plan development.

Urgent Condition: This is a situation experienced by the individual that, without timely intervention and treatment, is certain to result in an immediate emergency psychiatric condition.

Mission Statement

The mission of the Yolo County Alcohol, Drug and Mental Health Department is to enable individuals in our community who are affected by mental illness and serious emotional disturbances to achieve the highest quality of life and to live as contributing and successful members of their families and communities. To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture.

Values

ADMH holds respect for each beneficiary as its central value, including beneficiary choice, satisfaction, and confidentiality. ADMH is committed to developing and maintaining a system of care for children, adults, and older adults, that is culturally competent and family-centered. The following principles are the basis for the process of improving cultural competency and age-appropriate services:

- ✓ Planning and design of services will be delivered with respect for the diversity of beneficiaries.
- ✓ ADMH recognizes that the family, as defined by each culture, is a primary system of support and, therefore, should be incorporated into the planning of services whenever possible.
- ✓ ADMH will provide language accessibility and cultural competence within the service system to the extent possible within its resources.
- ✓ ADMH is committed to hiring staff that are proficient in serving a multi-cultural population.
- ✓ ADMH is committed to providing a comprehensive range of age-appropriate services for each child, adult, and older adult beneficiary. Provision of cost-effective, high quality services will be the overriding goal in the delivery of care and treatment to each beneficiary.
- ✓ ADMH is committed to providing timely and appropriate access to care.
- ✓ ADMH values prevention and early intervention as strategies to promote wellness, avert crises, and maintain each beneficiary within his/her community to the extent possible.
- ✓ ADMH staff will recognize and work with each beneficiary's own desired outcome(s) in the provision of care.
- ✓ Positive outcomes will be achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.

MEDICAL NECESSITY CRITERIA

All authorizations of routine services require prior justification of medical necessity. For purposes of authorization of planned specialty mental health services, medical necessity is determined by the ADMH Quality Management Team (QM). The ADMH Medical Necessity Checklist is the tool used by QM to assure consistency and maximum objectivity in their decision-making process.

OUTPATIENT SERVICES

Authorization Process

The following assumes that the provider is located in Yolo County and that the client is a Yolo County Medi-Cal-eligible beneficiary.

Initial Authorization – Routine, Non-Urgent Care

The ability to ensure timely access and appropriate utilization of services is a responsibility that Yolo County Alcohol, Drug, and Mental Health (ADMH) is committed to fulfill. It is the goal of ADMH to manage resources in a manner that allows all individuals requesting planned services to receive an initial intake assessment appointment as soon as possible, but no later than seven (7) calendar days from the initial request for services.

It is also a goal of ADMH that, for those individuals authorized to receive planned services, a scheduled appointment date with a service provider will occur within thirty (30) calendar days from the date of Quality Management (QM) approval.

ADMH staff shall complete initial assessments for those clients who request services through ADMH (points of entry include Woodland, West Sacramento, and Davis). Upon approval by QM, clients shall be referred to an appropriate county, organizational or individual provider for services.

A. If the client meets medical necessity, QM shall authorize services for an initial period (beginning retroactively to the first of the month that the intake occurred, plus thirty days from the day after QM reviewed the documentation). QM shall then determine the appropriate level of care and assign appropriate service provider(s).
    - The provider will be notified of the case assignment through the Disposition Form.
    - The provider will contact the client to notify him/her of the authorization and schedule the first appointment. The assigned provider shall make this contact and deliver services within thirty (30) calendar days of the date of the QM review.

B. If a Medi-Cal beneficiary is denied services due to lack of medical necessity or other allowable reasons for denials, QM shall notify the client in writing, using the Notice of Action (NOA) process. Non-Medi-Cal eligibles are notified of the denial in writing and are referred to other resources.

C. Upon notification of a client's referral, assigned providers shall:

1. Review the client's intake packet and other documentation forwarded by QM.

2. Contact the client to notify of authorization and to schedule the first service delivery appointment (within thirty (30) calendar days of the QM review date).
    - If unable to contact the client after thirty (30) calendar days, providers will document attempts to contact the client and complete a discharge summary and the relevant portion of the disposition form. Providers will then forward these documents to QM.

3. Meet with the client to discuss goals of services and complete a Client Plan. All initial and revised Client Plans must have client and provider signatures (as well as other required staff, family member, and/or guardian/conservator), and a Progress Note explaining the reason(s) that the client did not sign.
    - Clients are given copies of the Client Plan upon request.

4. If services are completed within the initial thirty (30) calendar days, providers shall complete a discharge summary and forward documentation to QM.

Authorization of Continued Services, or Add-on Services

If clients require more than six (6) months of outpatient services, a request for re-authorization of services must be submitted 30 days prior to the end of the current authorization period. Add-on services must also be authorized through the authorization process prior to service delivery.

A. All routine outpatient services continuing beyond the authorization period must have QM authorization. This process is critical as unauthorized delivery of services is ineligible for reimbursement. To obtain re-authorization of services, submit the Client Plan, a Re-Authorization/Add-On Services Request form, Medical Necessity Checklist, and the Medi-Cal eligibility confirmation to QM within thirty (30) calendar days of the date of initial authorization.

1. QM will evaluate requests for re-authorization on the basis of the Client Plan, continued medical necessity, chart documentation, and other relevant information.

2. If ongoing services are authorized, QM will:
    a. Authorize a standard length of service per the following guidelines:
        - Outpatient Services – up to 6 months
        - Day Treatment/Rehabilitation – 3-6 months
    b. Notify the current service provider.

3. If on-going services are not authorized due to lack of medical necessity or other allowable reasons for denial, QM will notify a Medi-Cal beneficiary through the Notice of Action process, or by letter for non-Medi-Cal eligibles. QM will also complete a discharge summary.

B. All Add-On services must have QM authorization. Add-On service authorizations are requested by submitting a Re-Authorization/Add-On Services Request form and a Client Plan.

1. QM will evaluate add-on services on the basis of the initial Client Plan. The request for add-on services must be submitted to QM for review prior to delivering these add-on services.

2. If add-on services are authorized, QM will notify the service provider, who will contact the client for further service delivery.

3. If add-on services are not authorized due to lack of medical necessity or other allowable reasons for denial, QM will notify Medi-Cal beneficiaries through the Notice of Action process, and by letter for non-Medi-Cal eligibles. QM will also complete a discharge summary.

4. Add-on services are authorized for a period of time to coincide with the end of the initial or most recent service authorization period. At the end of the original service authorization period, procedures for request for re-authorization are followed for all authorized services.

Discharge Summary

Providers are required to submit a discharge summary to ADMH within thirty (30) days of the completion or cessation of treatment of all ADMH clients who received mental health services.

Prescription Medications

Beneficiaries and providers utilize the California State Department of Health Services (DHS) process for authorization and/or reimbursement for prescription medications. Medications are not a part of ADMH.

OTHER OUTPATIENT AUTHORIZATION SCENARIOS

Yolo County Professional Provider; Client from another County
Authorization of services to be provided to any beneficiary from another county must be obtained from the authorization unit of the client's county of origin. Service authorization approval must be obtained to assure that the beneficiary's county of origin will reimburse ADMH for services delivered. A member of QM or designee shall be the primary contact to assure that necessary procedures are fulfilled to obtain service approval from the client's county of origin.

Yolo County Client; Professional Provider from another County
QM is responsible for authorization of all Private Network Provider requests not managed through the Administrative Service Organization (ASO), as well as for cases which cross county lines. Cases that cross county lines include cases in which:

- ADMH clients are treated by contract providers in other counties;
- ADMH clients are treated by out-of-Plan providers; and
- ADMH treats clients from other counties.

The private or public provider seeking to treat the ADMH beneficiary shall be required to meet the same authorization requirements as those providers who are located within Yolo County.

Initial Authorization

Emergency Admissions: Emergency hospital admissions do not require pre-authorization for the first 24 hours of inpatient stay. Within that 24-hour period, the hospital is required to call ADMH intake staff at 530-666-8630 to coordinate with the Crisis Unit.

Planned Admissions**:** All planned inpatient admissions must be pre-authorized by the ADMH QM. Providers should contact the intake staff for authorization.

Hospital Admissions directly from an Institution for Mental Disability (IMD): Such transfers must be coordinated through QM. Providers should contact the intake staff at 530-666-8630.

Urgent Care: Any beneficiary who needs urgent care during regular business hours (Monday through Friday 8a.m.-5p.m.) should be referred immediately to an ADMH Clinic for a face-to-face assessment with a mental health clinician and/or physician, as needed. Authorizations for subsequent care will be determined within one (1) hour. After hours, beneficiaries should be referred to the ADMH Crisis Unit at 888-965-6647 for both emergency and urgent care.

Ongoing Authorization

Authorization for inpatient services beyond the first 24 hours for emergency admissions must be obtained from QM (530-666-8787). Inpatient stays beyond the initially authorized stay for planned admissions must also be authorized by QM. ADMH staff will facilitate the hospital's communications with QM.

Case Management and Discharge Planning

The hospital discharge planner will assure that all clients admitted to acute inpatient facilities have an assigned case manager to monitor the inpatient stay and assure appropriate discharge planning.

Documentation and Final Review of TAR

1. TAR/Request for Mental Health Stay in Hospital: Within fourteen (14) days of discharge, the hospital shall provide ADMH with a properly completed TAR form and a copy of the client's medical record. ADMH licensed/waivered mental health staff will evaluate the case per current state specifications. After reviewing the TAR, the licensed/waivered mental health staff will 1) approve the TAR as written, or 2) request more information from the provider, or 3) deny the TAR.

ADMH licensed/waivered mental health staff review will be completed within fourteen (14) calendar days of receipt of the request. All adverse decisions by the licensed/waivered mental

health staff regarding inpatient TARs (payment denial) are subject to final review by an ADMH psychiatrist MD.

ADMH will process approved payments through EDS and provide the hospital billing office with a copy of the approved TAR.

Any inpatient provider appeal of a denied or modified payment ruled in favor of the provider will be processed for payment within fourteen (14) calendar days of receipt of a revised TAR.

Inpatient Professional Services

Because contracting acute care hospitals have negotiated rates, inpatient professional visits do not need a separate ADMH authorization. Reimbursement for professional visits will be dependent upon the authorization of each corresponding bed day (Limit: 1 assessment per hospitalization; 1 hospital visit per day).

Quality Assurance

The ADMH Quality Management Unit has the responsibility of assuring that high quality services are provided to the client in an effective and efficient manner. The Quality Management Unit reviews services and programs of providers in order to ensure:

1. Accessibility;
2. Services that are meaningful and beneficial to the client;
3. Services that are culturally and linguistically competent; and
4. Services that produce highly desirable results through the efficient use of resources.

Quality Improvement

ADMH establishes policies, structure, and processes to ensure continuous quality improvement through its Quality Improvement Committee (QIC). The ADMH Quality Management Unit oversees the QIC and coordinates with other performance monitoring activities.

The QIC will monitor clients' satisfaction with services that they are receiving from staff and providers. ADMH staff will evaluate contract performance based on mutually identified measurable objectives. The QM Program, on a periodic basis, reviews collected information, data, and trends relevant to standards of cultural competence and linguistic capabilities.

If the QIC finds that a provider may be deficient in rendering or managing care, or if other problem areas are discovered, procedures outlined in the Provider Problem Resolution Process will be initiated. If these deficiencies or problem areas are verified, corrective sanctions may be applied. These sanctions may include mandatory reviews of all claims, periodic review of medical records, or termination of the provider's contract with ADMH.

Training and Consultation

Upon request, ADMH Quality Management staff (and additional clinical staff, as needed) shall provide training and consultation to providers in the following areas:

- Medical necessity criteria,
- Clients' rights issues,
- Cultural competence and ethnic diversity;
- Medications and medication management,
- Outcomes, and
- Other quality components referenced in this manual.

PROVIDER SELECTION AND RETENTION

Individual Providers

Licensed psychiatrists (MD), licensed clinical psychologists (Ph.D.), licensed clinical social workers (LCSW), licensed marriage and family therapists (MFT), and licensed registered nurses (RN) (within their scope of practice), are eligible to be credentialed as individual providers with ADMH. Providers serving Yolo County Medi-Cal clients may become part of the ADMH provider network by submitting for review:

1. A confidential provider application;
2. Work history for the past 15 years;
3. Professional references from two licensed behavioral health clinicians;
4. Release forms for insurance and transcript verification;
5. A copy of the current license;
6. A Certificate of Insurance verifying that the provider has the amount of insurance established by the County Purchasing Department and approved by the Board of Supervisors;
7. Current Yolo County Business Tax Certificate; and
8. A W9 form.

The provider application packet shall be reviewed by the ADMH Quality Management team. Decisions regarding provider applications, including denials, will be given to the applicant in writing. If approved, a provider contract will be developed and submitted to the provider for signature.

PROVIDER SELECTION AND RETENTION

Organizational Providers

Organizational providers which offer mental health services through the Yolo County Alcohol, Drug and Mental Health Department are required to:

- Possess the necessary license to operate;
- Provide for appropriate supervision of staff;
- Have as Head of Service a licensed mental health professional or other appropriate individual as described in state regulations;
- Possess appropriate liability insurance;
- Maintain a safe facility with required fire clearances;

- Store and dispense medications in compliance with all applicable state and federal laws and regulations;

- Maintain client records in a manner that meets state and federal standards;

- Meet the standards and requirements of the ADMH Quality Management Program;

- Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to California laws and regulations, as well and local Yolo County requirements; and

- Meet any additional requirements that are established by ADMH as part of a credentialing or evaluation process.

Certification of Organizational Providers

- ADMH shall certify organizational providers in accordance with California Code and ADMH-DMH contract requirements.

- Certification of organizational providers shall occur prior to the date on which the provider begins to deliver services under the contract, and at least once every three (3) years after that date, except as provided for by state regulations.

- Organizational provider certification shall include an on-site review, in addition to a review of relevant documentation.

- The OIG *List of Excluded Individuals and Entities* is checked prior to hiring or contracting with entities. http://www.oig.hhs.gov/fraud/exclusions.html

Service Delivery Prior to Certification

- ADMH may allow an organizational provider to begin delivering services to beneficiaries prior to the date of the on-site review, provided that the provider's site is operational and has required fire clearances.

- The earliest date that the provider may begin delivering covered services is the *latest* date of the following:
    - The date the provider requested certification,
    - The date the site was operational, or
    - The date that required fire clearances were obtained.

- ADMH shall complete any required on-site review of a provider's sites within six (6) months of the date that the provider begins delivering covered services to beneficiaries at the site in question.

PROVIDER SITE CERTIFICATION

Organizational Providers

All organizational providers who contract with ADMH must be site certified by the Yolo County Alcohol, Drug and Mental Health Department. The Site Certification requirements cover the following categories, at a minimum, as appropriate:

1. Licensing and/or certification, as required,
2. Fire safety (a fire safety inspection with local fire marshal is the mandatory preliminary step in this process),
3. Physical plant,
4. Written operational documentation (policies and procedures and an administrative manual),
5. Physician availability,
6. Staffing,
7. Day care staffing ratios, and
8. Pharmaceutical services.

Site Certifications will be required every three (3) years, or when a provider relocates, changes their type of services, changes staffing, changes in ownership, or makes modifications to its physical plant/facility. ADMH will require a written program description from the facility prior to a Site Certification. Site Certification must be completed prior to the start of contracted reimbursable services.

Assessments

The Yolo County Alcohol, Drug and Mental Health Department uses an age-appropriate (child and adult) multi-cultural clinical assessment, which meets the current DMH requirements. The following areas are described by DMH as a part of a comprehensive client record:

- Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example, living situation, daily activities, and social support.
- Documentation shall describe client strengths in achieving client plan goals.

- Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
- Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.

- A mental health history shall be clearly documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
- A relevant mental status examination shall be documented.
- A five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

Timeliness and Frequency Standards for Assessments

ADMH standards for timeliness and frequency for assessments are as follows:

- An assessment is required prior to the approval of on-going services.
- An updated assessment is required whenever there are significant changes in a client's level of functioning or symptomatology, or annually.

Client Plans

In accordance with ADMH and DMH standards, Client Plans shall:

- Have specific observable and quantifiable goals identified in cooperation with the client.
- Identify the proposed type(s) of intervention.
- Have a proposed duration of intervention(s).
- Be consistent with the diagnoses.
- Be signed by:
    - The client, parent, guardian or conservator except when client refuses or is unavailable, and
    - The person providing the service(s).
- Be signed or co-signed by one of the following approved staff categories:
    - Licensed Physician
    - Licensed/Waivered Psychologist
    - Licensed/Waivered Clinical Social Worker
    - Licensed/Waivered Marriage and Family Therapist
    - Registered Nurse
    - Other staff approved by the Yolo County ADMH Director

In addition, ADMH and its providers shall ensure that:

- The Client Plan is used to establish that services are provided under the direction of an approved category of staff.
- The focus of intervention is consistent with the Client Plan goals.
- A Client Plan is required for all outpatient mental health services, including Adult, Children's, and Older Adult Mental Health Services; Adult and Children's Day Treatment Intensive; Therapeutic Behavioral Services; Day Rehabilitative Services; Adult Crisis Residential; and Adult Residential.
- Clients who receive Medication Support Services Only receive a separate Medication Plan.
- In the absence of a client signature, the client's level of participation, agreement, refusal, or unavailability must be documented.
- The client shall receive a copy of the Client Plan.

Timeliness and Frequency Standards for Client Plans

ADMH standards for timeliness and frequency of Client Plans are as follows:

- Providers shall ensure that the client plan is written within the initial service authorization period (thirty days of the QM review date).
- Client plans are required to be updated with each request for reauthorization of ongoing services (3 months or 6 months).

- A Medical Necessity Checklist must be submitted with each updated Client Plan.

Progress Notes

ADMH requires that Progress Note documentation will be entered on the day of service delivery. All late notes shall be entered as a "Late Progress Note" entry. Progress Note documentation shall contain the following information:

- Date of Service
- Client Medical Record number
- Client Name

- Service procedure code (identify type of service delivered)
- Duration of service
- Location of service

- A description of what was attempted and/or accomplished by the client, family (when applicable), and staff toward the goal
- Documentation of progress towards each Client Plan goal
- Description of changes in the client's medical necessity

- Mental health staff/practitioners' documentation of client encounters, including relevant clinical decisions and interventions
- Documentation of referrals to community resources and other agencies
- Documentation for follow-up care or, as appropriate, a discharge summary

- Signatures of the person providing the service, professional degree or licensure or, job title
- Legible signatures and notes. If the signature is not legible, the writer's name is printed legibly in proximity to the signature.
- Co-signatures by an approved category of staff for Progress Notes written by unlicensed staff who do not meet minimum educational and experiential standards

Frequency Standards for Progress Notes
Progress Notes shall be written for on the following schedule of frequency for specific service types:

Every Service Contact	Mental Health Services Collateral Services Medication Support Services Crisis Intervention Case Management/Brokerage Therapeutic Behavioral Services
Each Shift	Crisis Residential Crisis Stabilization Psychiatric Health Facility
Weekly Summary	Day Rehabilitation Adult Residential
Daily & Weekly Notes	Day Treatment Intensive

Timeliness Standards for Progress Notes
ADMH promotes, as a standard of practice, that **all progress note documentation shall be completed on the day of service delivery**.

Late Entry Progress Notes
Progress Note documentation shall be entered as soon as possible after the service is delivered. It is understandable that circumstances can occur that make timely entry of documentation unfeasible. Case managers, for example, are often delivering services in the field and travel from one appointment to the next. Clinical sessions, however, can usually be scheduled to end at a planned time, for example, a fifty (50) minute session with ten (10) minutes for documentation.

All mental health professionals understand and agree that timely documentation is a basic standard of care issue. ADMH promotes as a standard of practice that all Progress Note documentation shall be completed on the day of service delivery. If, however, unavoidable circumstances necessitate a late progress note entry after the day of service delivery, the note shall be written no later than five (5) working days after the day of service.

1. On the day of service delivery, the medical record number, name, service procedure code, service duration and service location, etc. are recorded on the clinician's Daily Transaction Sheet. The service duration only includes the actual service delivery time as the documentation time is recorded on the day that the documentation is completed.

2. On the day the documentation is completed, the account of time required to complete the documentation is recorded on the Daily Transaction Sheet. The Medical Record number, name, procedure code, (the same service delivery code entered the day service was delivered) and service location, etc. are entered. Next to the client's name, indicate "Late Entry" in parenthesis.

3. The progress note is dated with the current date; however, the note should begin with a statement that, "This is a late entry for service delivery on {indicate the date the service was delivered}."

4. Late Entry progress notes will be accepted for a maximum of up to five (5) working days after the day of service delivery.

Medication Documentation

ADMH requires the following documentation procedures regarding medication management and monitoring:

1. A signed *Medication Information and Consent form* must be reviewed with the client by the prescribing physician. This review includes information on side effects and must be signed by the client and filed in the client's chart. This review must be provided each time the client's prescription is initiated to a different class of medications.

2. All identifying information, including allergies, must be completed on a *Doctor's Order Sheet and Medication Record*. Known drugs prescribed by other medical physicians will also be noted.

3. All medication orders must be signed with first and last name and title of physician (no initials).

4. All medication prescribed and/or dispensed by the physician, or given by the nurse with a physician's order, must be noted on the *Doctor's Order Sheet and Medication Record* and recorded in the Progress Note of the client's chart.

5. Clients will be re-evaluated by the psychiatrist at least every three months for dose/frequency of injectable and oral medication. Medication must be re-ordered at least every three months.

6. Physicians may dispense oral medication in amounts greater than a daily dose on an emergency basis only.

7. Laboratory tests for patients on medications requiring laboratory tests will be ordered according to minimum protocol.

Medication monitoring for all programs is completed through the Medication Monitoring process in cooperation with the consulting pharmacist. Monitoring activities include a review of clinical records and consultation, as requested.

DAY TREATMENT INTENSIVE (DTI) & DAY REHABILITATION (DR)

Payment Authorization and Service Requirements

Overview

The Yolo County Alcohol, Drug and Mental Health Department (ADMH) contracts with organizational providers for delivery of Day Treatment Intensive (DTI) and Day Rehabilitation (DR) services. The ADMH Quality Management unit maintains a current list of providers.

Although ADMH does not deliver DTI or DR, ADMH is responsible for:

- Determining a client's need for Day Treatment Intensive or Day Rehabilitation services.
- Ensuring that the client has access to these services.
- Authorizing payment for these services, and
- Supervising the quality of these services.

Service Requirements – Day Treatment Intensive and Day Rehabilitation

In order to be certified as a Day Treatment Intensive or Day Rehabilitation program, organizational providers must offer, at a minimum, the following components of service:

A. Community meetings — Meetings that occur at a minimum of once a day, but may occur more frequently as necessary, to:
   - Address issues pertinent to the continuity and effectiveness of the therapeutic milieu that may, but are not required to be part of the continuous therapeutic milieu;
   - Actively involve staff and clients;
     - » For Day Treatment Intensive, include the a staff person whose scope of practice includes psychotherapy;
     - » For Day Rehabilitation, include a staff person who is a physician;
       - ◦ A licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist;
       - ◦ A registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist;
   - Address relevant items including, but not limited to what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or

for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up.

B. A Therapeutic Milieu — A therapeutic program that is structured by the service components below with specific activities being performed by identified staff; takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program). The therapeutic milieu also includes the following:

- Staff and activities that teach, model and reinforce constructive interactions;
- Peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
- Involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers, and
- Behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

C. Therapeutic Milieu Components — The therapeutic milieu service components described below must be made available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. (For example, a full-day program that operates five days per week would need to provide a total of 15 hours for the week; a full-day program that operates for seven days a week would need to provide a total of 21 hours for the week.)

- Day rehabilitation must include:
  - » Process groups, which are groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.
    Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.
  - » Skill building groups, which are groups in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.
  - » Adjunctive therapies, which are non-traditional therapies in which both staff and clients participate that utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.
- Day treatment intensive must include:
  - » Skill building groups and adjunctive therapies as described above. Day treatment intensive may also include process groups as described above.
  - » Psychotherapy, which means the use of psychosocial methods within a professional relationship to assist the client or clients to achieve a better

psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy must be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

D. An established protocol for responding to clients experiencing a mental health crisis — The protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.

E. A detailed weekly schedule that is available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.

F. Staffing ratios that are consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352, and, for day treatment intensive, that include at least one staff person whose scope of practice includes psychotherapy. Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts. ADMH requires that at least one staff person is present and available to the group in the therapeutic milieu for all scheduled hours of operation.

ADMH requires that if day treatment intensive or day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. ADMH requires that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

G. An expectation of client participation — ADMH expects that the client will be present for all scheduled hours of operation for each day. When a client is unavoidably absent for some part of the hours of operation, ADMH will ensure that the provider receives Medi-Cal reimbursement for DTI and DR for an individual beneficiary only if the client is present for at least 50 percent of the scheduled hours of operation for that day.

H. Documentation standards — of day treatment intensive and day rehabilitation that meets the documentation standards described in Section III under Procedures. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/ waivered/ registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

I. At least one contact (face-to-face or by an alternative method (e.g., e-mail, telephone, etc.)) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for day treatment intensive and day rehabilitation.

J. A written program description for Day Treatment Intensive and Day Rehabilitation describing the specific activities of the service and reflecting each of the required components of the DTI and DR. ADMH will review the written program description for compliance with this section for individual and group providers that begin delivering DTI or DR before services are provided for ADMH clients. ADMH will retain the authority to set additional higher or more specific standards provided they are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary DTI and DR services.

Payment Authorization – Day Rehabilitation

A. ADMH requires that DTI and DR providers request an initial ADMH payment authorization for DTI or DR services.
- Payment authorization shall follow the authorization process outlined in the policy Intake and Authorization Process of Outpatient Services, in regard to medical necessity, involvement of licensed mental health professionals in the decision process, and consistent application of review criteria integral to the Utilization Management Program (Quality Management Team activities).
- In regard to timelines for DTI or DR payment authorizations, ADMH shall adhere to the following:
    - Standard authorizations: ADMH will provide notice of approval or denial of payment authorization within fourteen (14) calendar days following the receipt of the request for payment authorization.
    - Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, ADMH will provide notice of approval or denial of payment authorization within three (3) working days after receipt of the request for payment authorization.

» ADMH will authorize DTI or DR for an initial period, beginning retroactively to the first of the month that the intake occurred, plus thirty days from the day after the Quality Management team reviewed the documentation.
» Upon request for continuation of ADMH payment authorization for services, ADMH will authorize DTI or DR for a standard period of six (6) months.
» Notification to the client regarding denials or modified authorizations shall follow the procedure outline in the Notices of Action policy.
» ADMH will notify the provider if a request for ADMH payment authorization is denied or if ADMH authorized services in an amount, duration, or scope that is less than requested by the provider. This notice does not have to be in writing.

Payment Authorization – Same Day Services

A. If an organizational provider will be providing routine mental health services (excluding TBS) on the same day as DTI or DR, the provider must follow the payment authorization timelines described in Section I above.

B. Providers shall request payment authorization for continuation of these services on the same cycle required for continuation of the concurrent DTI or DR services (6 months).

Required Documentation

A. Day rehabilitation requires, at a minimum, the following documentation:
- Assessments
- Client Plans
- Progress notes on activities
- Medical Necessity

Supervision and Quality Management

Although Yolo County currently contracts DR and DTI services to organizational providers, it will continue to maintain responsibility for determining the need for, providing access to, and managing these Medi-Cal specialty mental health services.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Payment Authorization and Service Requirements

Overview

Therapeutic Behavioral Services (TBS) are an EPSDT-supplemental service for full-scope

Medi-Cal beneficiaries under the age of 21 years who meet medical necessity, as well as criteria specific to TBS.

Therapeutic Behavioral Services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) jeopardizing the client's current living situation or planned transition to a lower level of placement. The purpose of providing Therapeutic Behavioral Services is to further the client's overall treatment goals by providing additional therapeutic services during a short period of time.

The Yolo County Alcohol, Drug and Mental Health Department (ADMH) contracts with outside providers for delivery of Therapeutic Behavioral Services. The ADMH Director or designee shall maintain a current list of providers.

Although ADMH does not deliver Therapeutic Behavioral Services, ADMH is responsible for:

- Determining a client's need for Therapeutic Behavioral Services,
- Ensuring that the client has access to these services, and
- Supervising the delivery and quality of these services.

Therapeutic Behavioral Services:

- Provide critical, short-term supplemental support services for full-scope Medi-Cal clients for whom other intensive specialty mental health Medi-Cal reimbursable interventions have not been, or are not expected to be, effective without additional supportive services;
- Are targeted towards clients who, without this service, would require a more restrictive level of residential care, and are designed to:
    - Prevent placement of the client in a more restrictive residential level of care; or
    - Enable placement of the client in a less restrictive residential level, such as enabling a discharge from acute care, a step down from a group home to a foster home, return to natural home, etc.
- Are consistent with the System of Care principles and the Wraparound process; and
- Meet Medi-Cal standards, EPSDT regulations, and the court-mandated requirements of Emily Q. et al v. Belshe and Emily Q. v. Bonta.

Service Description

- The clinician providing Therapeutic Behavioral Services is available to provide individualized one-to-one behavioral assistance and one-to-one interventions in order to accomplish the outcomes specified in the written Service Plan.

- TBS will be provided for a specified short-term period that may vary in length and may last up to 24 hours a day, depending upon the needs of the client.

- TBS may be continued even after the client has met his/her behavioral goals outlined in the TBS Service Plan when TBS is still medically necessary to stabilize the client's behavior and reduce the risk of jeopardizing the client's current or potential living situation.

Service Delivery Requirements

A. Therapeutic Behavioral Services activities focus on:
    - Resolution of target behaviors or symptoms which jeopardize existing placements or which are a barrier to transitioning to a lower level of residential placement, and
    - Completion of specific treatment goals. Therapeutic Behavioral Services must be expected in the clinical judgment of ADMH to be effective in addressing the above focus to meet the goals of the Service Plan.

B. Therapeutic Behavioral Services are to be decreased when indicated. TBS shall be discontinued when the identified behavioral benchmarks have been reached, or when reasonable progress towards the behavioral benchmarks are not being achieved and are not reasonably expected to be achieved in the clinical judgment of ADMH.
    - The provision of TBS is intended to be a short-term, time-limited provision and is not appropriate for maintaining a client at a specified level for the long-term.

C. TBS providers shall meet statewide provider selection criteria specified in state regulations. TBS must be provided by licensed practitioners of the healing arts (LPHA) or trained staff members (TBS Aide) who are under the direction of an LPHA.

Notifying Clients of Therapeutic Behavioral Services

A. ADMH shall notify Medi-Cal clients who are under the age of 21 years (and their representatives) of their right to Therapeutic Behavioral Services through written informing materials in the following circumstances:
    - At the time of admission with an emergency psychiatric condition to an ADMH contract hospital (for more information, refer to the policy, *EPSDT and TBS Notices at Time of Emergency Psychiatric Admission to Contract Hospitals*)
    - At the time of admission to a skilled nursing facility with a special treatment program for the mentally disordered (SNF/STP) or a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMD).
    - At the time of placement in a Rate Classification Level (RCL) 13-14 foster care group home.
    - At the time of placement in an RCL 12 foster care group home if ADMH is involved in the placement.

B. These informing materials are available in English and in Spanish. Additional types of language assistance shall be provided as necessary and at no charge to the client.

Determining TBS Eligibility

To qualify for Therapeutic Behavioral Services, a client must meet the criteria in Sections A, B, and C.

A. Eligibility for Therapeutic Behavioral Services: client must meet criteria #1 and #2, below:
    1. Full-scope Medi-Cal client under age 21 years of age.
    2. Meets ADMH medical necessity criteria.

B. Member of the Certified Class – must meet criteria 1, 2, 3, or 4.
    1. Client is placed in a group home facility of RCL 12 or above and/or a locked treatment facility for the treatment of mental health needs (this facility must not be an Institution for Mental Disease as placement in this facility disqualifies clients from receiving federally-reimbursed Medi-Cal services); or
    2. Client is being considered by County for placement into a foster care group home RCL 12 through 14, or Metropolitan or Napa State Hospitals, or a skilled nursing facility, or an Institution for Mental Disease; or
    3. Client has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; or
    4. Client previously received Therapeutic Behavioral Services while a member of the certified class.

C. Need for Therapeutic Behavioral Services—must meet criteria 1 and 2.
    1. The client is receiving other specialty mental health services.
    2. It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of Therapeutic Behavioral Services:
        a. The client will need to be placed in a higher level of residential care, including acute care (including acute psychiatric hospital inpatient services and psychiatric health facility services) because of a change in the client's behaviors or symptoms which jeopardize continued placement in the current facility; or
        b. The client needs this additional support to transition to a lower level of residential placement. Although the client may be stable in the current placement, a change in behavior or symptoms is expected and Therapeutic Behavioral Services are needed to stabilize the child in the new environment. (ADMH or its provider must document the basis for the expectation that the behavior or symptoms will change.)

Clients at Risk of More Restrictive Placements

If ADMH is considering placement of an EPSDT-eligible beneficiary into a foster care group home RCL 12 through 14, or Metropolitan or Napa State Hospitals, or a skilled nursing facility, or an Institution for Mental Disease, ADMH must:

A. Consider whether the provision of TBS will allow the child or youth to remain in his/her current living situation; and

B. Ensure that the client receives services, if ADMH determines that placement to the higher level of care can be prevented; or

C. Follow certification procedures required by the state, if ADMH determines that the placement cannot be avoided. For more information on this certification process, please refer to the ADMH policy and procedure *TBS Certification*.

TBS Authorization Process

Service Authorization

- Requests for Therapeutic Behavioral Services shall be directed to the ADMH Assistant Director or designee (ADMH TBS Coordinator) for assessment consideration.

- The TBS Coordinator will complete the Yolo County Authorization Checklist and make initial service referral to appropriate TBS provider.

- The TBS provider will make a Service Authorization Request to Quality Management (QM).

- The TBS Coordinator will provide oversight coordination of the completion of the TBS assessment and Client Plan by the provider.

- Quality Management will authorize services as appropriate.

All requests for TBS services made by Medi-Cal clients to ADMH staff must be referred to the ADMH TBS Coordinator regardless of outcome.

Authorization Timelines

A. Standard Authorization Decisions: ADMH shall provide authorization notice as quickly as the client's health condition requires, but not more than fourteen (14) calendar days from the receipt of the request for service.
    1. The client may request an extension of up to fourteen (14) additional calendar days.
    2. ADMH may request an extension of up to fourteen (14) additional calendar days if more information is required and the extension is in the client's best interest (as determined by ADMH).

B. Expedited Authorization Decisions: for cases in which ADMH or its provider indicates that the standard authorization timeframe could seriously jeopardize the client's life or health, or his/her ability to attain, maintain, or regain maximum function, ADMH must

provide authorization notice as quickly as the client's health condition requires, but not more than 3 working days after receipt of the request for service.

1. The client or provider may request an extension of up to fourteen (14) calendar days.
2. ADMH may request an extension of up to fourteen (14) calendar days if more information is required and the extension is in the client's best interest (as determined by ADMH).
3. To utilize this expedited process, the provider shall complete an Expedited Authorization Request form. ADMH may not deny a provider's request to use this expedited process.

C. Denials or Modifications of Requests for Service

1. In the event that ADMH denies or modifies the request for services, a Notice of Action (NOA-A or NOA-B) will be sent to the client. The provider requesting the service must be notified as well, but may be given notice verbally.
2. If ADMH is not able to make a TBS authorization decision within the specified timeframe, ADMH shall deny the request and submit a Notice of Action to the client.
3. All client protections under Title 9, Chapter 11 are applicable to TBS services. Clients have the right to receive a Notice of Action, access the ADMH appeals process, and access the State Fair Hearing process after completing the ADMH appeals process.
4. Refer to the Notices of Action (NOA) section in this Handbook for more information.

Service Plan and Documentation

A. There must be a written Service Plan for Therapeutic Behavioral Services, completed, as a component of an overall Service Plan for specialty mental health services. The TBS Service Plan will identify all of the following:

1. Specific target behaviors or symptoms jeopardizing the current placement or presenting a barrier to transitions, e.g. tantrums, property destruction, assaultive behavior in school.

2. Specific interventions to resolve the behaviors or symptoms, such as anger management techniques.

3. Specific outcome measures that can be used to demonstrate the frequency of targeted behaviors has declined, and replaced with adaptive behaviors.

4. Transition Plan: as a short-term service, each TBS Service Plan must include a TBS Transition Plan. This plan will outline the process for decreasing and/or discontinuing Therapeutic Behavioral Services when they are no longer needed, or appear to have reached a plateau in benefit effectiveness. When applicable, the plan shall also include a process for the client's transition to adult services when

the client turns 21 years old and is no longer eligible for TBS. This plan should assist parents and/or caregivers to gain the skills and strategies to provide continuity of care once this service has been discontinued.

5. The TBS Service Plan will be reviewed by ADMH staff to ensure that Therapeutic Behavioral Services continue to be effective and that the client is making progress towards the specified, measurable outcomes. If necessary, the TBS Service Plan should be:
    a. Adjusted to identify new target behaviors, interventions, and outcomes as necessary and appropriate; and
    b. Reviewed and updated whenever there is a change in the client's residence.

B. A Progress Note is required for each time period that a Therapeutic Behavioral Services Aide spends with the client. The TBS Progress Note is completed by the TBS Aide.

1. The Progress Note should include significant interventions that address the goals of the Service Plan. The Progress Notes do not have to justify staff intervention or activities for all billed minutes, just each time period spent with the client.

2. TBS staff shall complete documentation on a daily basis or on days when services are provided.

3. Time spent traveling and documenting progress notes is Medi-Cal billable. On-call time for the staff person providing TBS is not Medi-Cal billable.

Supervision and Quality Management

Although Yolo County currently contracts therapeutic behavioral services to outside providers, it will continue to maintain responsibility for determining the need for, providing access to, and managing Medi-Cal specialty mental health services.

A. The ADMH Clinical Supervisor, Quality Management Coordinator, and Quality Management Clinician will provide the appropriate oversight and responsibility for the following:
    1. Reviewing and maintaining the policy and procedures for the TBS program;
    2. Maintain compliance with state regulations;
    3. Maintain compliance with claiming and reporting requirements; and
    4. Ensure distribution of Notices of Action to Medi-Cal clients and DMH.

B. The Therapeutic Behavioral Services contracting provider will provide the following:
    1. Recruit and screen Therapeutic Behavioral Services Aides;
    2. Train TBS Aides;
    3. Provide support to TBS Aides;
    4. Coordinate TBS on a day-to-day basis;
    5. Maintain written documentation of all services provided in a standard that meets

ADMH requirements; and
6. Perform other duties as assigned by ADMH.

C. Clinical Supervision
   1. As noted, Therapeutic Behavioral Services must be provided by a licensed practitioner of the healing arts or trained staff members who are under the direction of a licensed practitioner of the healing arts, as defined in the contract between DMH and ADMH.
   2. ADMH will direct a licensed designee to oversee Therapeutic Behavioral Services. All decisions regarding clinical treatment of a client who receives TBS must meet ADMH approval prior to authorization. All decisions regarding TBS eligibility, assessment, Service Planning, hiring, retention, training, support, will be subject to the final approval of ADMH.

Out-of-County Placements

A. If an ADMH Medi-Cal client is placed in an out-of-county facility and a request for TBS services is made, ADMH is responsible for determining eligibility and coordinating service with the out-of-county ADMH or contractor.
   1. A list of TBS contacts in each county is available on the DMH website at www.dmh.ca.gov. This list includes each county mental health plan's TBS contact information, including the Mental Health Director, the Children's Coordinator, the TBS Coordinator, the out-of-county Placement Coordinator, the county contact for TBS authorization, and the county contact for county interagency agreements.

B. ADMH is responsible for the oversight of its out-of-county placements requesting or receiving TBS, including:
   1. Participating in the interagency placement committee for placement of any child/youth with serious emotional disturbances in a group home program at rate classification level (RCL) 13 or 14 as required under Section 4096 of the W&I Code and completing a TBS certification form documenting that TBS was considered as an alternate to placement and the reason TBS will not prevent the placement;
   2. Completing a TBS certification form documenting that TBS was considered as an alternate to placement and the reason TBS will not prevent the placement if ADMH is involved in the placement for a group home at RCL 12;
   3. Participating in regularly scheduled placement review or discharge planning meetings for any EPSDT eligible child/youth who is a patient at Metropolitan or Napa State Hospitals and completing a TBS certification form if it is determined that TBS in combination with other EPSDT services would not allow the child/youth to return to a lower level of care;
   4. Notifying DMH as soon as there is a change in county services or providers that affects 25 % or more of ADMH beneficiaries who are receiving services from ADMH;
   5. Ensuring that TBS may be used when the child/youth needs additional support to

transition to a lower level of residential placement; and

6. Continuing TBS even after a child/youth has met the behavioral goals in his or her TBS plan when TBS is still medically necessary to stabilize their behavior and reduce the risk of regression.

C. Annually, ADMH is required to report changes in staff who are responsible for coordinating provision of TBS for out-of-county placements. ADMH is also required to report changes, additions, and reductions in contracts with other county mental health plans and agencies that affect provision of TBS services for out-of-county placements.

Providing TBS in Group Homes

A. It is the responsibility of ADMH to ensure that Medi-Cal funding for Therapeutic Behavioral Services does not duplicate other funding for the same service. Some group home RCL 13 and 14s are required to provide one-to-one assistance as part of mental health certification. If Therapeutic Behavioral Services are provided in a group home with such a requirement, ADMH clearly specifies that this service is in addition to and different from the services provided through the group home's one-to-one staffing.

B. In addition, if a group home or other provider is using their staff to provide Therapeutic Behavioral Services, there must be a clear audit trail to ensure that there is not duplicate funding.

Notices of Action

As noted above, ADMH shall issue Notices of Action regarding denials or modifications of Therapeutic Behavioral Services consistent with state law and requirements. Within one month of being issued, copies of these Notices of Action shall be submitted to DMH at the following address:

TBS Coordinator
Department of Mental Health
1600 9th Street, Room 100
Sacramento, CA 95814
Fax (916) 653-9194

Reporting Requirements to DMH

A. Within 30 days of inception of Therapeutic Behavioral Services to a client, ADMH submits the information specified in the format required by the State.

B. If ADMH approves TBS for a fourth authorization period for a client, ADMH will submit a written report to the ADMH Director and the Deputy Director of Systems of Care at DMH within five (5) working days of the authorization decision. The written report will include:
    - A summary of the TBS services required,

- Justification for the additional authorization,
- A termination plan with clearly established timelines and benchmarks, and
- A planned date for termination of TBS.

C. Quality Management will conduct a review of paid claims data to ensure that information is submitted for every client receiving Therapeutic Behavioral Services. If the required data is not submitted for a client for whom Therapeutic Behavioral Services are claimed, ADMH will follow up with the provider to ensure the data is submitted. If the provider still does not submit the information, or provides services that have not been pre-authorized, then the claim may be disallowed.

Non-Reimbursable Therapeutic Behavioral Services

Therapeutic Behavioral Services are **not** reimbursable under the following conditions:

A. When the needs for Therapeutic Behavioral Services are solely:
    1. For the convenience of the family or other caregivers, physician, or teacher;
    2. To provide supervision or to assure compliance with terms and conditions of probation;
    3. To ensure the client's physical safety or the safety of others, e.g., suicide watch, or
    4. To address conditions which are not part of the client's mental health condition.

B. For clients who can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day may not need this level of service.

C. For client who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.

D. When the client is an inpatient of a hospital mental health unit, psychiatric health facility, skilled nursing facility (SNF), crisis residential program, Institution for Mental Diseases (IMD), or locked juvenile justice setting (such as Juvenile Hall).

Approvals

When the ADMH Quality Management Team authorizes services on behalf of a beneficiary, a confirming letter will be mailed to the beneficiary, with the beneficiary's consent. A written authorization will be sent to the requesting provider.

Denials or Modified Approvals

If ADMH denies a request for planned services as not meeting medical necessary criteria, gives approval to services different than those requested (in type, frequency, or duration), or fails to provide services or problem resolutions within specified timelines, ADMH shall complete a Notice of Action (NOA) specific to the event and distribute it to both the beneficiary and the service provider within a regulated timeframe.

There are five types of actions and an appropriate NOA form for each action:

Type of Notice of Action	Description of Notice of Action
NOA-A (Assessment)	ADMH determines that the client does not meet medical necessity criteria and no specialty mental health services will be provided.
NOA-B (Denial of Services)	ADMH denies or modifies a request for payment for a service that has not yet been provided.
NOA-C (Post-Service Denials)	ADMH denies or modifies a request for payment for a service that has already been provided.
NOA-D (Delayed Grievance/Appeal Decisions)	ADMH has not acted within the timeframes for a disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
NOA-E (Lack of Timely Services)	ADMH fails to provide services in a timely manner, as determined by ADMH.

When applicable, the NOA forms include information about the ADMH appeal process. All NOA forms include information on the back (NOA-BACK) that explains the State Fair Hearing process.

Overview

Whether beneficiaries are treated by ADMH staff or by contract provider staff, they are entitled to utilize Problem Resolution Process. This process involves procedures for filing *grievances, standard appeals,* and *expedited appeals.* In certain situations, beneficiaries also have access to the State Fair Hearing Process. Providers are required to advise all beneficiaries of their right to use these procedures.

Definitions

- ***Action:*** *An action is when ADMH or its providers do one of the following*:
    - Denies or limits a requested service through the authorization process (this includes the type of service or the level of service);
    - Reduces, suspends, or terminates a previously authorized service;
    - Denies, in whole or in part, payment for a service;
    - Fails to provide services in a timely manner, as determined by ADMH; and/or
    - Fails to act within the timeframes for a disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- *An* ***Appeal*** is a request for review of an action.
- A ***Grievance*** is an expression of dissatisfaction about any matter other than an action. Any problem that a client may have which does not involve an action must be filed as a grievance.
    - Possible grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or staff member, or failure to respect the client's rights.

Resolution Policies

- Contract providers shall utilize the ADMH "Client Problem Resolution Guide" to inform the beneficiary of their rights and processes to file a grievance.

- A beneficiary may choose not to discuss his/her grievance with the contract provider prior to initiating the problem resolution process through ADMH.

- A client may authorize another person, including his/her attorney, to act on his/her behalf.
    - In the appeal process, the client may also select a provider as his/her representative.

- Information regarding grievances and appeals shall be maintained in a confidential manner and shall only be discussed with those directly involved in the matter, or as required by state or federal laws or regulations.

- ADMH and its providers will not subject any client who may file a request for problem resolution to discrimination or penalty. Any report of retaliatory behavior by ADMH or

contract staff shall be investigated and may be cause for disciplinary action, including possible dismissal depending on the seriousness of the retaliatory action.

- ADMH has designated specific staff member(s) to aid clients in the problem resolution process. These individuals will also provide status of a client's grievance or appeal, upon request.

- ADMH has authorized certain individual(s) to make decisions regarding grievances and appeals. These individuals shall not be involved in any previous level of review or decision-making regarding the subject of the grievance or appeal.
    - If the situation is clinical in nature, the person(s) making the decision must be a mental health care professional with the appropriate clinical expertise in treating the beneficiary's condition. Such situations requiring clinical expertise include:
        - Appeals based on lack of medical necessity;
        - Grievances regarding denial of expedited resolution of an appeal; and/or
        - Grievances/appeals that involve clinical issues.

- An ADMH designee shall confidentially maintain a Grievance and Appeal Log for tracking problems reported by clients.
    - At a minimum, the log entry shall include the client's name, the date of receipt, the nature of the problem, and the final disposition of the grievance or appeal (i.e., the date the decision is sent to the client or documentation explaining the reason(s) for no final disposition).

State Fair Hearings

- Clients have a right to request a State Fair Hearing <u>after</u> completing the Yolo County ADMH Problem Resolution Process.
    - Clients must first exhaust the county Problem Resolution Process before filing for a State Fair Hearing.

Providing Information to Clients

- ADMH intake and/or support staff will provide clients with the Client Problem Resolution Guide at intake.

- Problem resolution materials, including self-addressed envelopes, will be available at all provider sites. This material will be maintained in visible locations.

- Problem resolution materials are available in all Yolo County threshold languages, currently English, Spanish and Russian. Clients who are visually impaired shall be able to access the information via audiotape. Bilingual and interpreter services are also available to assist with the process.

- Information regarding the ADMH problem resolution process is also available through the toll-free 24-hour telephone system.

- Changes to the problem resolution process and/or clients' rights shall be posted in a prominent location at all provider sites.
    - ADMH will update brochures and informing materials as soon as possible, but at least within 90 days, to reflect any new regulations.
    - ADMH will provide any updated brochures or informing materials to providers in a timely manner.

Grievance Process

1. Clients may file a grievance verbally or in writing.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf.

3. When an ADMH provider receives a grievance, he/she shall immediately notify Quality Management staff. If the grievance is written, the provider or designated staff shall date/time stamp the written document and fax/forward it to ADMH Quality Management immediately.

4. Designated ADMH Quality Management staff shall record the grievance (verbal or written) in the confidential Grievance and Appeals Log within one (1) working day of the date that the provider received the grievance.

5. Designated ADMH Quality Management staff shall promptly acknowledge receipt of the verbal or written grievance to the client <u>in writing.</u>

6. The client (and his/her representative) will be notified of the grievance decision in writing within sixty (60) calendar days of receipt of the grievance.
    - This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if ADMH determines that the delay is necessary and is in the best interest of the client.
    - If a client cannot be reached (i.e., returned mail), ADMH will document the notification effort in the Grievance and Appeals Log.

7. ADMH will also notify any provider(s) or staff person(s) cited in the grievance of the final decision, <u>in writing</u>.

8. If ADMH fails to notify the client or other affected parties of its decision within the allowable timeframe, the client will be given a Notice of Action advising that he/she has a right to request a state fair hearing.
    - The Notice of Action will be given on the date that the timeframe expires.

9. AMDH shall inform the client that if he/she is not satisfied with decision, the client has a right to request a state fair hearing after completing the Yolo County ADMH Problem Resolution Process.

10. The Yolo County Alcohol, Drug and Mental Health Department will strive to provide resolution of a client's grievance as quickly and simply as possible.

Appeals Processes

Standard Appeals

1. Clients may file an appeal verbally or in writing. The appeal must be made in response to an action.
    a. The appeal must be filed within ninety (90) days of the date of the action.
    b. A client must follow up a verbal appeal with a signed, written appeal.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf.
    a. In the appeal process, the client may also select a provider as his/her representative.

3. When a provider receives an appeal, he/she shall date/time stamp the appeal and immediately fax/forward it to ADMH Quality Management staff.

4. ADMH Quality Management staff shall record the appeal (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt by the provider.

5. ADMH Quality Management staff shall promptly acknowledge receipt of the verbal or written appeal to the client <u>in writing</u>.

6. The client will be given the opportunity to present evidence and allegations of fact or law. This component may be done in person or in writing.

7. Before and during the appeal process, the client and/or his/her representative will be allowed the opportunity to examine the client's chart and any other documents relevant to the appeal.

8. A decision regarding the appeal must be made within forty-five (45) calendar days of receipt of the appeal.
    a. If request for an appeal was first given verbally, the timeline requirements begin on that day, not the day when the written follow-up is received from the client.
    b. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
    c. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if ADMH determines that the delay is necessary and is in the best interest of the client.

9. ADMH Quality Management staff will notify the client or his/her representative <u>in writing</u> of the appeal decision. The notice will include:
    a. The results of the appeal process and the date the appeal was made.

b. Information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.

10. ADMH will also notify any provider(s) or staff person(s) cited in the appeal of the final decision in writing.

11. If ADMH Quality Management staff fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a Notice of Action (NOA-D) by ADMH Quality Management staff, advising that the client has a right to request a State Fair Hearing.
    a. The Notice of Action (NOA-D) will be given on the date that the timeframe expires.

12. ADMH will promptly provide or arrange and pay for the disputed service(s), if the decision of the appeal reverses the decision to deny services.

Expedited Appeals

1. Clients may file an expedited appeal verbally or in writing. The expedited appeal must be made in response to an action.
    a. The expedited appeal process may ONLY be used when the standard appeal process could jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function.
    b. **NOTE**: A client does NOT need to follow up a verbal expedited appeal with a signed, written appeal.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf. In the appeal process, the client may also select a provider as his/her representative.

3. When a provider receives an appeal, he/she shall date/time stamp the appeal and immediately fax/forward it to ADMH Quality Management staff.

4. ADMH Quality Management staff will record the appeal (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt.

5. ADMH Quality Management staff shall promptly acknowledge receipt of the verbal or written appeal to the client in writing.

6. ADMH Quality Management staff will then review the request for an expedited appeal in consultation with clinical staff who have not been involved in any previous decision-making regarding the matter and have the appropriate level of clinical expertise.
    a. If the request for an expedited appeal is denied, the appeal will be transferred to the standard appeal process and resolved within the timeframe specified in that process.

i. ADMH will make reasonable efforts to give the client prompt verbal notice of the denial of the expedited appeal process and follow up with a written notice within two (2) calendar days.

b. If the request for an expedited appeal is granted, the client and/or his/her representative may present evidence in person or in writing and may examine his/her case file and any other records pertaining to the appeal, before and during the appeal process

7. A decision regarding the appeal must be made within **three (3) working** days of receipt of the appeal. All affected parties (including client, providers, staff members, etc.) must be notified verbally, as well as in writing, of the decision within this timeframe.
    a. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if ADMH determines that the delay is necessary and is in the best interest of the client.

8. ADMH will notify the client or his/her representative of the expedited appeal decision verbally and in writing. The notice will include:
    a. The results of the appeal process and the date the appeal was made.
    b. Information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.

9. ADMH will also notify any provider(s) or staff persons cited in the expedited appeal of the final decision, verbally and in writing.

10. If ADMH fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a Notice of Action (NOA-D) advising that he/she has a right to request a State Fair Hearing.
    a. The Notice of Action (NOA-D) will be given on the date that the timeframe expires.

11. ADMH will promptly provide or arrange and pay for the disputed service(s), if the decision of the appeal reverses the decision to deny services.

Aid Paid Pending

In certain instances, ADMH will provide aid paid pending (APP) to beneficiaries who request continued services and have filed a timely request for an **appeal or state fair hearing**.

1. A timely request is ten (10) days from the date the Notice of Action (NOA) was mailed, or ten (10) days from the date the NOA was personally given to the beneficiary, or before the effective date of the change, whichever is later.

2. The beneficiary must either have an existing service authorization which has not lapsed, and the service is being terminated, reduced, or denied for renewal by the MHP; or, the beneficiary must have been receiving specialty mental health services under an exempt pattern of care.

- An exempt pattern of care is the denial of a provider's request to continue a pattern of care that has been exempt from authorization by the MHP and would require an NOA.
- An exempt pattern of care may exist in a situation when a county has a policy that permits a predetermined amount of services to be provided without prior authorization. (For example, a county allows providers three visits without prior authorization. A provider subsequently requests authorization for an additional three visits.)

3. This action will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, the date an appeal is resolved, or a hearing decision is rendered; or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

Please note: A beneficiary may file an appeal or a state fair hearing request about an action whether or not a Notice of Action (NOA) has been issued. However, clients must first exhaust the Yolo County ADMH Problem Resolution Process before filing for a state fair hearing.

Quality Management

At each monthly meeting, the Yolo County ADMH Quality Improvement Committee shall review recent grievance and/or appeal decisions for appropriateness of ADMH responses and identify any significant trends that may influence policy- or program-level actions, including personnel actions. Recommendations will be addressed with the ADMH Director.

Problem Resolution Documentation

Grievance, Standard Appeal, and Expedited Appeal Logs

1. Designated ADMH Quality Management staff shall record the grievance or appeal (verbal or written) in the appropriate log within one (1) working day of the date of receipt.
    a. The log shall include, but is not limited to:
        i. Name of the beneficiary;
        ii. Date of receipt of the grievance or appeal;
        iii. Nature of the problem; and
        iv. Final disposition, including:
            - Date of final decision
            - Final resolution or explanation of reasons if there was not a disposition
            - Date the decision or explanation is sent to the client
    b. Information regarding grievances and appeals shall be maintained in a confidential manner and shall only be discussed with those directly involved in the matter, or as required by state or federal laws or regulations.

State Fair Hearing and Notice of Action

1. A written Notice of Action shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action. The action shall specify:
    a. The action taken by ADMH
    b. Reason for the action taken
    c. Citation of the specific regulations supporting the action
    d. Client's right to a State Fair Hearing, including:
        i. The method by which a hearing may be obtained
        ii. Client may be self-represented
        iii. Client may be represented by an authorized third party, such as legal counsel, relative, friends, or any other person
    e. Explanation of the circumstances under which specialty mental health services will be continued if a State Fair Hearing is requested.
    f. Time limits for requesting a State Fair Hearing
    g. Client's right to continued services while the hearing is pending, if he/she has filed a timely request for an appeal or state fair hearing

2. Clients have the right to request a State Fair Hearing <u>after</u> completing the Yolo County ADMH Problem Resolution Process.

PROBLEM RESOLUTION PROCESSES

Provider

Provider problem resolution and appeal procedures are covered under the Billing and Payment Procedures section of this document (below).

BILLING AND PAYMENT

Overview

Payment policies and procedures contained herein are intended to provide a general overview of how providers receive reimbursement from ADMH. However, each individual provider's contract with ADMH supersedes any information contained herein.

Payment Policies

Payment will be authorized for valid claims for specialty mental health services if:

- ✓ The services were pre-authorized by the ADMH Quality Management Team.
- ✓ Services were delivered by a contract or otherwise authorized provider.
- ✓ Services were within the range of pre-selected service codes allowed by the provider's scope of practice and contract agreements.
- ✓ The beneficiary is eligible for Medi-Cal. *<u>Note</u>: Service authorization does not guarantee Medi-Cal eligibility. It is the provider's responsibility to assure that the client is eligible. The provider may call ADMH for assistance in verification of eligibility.*

Billing Procedures

The provider's billing must be on the CMS-1500 form (standardized insurance claim format). All billings should be sent to:

Accounts Payable
Yolo County Alcohol, Drug, and Mental Health Department
137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695
530-666-8634

Billings must contain the following information, at a minimum:

- ✓ Beneficiary name

- ✓ Beneficiary Social Security number
- ✓ Beneficiary Medi-Cal number
- ✓ Diagnosis
- ✓ Date, service code, description, total minutes, and fee for each service
- ✓ Total amount being billed

Payment Procedures

The processing and payment of claims involves the following steps:

1. Professional service claims are processed on a line-by-line basis. Inpatient facility claims are paid on a total claim basis.

2. Claims are subjected to a comprehensive series of edits and audits.

3. Claims that meet all edit and audit requirements, and are in compliance with payment policies, are processed for payment by the Yolo County Auditor.

Note: Hospitals that bill Medi-Cal directly will be paid through the State's automated payment system.

Payment Inquiries

Billing inquiries may be made by calling 530-666-8630, or in writing with a copy of the original billing attached.

Important Points Regarding Claims

Treatment of any Medi-Cal beneficiary must be performed by the practitioner whose services were authorized. A provider shall not bill for treatment provided by another practitioner or an assistant.

Providers may not legally bill a Medi-Cal beneficiary for services authorized by ADMH.

Provider Problem Resolution Processes

The Yolo County Alcohol, Drug and Mental Health Department (ADMH) will work cooperatively to resolve any problems identified by providers in a sensitive and timely manner, utilizing both a Provider Problem Resolution Process and a Provider Appeal Process. These processes may be accessed by ADMH providers to address payment authorization issues and other complaints and concerns.

ADMH shall work closely with providers to resolve disputes in a timely, efficient manner, and will strive to provide a means for clients to continue receiving medically necessary services while disputes are being resolved.

Provider Problem Resolution Process

1. A provider, whether an individual professional or an organization, may contact ADMH at any time to resolve payment authorization issues or other complaints and concerns.
    a. ADMH will work cooperatively with the provider to resolve problems in a simple, informal, and timely manner.
    b. The provider may notify ADMH of the complaint or concern verbally (via the Deputy Director or designee) or in writing.

2. In most cases, if the Deputy Director or designee cannot immediately resolve the matter, a response to the provider's concern will occur within five (5) working days of notification that a concern exists.
    a. In cases involving Residential Treatment Program Providers, ADMH shall accelerate the time line to respond within forty-eight (48) hours of receipt of the provider's complaint.

3. Whenever ADMH produces a written response to a provider complaint, the response is filed in ADMH Grievance and Appeal Log.

Provider Appeal Process

1. A provider may appeal a denied or modified request for ADMH payment authorization or a dispute with ADMH concerning the processing or payment of a provider's claim to ADMH.
    a. Providers have the right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun.

2. A provider may initiate the appeal process through a written request submitted to the ADMH Billing Supervisor.
    a. The Billing Supervisor will document the date of receipt of the appeal in the ADMH Grievance and Appeal Log. The resolution and date of response to the appeal are also recorded in the log.
    b. The appeal should clearly identify the provider's concerns and may include any supporting documentation that will assist in the problem resolution.

c. The written appeal must be submitted to ADMH within ninety (90) calendar days of the date of receipt of the non-approval of payment, or within ninety (90) calendar days of the failure of ADMH to act on the request for payment.

3. The ADMH Director or designee shall review the written appeal and any associated documentation.
    a. If the appeal concerns the denial or modification of a ADMH payment authorization request, ADMH shall utilize staff who were not involved in the initial denial or modification decision.

4. ADMH shall respond to the provider's appeal with a decision in writing within sixty (60) calendar days from the receipt of the provider's appeal request.
    a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider, and any action required by the provider to implement the decision.
    b. If the appeal is denied or not granted in full, the provider shall be notified of any right to submit an appeal to the California Department of Mental Health (Section C below).

5. If applicable, ADMH may request a provider to submit a revised request for ADMH payment authorization.
    a. The provider shall submit a revised request within thirty (30) calendar days from receipt of the ADMH decision to approve the ADMH payment authorization request.
    b. ADMH shall process the provider's revised request for payment within fourteen (14) calendar days from the date of receipt of the provider's revised request for payment authorization.

6. **If ADMH does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied by ADMH.**

Provider Appeals to the California Department of Mental Health

1. Hospitals and inpatient services providers may appeal directly to the California Department of Mental Health (DMH) when an ADMH payment authorization request for **emergency services** has been denied or modified via the provider resolution process. Such denials or modifications are eligible for DMH appeals if the ADMH decision was based on the following issues:
    a. The provider did not comply with the required timelines for notification or submission of the ADMH payment request, or
    b. The medical necessity criteria were not met.

2. If a provider chooses to appeal to DMH, the appeal shall be submitted in writing, along with supporting documentation, within thirty (30) calendar days from the date of the ADMH written decision of denial.

a. The provider may appeal to DMH within thirty (30) calendar days after sixty (60) calendar days from submission to ADMH, if ADMH fails to respond.
b. Supporting documentation shall include, but not be limited to:
    i. Any documentation supporting allegations of timeliness, if at issue, including fax records, telephone records or memos.
    ii. Clinical records supporting the existence of medical necessity if at issue.
    iii. A summary of reasons why ADMH should have approved the request for ADMH payment authorization.
    iv. A contact person(s) name, address and telephone number.

3. DMH shall notify ADMH and the provider of its receipt of a request for appeal within seven (7) calendar days.
    a. The notice to ADMH shall include a request for specific documentation supporting denial of ADMH payment authorization and for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal.
        i. ADMH shall submit the requested documentation within 21 calendar days or DMH shall decide the appeal based solely on the documentation filed by the provider.

4. DMH shall have sixty (60) calendar days from the receipt of the ADMH documentation, or from the twenty-first (21st) calendar day after the request for documentation (whichever is earlier), to notify the provider and ADMH of its decision, in writing.
    a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider and ADMH, and any actions required by the provider and ADMH to implement the decision.
    b. At the election of the provider, if DMH fails to act within the sixty (60) calendar days, the appeal may be considered to have been denied by DMH.
    c. DMH may allow both a provider representative(s) and ADMH representative(s) an opportunity to present oral argument to DMH.

5. If the appeal is upheld, the provider shall submit a revised request for ADMH payment authorization within thirty (30) calendar days from receipt of the DMH decision to uphold the appeal.
    a. If applicable, ADMH shall have fourteen (14) calendar days from the receipt of the provider's revised ADMH payment authorization request to approve ADMH payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process ADMH payment authorization.

CONTRACT PROVIDER

Responsibilities

Providers who treat ADMH Medi-Cal beneficiaries have responsibilities to:

- ✓ At the beginning of each month, verify Medi-Cal eligibility of:

- All clients served, and
- Beneficiaries for whom they seek service authorization.

✓ Inform beneficiaries of their right to access the ADMH grievance and appeals processes, including the right to access a State Fair Hearing after completing the ADMH Beneficiary Problem Resolution Process. The contract provider shall give each beneficiary a copy of ADMH Client Problem Resolution Guide during the first meeting with the client and again at the annual assessment.

✓ Ensure the following beneficiary rights:
- The right to receive information in accordance with CFR, Title 42, Section 438.10;
- The right to be treated with respect and with due consideration for his/her dignity and privacy;
- Beneficiary rights concerning the confidentiality and integrity of his/her protected health information in accordance with HIPAA;
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand;
- The right to participate in decisions regarding his or her health care, including the right to refuse treatment;
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- The right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in CFR, Title 45, Sections 164.524 and 164.526; and
- The right to be furnished health care services in accordance with CFR Title 42, Sections 438.206 – 210, including information on CHDP and Healthy Families.

✓ Provide ADMH Quality Management (QM) with all requested information in order to facilitate initial and/or ongoing authorization of services, and assist the beneficiary with the process of any necessary communication with QM.

✓ Provide culturally-competent services that are sensitive to the needs and preferences of the beneficiary;

✓ Seek reimbursement from ADMH for only those services with are specified by, and authorized by, QM.

✓ Schedule an initial visit with an authorized beneficiary within thirty (30) calendar days of receipt of authorization.

✓ Request consultation with QM regarding any potentially planned admission of a beneficiary into an inpatient facility.

- ✓ Provide services to beneficiaries in accordance with legal and ethical standards as stipulated by all relevant professional, federal, state, and/or local regulatory and statutory requirements, and as outlined in the provider contract with ADMH.

- ✓ Maintain clinical records according to ADMH standards. 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 treatment.
  - Maintain clinical records for at least seven (7) years from the last date of service to the beneficiary; produce and maintain documentation that pertains to the services provided to beneficiaries under the contract provisions of ADMH, available for inspection, examination or copying;
    - By ADMH, the State Department of Mental Health, the State Department of Health 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 agreed upon location; and
    - In a form maintained in accordance with the general standards applicable to such record keeping.

- ✓ Use DSM-IV diagnostic codes, or the most recent version of the DSM Manual. ***ICD-9-CM codes are not acceptable.***

- ✓ Follow strict confidentiality guidelines to assure the beneficiary's privacy when referrals to other agencies and providers are necessary. Information regarding the beneficiary will not be provided without written permission from the beneficiary or the beneficiary's legal representative.

- ✓ Maintain a log of beneficiary grievances and appeals. For more information, see the section on the beneficiary problem resolution procedure.