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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Fee-For-Service Provider Operations Handbook

Adult/Older Adult Mental Health Services
Children and Adolescent's Mental Health Services
Edition December 27, 2017

Funding for services is provided by the County of San Diego Health and Human Services Agency.

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Dear Provider:

The Fee-for-Service (FFS) Provider Operations Handbook has been updated to reflect changes implemented in the Fee-for-Service Medi-Cal network for the County of San Diego Behavioral Health Services Mental Health Plan (MHP).

REVISIONS/ NEW PROCEDURES

When reviewing the new handbook, please pay close attention to the following:

- **Client Rights**
  - There have been updates to the Notice of Action (NOA) Forms

- **Authorization for Reimbursement for Services**
  - Authorizing Outpatient Services
    - New process was established to align with the Affordable Care Act (ACA) which requires assessing for severity (mild, moderate or severe)
    - Information added on checking/verifying eligibility
  - General Authorization Reminders - New information added relating to number of sessions authorized and how you will be notified
  - Outpatient Services – Assessment Authorization - Pre-authorization for *Initial Assessment* not required
  - Outpatient Services – Initial 12 Sessions and Continuing Sessions - Outpatient Authorization Request Form (OAR) must be completed and submitted to Optum Public Sector when sessions are requested beyond the initial assessment

- **Requesting Authorization** - Matrix created to explain obtaining authorization based on the Severity Index
  - Clients with No Insurance or Financial Resources - Emergency Screening Unit has moved from Chula Vista to 4309 Third Ave., San Diego, CA 92103, (619) 421-6900

- **Quality Management Program**
  - Quality of Care **-** - Revised to reflect the oversight of the Optum Quality Improvement Team, Medical Director and the Clinical Quality of Care Committee
  - Outpatient Provider Reviews - Reflects changes to the site and treatment record review process that was shifted from the County's Quality Management Department to the Optum Quality Improvement Department. All providers will participate in a Medi-Cal Treatment Record and Site Review at least once during their three (3) year re-credentialing cycle
  - Documentation Standards for Outpatient Client Records - Reflects BHETA Documentation Training is a requirement for all FFS Providers.
  - Inpatient Professional Service Reviews - Reflects the requirement for an annual review of providers rendering inpatient professional services

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- Access Standards – Updated to reflect Senate Bill 1135 standards of 48 hours for Urgent appointments and 10 business days for Non-Urgent Appointments

- **Provider Contracting:**
  - A site review is now required as part of the initial credentialing process
  - Reporting Requirements – 805 and NPBD – Reflects actions required the event that a provider's network participation is restricted or terminated due to quality issues

- **Provider Obligations**
  - Notification of Status Change changed to Verification of Providers Demographic and Practice Information – Updated to include requirements based on Senate Bill 137 and the providers obligations to verify and attest to the accuracy of demographic and practice information once every 6 months

  - Requirement to Notify in Case of Incident – Updated to highlight contract requirement to notify Optum Public Sector in writing within 10 business days of actions against a provider's license, lapse of Malpractice Insurance, change in business ownership, legal action pending against a provider for professional negligence, etc.

  - Wait Time Attestation - Providers are required to complete a Wait Time Attestation twice a year to reflect the time a client must wait to get an appointment at each office in which the provider renders services

  - Requirement to Notify in Case of Status and Practice Changes - Updated to highlight contract requirement to notify Optum Public Sector within 10 business days of changes to the status or demographics of the provider's practice

  - Practice Information Verification and Validation – Reflects requirements related to Senate Bill 137 requiring all providers to attest to the accuracy of the demographics, contact information and clinical specialties every 6 months.

  - Information Privacy and Security Provisions – Explains the requirement to protect the privacy and security of Optum Public Sector and County information that the provider may create, receive, access, store, transmit and/or destroy

- **Claims and Billing**
  - LMFT/LPCC Providers Medi-Cal Eligibility Verification - Updated to reflect the process for LPCC's to verify eligibility

  - Submitting Claims for Medi-Cal Services - Updated to reflect the requirement to bill with ICD-10 codes

- **Claims Clusters –** Have been updated to reflect the most current claims clusters that may appear on the provider's authorization.

Please visit our new website at https://www.optumsandiego.com to download forms or to save the handbook and forms to your desktop for easy access.

Please remember that we urge you to coordinate care with all treating professionals involved with your clients. This includes treating psychiatrists, pain management professionals, pediatricians, and PCPs, as well as any other treating professionals who work with your clients.

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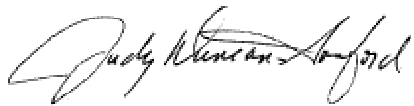
REMINDER: Medi-Cal regulations require that providers have an emergency referral on their outgoing voice messages. You may refer callers to the Access and Crisis Line (ACL) at (888) 724-7240.

Please contact us when you want to be closed to new referrals, and remember to call us when you are ready to accept new referrals. As always, please send us an email or letter about any changes to your practice.

Optum Provider Services staff can be reached at (800) 798-2254, option 7 with any questions about the updated handbook. And thank you for working with Optum in serving the County of San Diego Medi-Cal beneficiaries.

Best Regards,



Judy Duncan-Sanford, LMFT
Manager of Provider Services

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Introduction

This *Fee-for-Service (FFS) Provider Operations Handbook* was developed to give providers the information needed to participate in the Medi-Cal Fee for Service (FFS) network in the County of San Diego Mental Health Plan (MHP). The County of San Diego, the state's local Mental Health Plan, is responsible for the administration of inpatient and outpatient Medi-Cal and realignment-funded Specialty Mental Health Services.

Services for the County of San Diego MHP are governed by the requirements of Title 9 of the California Code of Regulations, Chapter 11, Specialty Mental Health Services (referred to in this document as Title 9), 42 Code of Federal Regulations, and the policies and procedures outlined in the Medi-Cal Provider Manual. Many of the policies and procedures outlined in this Handbook are based on the Title 9 requirements and the procedures described in the State of California Medi-Cal Provider Manual. Providers are encouraged to review these documents closely.

Take note:

Providers can access the Medi-Cal Provider Manual at the Optum Public Sector website at **www.optumsandiego.com**

To view this FFS Provider Operations Handbook electronically, providers may go to the Optum Website at www.optumsandiego.com > County Staff & Providers > Fee For Services Providers > Manuals. Title 9 regulations can be viewed at the State website or purchase by calling (800) 888-3600.

The Role of Optum Public Sector

In its role as the Administrative Services Organization (ASO) for the County of San Diego's publicly funded mental health system, Optum Public Sector:

- Operates a 24-hour Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care, including mental health and substance use disorder services, referrals, and information.
- Facilitates access to emergency mental health services for residents of San Diego County
- Conducts medical necessity and utilization management review on Adult/Older Adult and Child/Adolescent inpatient hospital and outpatient FFS services, and Child/Adolescent day program services
- Authorizes the reimbursement for FFS services provided by individual and group-based FFS providers, non-emergency inpatient care providers, and MHP payment for day program services and certain mental health services that occur on the same day as day program services
- Authorizes the payment for Adult/Older Adult and Child/Adolescent inpatient hospital services
- Credentials and contracts with individual and group-based FFS providers
- Processes and pays FFS claims

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For general information, Optum Public Sector San Diego can be reached at (619) 641-6800. In addition, the website provides links to this Medi-Cal Provider Manual and helpful forms and documents about the FFS network procedures.

Please refer to the *Treatment, Evaluation and Resources Management (TERM) Provider Handbook* for the policies and procedures that govern the TERM network requirements. The TERM Provider Handbook can be accessed at: https://www.optumsandiego.com.

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Beneficiary Rights

This section summarizes the responsibilities of Optum Public Sector and individual and group-based FFS providers regarding confidentiality of client and family information and records, and client and family rights.

Confidentiality

Maintaining the confidentiality of client and family information is of vital importance, not only to meet legislative and regulatory mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

Optum Public Sector Responsibilities

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) are federally mandated privacy regulations that govern all Individually Identifiable Health Information, and impact how identifiable information can be released and used for clinical coordination of care. Following State and Federal mandated privacy regulations is an important aspect of Optum Public Sector clinical and administrative policies and procedures. Optum Public Sector holds each employee responsible for respecting and protecting the confidentiality of clients, families, and providers at all times. Optum Public Sector employees are required to uphold the following policies and procedures pertaining to confidentiality:

- As a condition of employment, each employee signs a confidentiality agreement requiring compliance with all confidentiality protocols
- Employees are informed about policies, as well as applicable State and Federal legislation, regarding patient anonymity and the confidentiality of clinical information
- All client treatment information gathered during the course of daily operations, case management, and provider site and record reviews is protected through strictly secure access
- Optum Public Sector clinical and administrative staff have access to case data and files on a limited basis only as necessary to perform their job
- Documents containing client Personal Health Information (PHI) are faxed only to the indicated provider of services

Provider Responsibilities

Following the HIPAA Privacy and Security Regulations is also a requirement for providers. Every provider must provide a written notice of information practices known as a “Privacy Notice” to all clients. This notice must include:

- Mandated reporting requirements when a client presents as a current danger to self or others;

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- Mandated reporting requirements concerning the abuse or neglect of children or older adults;
- The review of records by third party payers for authorization or payment purposes
- Clients' rights to review and obtain their medical records.

Each provider is required to act in accordance with good clinical judgment, professional ethical standards, and within State and Federal law to ensure that all written and verbal communication regarding each client's medical clinical record is kept strictly confidential. Providers also are required to maintain all client records and documentation in secure, locked storage for a minimum of seven (7) years. In addition, fax machines that receive client information must be kept in a secure location away from unauthorized viewing.

The MHP requires providers to inform clients and families, through written information, about clients' rights, the legal limits of confidentiality, and to obtain the client's (or conservator/ legal guardian's) signature acknowledging understanding of these limits.

Providers may contact the appropriate State Licensing Board or professional association for further information regarding legal and ethical reporting mandates.

Take note:

Clients have the right to review and obtain copies of their mental health records.

Client Rights

Under new federal regulations, the term "Notice of Action" (NOA) has been replaced with "Notice of Adverse Determination." However, because this ne terminology may be confusing for beneficiaries, Department of Health Care Services (DHCS) will retain use of "NOA" for ease of understanding.

Notice of Adverse Benefit Determination – Assessment (NOA-A)

On occasion, a client referred by the MHP is assessed, and in the provider's professional judgment, does not meet medical necessity criteria for Specialty Mental Health Services as outlined in Title 9, Section 1830.205. Should this occur, the provider is required to give the client a NOTICE OF ADVERSE BENEFIT DETERMINATION-A (NOA-A). The NOA-A describes the client's Medi-Cal rights. These rights include the right to a Second Opinion, the right to file a grievance or appeal, and the right to request a State Fair Hearing after completing the County appeal process. If the client chooses to exercise any of these rights, he or she may contact the appropriate office, as indicated on the (NOA-A) and under the section "Your Hearing Rights" section of the form.

The provider must check the reason medical necessity criteria were not met on the NOA-A prior to giving it to the client. It also is important that the provider contacts Optum Public Sector Utilization Management at (800) 798-2254, option 4, to advise Optum Public Sector regarding the assessment findings and the NOA-A.

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Copies of the NOA-A and NOA-BACK may be found online at the *FFS Provider Forms Section.* Please obtain a copy for your use

Notice of Adverse Benefit Determination – B (NOA-B)

The NOA-B describes the client's right to a Second Opinion, the right to file a grievance or appeal, and the right to a State Fair Hearing. Whenever services are reduced, denied, or terminated, Title 9 regulations require that the client receives a completed NOA-B form from Optum Public Sector. If Optum Public Sector determines that treatment should be terminated or reduced in frequency, the client will receive an NOA-B form.

Optum Public Sector will send the provider a copy of the NOA-B, which was sent to the client, along with a Letter of Determination, written specifically for the provider. If a provider makes a clinical decision that a client's treatment should be terminated or reduced, no NOA form is needed.

If the client chooses to exercise the right to a Second Opinion, the right to file a grievance or appeal, or the right to request a State Fair Hearing, he/she may contact Optum Public Sector, or the appropriate State or County office, at the telephone numbers indicated on the front (NOA- B) and in the "Your Hearing Rights" section of the form.

Copies of the NOA-B may be found online www.optumsandiego.com under the *FFS Provider Forms Section*. Please obtain a copy for your use.

Notice of Adverse Benefit Determination – C (NOA-C)

The NOA-C is the Post-Service Denial of Payment form. Optum Public Sector will send an NOA-C to the client when the MHP denies or modifies a request for payment by a FFS provider of Specialty Mental Health Services that were already delivered to the client. The NOA-C informs the client that he/she is not responsible for reimbursing the provider for services that were denied reimbursement by the MHP.

Copies of the NOA-C may be found online at www.optumsandiego.com under the *FFS Provider Forms Section*. Please review a copy to become familiar with its contents.

Client Problem Resolution Process

The MHP is mandated by law to support the rights of Medi-Cal clients to have access to a fair, impartial, effective process through which the client can seek resolution of a problem encountered in accessing or receiving mental health services. The grievance and appeal procedures, mandated by law, including timelines, are designed to address problems quickly and thoroughly, so that the individual can continue on his or her road to recovery. These rights pertain only to services reimbursed by Medi-Cal.

Take note:

NOA- Notice of Adverse Benefit Determination:
A standard State form given to clients when services are reduced, denied, or terminated.

NOA-A:
Given when an initial assessment determines medical necessity criteria are not met for Specialty Mental Health Services.

NOA-B:
Given when Specialty Mental Health Services are reduced, denied, or terminated by MHP.

Take note:

Post-Service Denial of Payment form

NOA-C:
Given to a client when a provider requests approval of Specialty Mental Health Services that have already been delivered and the request is denied or modified by the MHP.

The **NOA-C** informs the client that he/she is not responsible for reimbursing the provider for the services that were denied reimbursement by the MHP.

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Clients always have the option of bringing an issue directly to the FFS provider. In addition, there are three (3) problem resolution processes, with a fourth option available after completion of the County Appeal process. They include the following choices:

- Grievance process;
- Appeal process (in response to an "action" as defined below); and
- Expedited appeal process (available in certain limited circumstances);
- The State Fair Hearing is an option available to Medi-Cal beneficiaries who have completed the County appeal process or who have not received resolution of a grievance or appeal within State mandated time frames, or as an addition to these processes.

Grievance, appeal, and action are defined by the Federal Medicaid Regulations (42 CFR 422.128) governing the beneficiary problem resolution process as:

- **Grievance:** An expression of dissatisfaction about any matter other than an action (as action is defined).
- **Action:** An action occurs when the MHP
- does at least one of the following:
    - Denies or limits authorization of a requested service, including the type or level of service;
    - Reduces, suspends, or terminates a previously authorized service;
    - Denies, in whole or in part, payment for a service;
    - Fails to provide services in a timely manner, as determined by the MHP; or
    - Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- **Appeal**: A request for review of an action (as action is defined above)

Title 9 regulation states that providers must post the Grievance and Appeal posters (in English, Spanish, Vietnamese, Arabic, Farsi, and Tagalog) in the waiting room or other visible area to ensure clients are advised of their rights. As well, providers are required to have the Client Grievance/Appeal Form available for all clients. A self-addressed envelope to the appropriate advocacy agency must be provided with the Grievance/Appeal Form. The right of the client or family to express concerns regarding services provided by the MHP is described in the MHP Grievance and Appeal Procedures, A Consumer's Guide. The brochure also contains issue resolution procedures for resolving concerns.

Title 9 also requires that these brochures, grievance and appeal filing forms, and self-addressed envelopes are available to both clients and staff working in a

Take note:

Providers are required to post the Grievance and Appeal posters (in English, Spanish, Vietnamese, Arabic, Farsi, and Tagalog) in the waiting room or other visible area to ensure clients are advised of their rights. Providers are also required to have the Client Grievance/Appeal Form easily available for all clients. A self-addressed envelope to the appropriate advocacy agency must be provided with the Grievance/Appeal Form.

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clinical settings in the six (6) threshold languages without the need for a verbal or written request. Additional copies of the Grievance and Appeal posters, brochures, and fill-in forms may be obtained by contacting the County of San Diego Strategic Planning and Administration Unit at (619) 563-2713. Separate brochures are available in each of the following languages: English, Spanish, Vietnamese, Arabic, Farsi, and Tagalog.

Grievance and Appeal Process

At any time the client chooses, the client may contact the Center for Consumer Health Education and Advocacy (CCHEA) at (877) 734-3258 (for issues relating to outpatient, day treatment and all other outpatient services) or Jewish Family Services Patient Advocacy Program at (800) 479-2233 (for issues relating to inpatient and other 24 hour care programs).

CCHEA or Patient Advocacy Program will contact the provider involved in the grievance and appeal. All MHP providers are required to cooperate with the problem resolution process. The full participation and timely cooperation of the provider is essential in honoring the client's right to an efficient, effective problem resolution process. The expectation is that the advocate and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue. Non-participation or non-cooperation with the grievance and appeal process may result in the provider being disciplined up to and including contract termination.

Providers who do not resolve the grievance and appeal with the advocacy organization during the problem resolution process will receive two letters from the advocacy organization (CCHEA or Jewish Family Services Patient Advocacy). One is a copy of the disposition sent to the client, and the other is a letter requesting that the provider writes a Plan of Correction and submits it within 10 working days directly to the MHP. Providers are required to complete the Plan of Correction. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP.

If a provider disagrees with the findings of the grievance or appeal investigation and does not agree to write a Plan of Correction, the provider may write a request for administrative review by the MHP. This request shall be submitted within 10 working days of receipt of the grievance disposition to:

Alfredo Aguirre, LCSW
Director of Behavioral Health Services
3255 Camino Del Rio South
San Diego, CA 92108

The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Take note:

Clients have the right to:

- Access a **Second Opinion**
- File a **Grievance** or **Appeal**
- Request a **State Fair Hearing** for appealable issues before, during, or within 90 days after the beneficiary problem resolution process whether or not they have received a Notice of Action

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It is the provider's responsibility to periodically inform clients regarding their right to file a grievance and/or appeal to express dissatisfaction with MHP services without negative consequences of any kind.

The information received through the client and family-friendly processes described here is used by the MHP to direct its resources toward improvement of the system of care. The participation of a provider in this process is viewed as a reflection of provider efficiency and integrity, as well as the FFS provider's genuine wish to improve the quality of care and service.

Client Right to Request a State Fair Hearing

Providers are required to give each client a MHP beneficiary handbook at the client's first appointment, and upon request. The handbook describes adult/older adult services and children's services (Guide to Medi-Cal Mental Health Services). The handbook is written and distributed by the County MHP Quality Improvement (QI) Department. Additional copies may be obtained by calling the Strategic Planning and Administration Unit at (619) 563-2713. The beneficiary handbook contains a description of the services available through the MHP, a description of the required process for obtaining services, a description of the MHP problem resolution process (including the grievance and appeal resolution processes). It also includes a description of the beneficiary's right to request a State Fair Hearing within 90 days after the completion of the County's beneficiary problem resolution process, whether or not they have received an NOA. Clients may also request a State Fair Hearing if their grievance or appeal resolution process is not completed according to State mandated timelines. Providers are required to verbally inform their clients or conservator/legal guardians that they have the right to request a State Fair Hearing within 90 days after the completion of the beneficiary problem resolution process, whether or not they have received a NOA.

Medi-Cal clients may request a State Fair Hearing within 90 days after the client uses the beneficiary appeal resolution process or if their grievance or appeal resolution is not completed according to State mandated timelines.

Take note:

Providers are required by Title 9 to give each client a **MHP beneficiary handbook** at the client's first appointment, or upon request. To obtain a copy of the **beneficiary handbook** which is available in English, Spanish, Vietnamese, Tagalog, Farsi, and Arabic, contact the County of San Diego Strategic Planning and Administration Unit at (619) 563-2713.

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Complaint Log

FFS providers are required by Title 9 to maintain a log in which all client or family concerns are delineated. Clients may express concerns or complaints verbally or in writing. The log must include the following elements:

- Complainant's name
- Date the complaint was received
- Name of person logging the complaint
- Nature of the complaint
- Nature of the complaint resolution
- Date of resolution

The MHP may request a copy of the provider's Complaint Log at any time. The log is reviewed during onsite reviews conducted by the MHP.

Advance Health Care Directive Information

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

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers are asked do the following for new clients (For a checklist of the items to be given to new clients, please see the online form *Provider Initial Client Contact Checklist*):

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive

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3. If the client, who has an Advanced Directive, wishes to bring in a copy, the provider shall add it to the client's current medical record
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate
5. Provide the same standard of care, and not condition the provision of care, or otherwise discriminate, against as individual based on whether or not he or she has an Advance Directive
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with Advance Directives

The MHP provides an informational brochure on Advance Directives, available in the five (6) threshold languages, which is to be given out to new clients or members of the community who request it. Copies may be obtained through the MHP or by calling (619) 563-2713, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

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

Take note:

Clients may contact a licensed or master's level counselor **24 hours a day, seven days a week,** by calling the **ACL** at:

(888) 724-7240

Hearing impaired clients should call: **(619) 641-6992 or dial 711 for California Relay.**

Termination of Treatment

Clients have the right to be notified of a provider's termination from the network. In addition, when a provider terminates with a client, for whatever reason, the provider is obligated to manage the termination in a clinically appropriate manner. When the client continues to need treatment, the provider is expected to help the client transition to another provider either in the FFS Network or at an organizational provider or County operated clinic. Providers are also expected to assist clients in transitioning to community services such as peer support, self-help, or 12 Step programs. Access and Crisis Line staff are available to assist with referrals to other providers or community services.

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Additional Beneficiary Rights

Title 9 also ensures beneficiaries the following rights:

- The right to be treated with respect and with due consideration for his/her dignity and privacy;
- 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/her health care, including the right to refuse treatment;
- The right to request and receive a copy of his/her Protected Health Information (PHI); and the right to request to amend his/her PHI;
- The right to be furnished health care services;
- The right to freedom from any form of restraint or seclusion as specified in federal regulations on the use of restraints and seclusion.

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Accessing Services

Optum Public Sector has been operating the County of San Diego Access and Crisis Line (ACL) on behalf of the MHP since 1997. The ACL may be the client's, or the family's initial access point into the County of San Diego MHP.

The ACL is a free, telephonic service available 24 hours a day, 7 days a week, and 365 days a year for the residents of San Diego County at (888) 724-7240, TTY (619) 641-6992, or California Relay 711. The ACL provides crisis intervention, suicide prevention, information and referrals for mental health and substance use disorders.

The San Diego ACL is operated by a sophisticated clinical team comprised of Licensed and Master's level counselors that have earned the highest evaluations by the leading national program evaluators, the American Association of Suicidology (AAS) and CONTACT USA for online emotional support, CHAT.

The ACL offers online emotional support via CHAT Mon-Fri 4pm-10pm by logging onto any computer, smartphone or tablet via http://up2sd.org/ or https://www.optumsandiego.com/

Our clinical team has established a foundation of clinical management practices that includes an emphasis on evidence based best practices, holistic health, suicide prevention, recovery/resiliency and community partnerships. Our multicultural and multilingual team enables us to better meet the diverse needs of our community. We have bicultural and bilingual Spanish/English counselors available during the highest call times. We also utilize The Language Line which enables us to assist our community in over 150+ languages with the same priority of 911 operators. ACL clinicians are all trained in Motivational Interviewing as a best practice technique for engaging callers. All our ACL clinicians receive training in access to care time frames based on acuity. Our clinicians are trained to triage and identify each caller's needs to facilitate face-to-face assessment and intervention within one hour for emergencies, 72 hours for urgent referrals, and 28 calendar days for routine assessments. ACL clinicians utilize their formal clinical training, years of experience, crisis intervention skills, and knowledge of the system of care to effectively manage callers in crisis.

The following section provides guidelines on making referrals to, and receiving referrals from, the ACL.

Take note:

"The accreditation of the Access and Crisis Line recognizes the stellar processes Optum has put in place to ensure those in crisis get the resources they need." – Nick Macchione, Director of San Diego County Health and Human Services Agency

Take note:

The accreditation is validation that the partnership between the County and Optum is effective in supporting people during a crisis and linking them to community resources." – Former Chairman Ron Roberts, San Diego County Board of Supervisors

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Referrals to the ACL

It is appropriate to refer to the ACL those persons who need:

- Access to publicly-funded Specialty Mental Health and Substance Use Disorder Services
- Crisis intervention for urgent situations such as:
    - Suicide attempts or threats
    - Symptoms of mental illness (e.g., depression, manic behavior, anxiety)
    - Symptoms of dual or multiple diagnoses, including substance abuse, HIV, or AIDS
    - Spouse, elder, or child abuse
    - Marital and/or family relationship problems
- Information about mental health and mental illness
- Information about alcohol or other drug abuse
- Referrals to community resources for vocational, financial, medical, and other concerns

Take note:

Providers must have emergency contact information available on their voice messaging system for 24-hour a day crisis calls.

Provider Interface with the ACL

Providers may use the ACL as an adjunct to services in emergencies and after hours, to provide effective emergency response and back up. Office voicemail messages may state, "If this is a mental health emergency or crisis, please contact the San Diego ACL at (888) 724-7240. If this is a life threatening situation, please hang up and dial 911". Note that providers must have emergency contact information available (e.g. on - call pager, 911, or the Access and Crisis Line) on their voice messaging system for 24-hour a day crisis calls. However, the ACL is *not* appropriate for routine use for clients whose clinicians are out of town or out of the office for an extended period of time. In these types of situations, it is best to proactively connect your client with another mental health provider to oversee your clients in your temporary absence.

If a client is high risk and may be calling the ACL for additional support, providers may call the ACL in advance on behalf of the client. To facilitate the most effective response to the high risk client's needs when he or she calls, please give the ACL the following information:

- Client name and date of birth
- Client address and telephone number
- Provider name, program name, and telephone number
- Summary of clinical information (diagnosis, medications and medication compliance, pertinent treatment)
- Current issues (including suicide or homicide risk)

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- Current resources, such as supportive family members
- Safety Plan, Behavioral Intervention Plan, etc.
- Recommended coping methods and recommended response

Request that the client signs a Release of Information before giving the information to the ACL staff and maintain the signed Release in the client's file.

Receiving Referrals from the ACL

ACL staff makes appropriate referrals using their clinical judgment and knowledge of Title 9 medical necessity criteria. Referrals also take into consideration the following items:

- Urgency of need
- Type of treatment or services indicated
- Geographic location
- Any specific client requests, such as provider language or ethnicity

Confirming Eligibility

Note: The provider must confirm eligibility status of clients before services are rendered. Providers must call the State-maintained Automated Eligibility Verification System (AEVS) at (877) 734-3258 or go to www.medi-cal.ca.gov to verify the clients' eligibility status. Authorization for services is not a guarantee that the client has Medi-Cal benefits, or that a client is eligible during a given month. Medi-Cal reimburses for medically necessary services provided during a month in which the client is eligible, and has active Medi-Cal within San Diego County.

Emergency Psychiatric Condition

Title 9 defines an "Emergency Psychiatric Condition" as a condition in which the person, due to a mental disorder, is a current danger to self or others or is immediately unable to provide for or utilize food, shelter, or clothing. These situations indicate the need for psychiatric inpatient hospital or psychiatric health facility services.

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

In an emergency situation, ACL staff makes direct contact with 9-1-1 to initiate active rescue services for any individual who is at risk. A follow-up call is made to police dispatch by ACL staff to determine the status of the client and to ensure that the client was evaluated and appropriate crisis services were provided.

Take note:

Verify eligibility

It is the provider's responsibility to verify a client's Medi-Cal eligibility status.

Providers can call the **Automated Eligibility Verification System** (AEVS) at **(800) 427-1295** to verify client eligibility status.

Take note:

Providers are asked to notify **Provider Services** at **(800) 798-2254, option 7** if they are not accepting new clients (referrals) or if the office location has changed.

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Urgent Psychiatric Condition

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

If the client's condition is serious, but does not warrant immediate admission to a facility, ACL staff performs a telephonic risk screening and may utilize PERT. If the problem is urgent, the ACL staff may contact the provider directly to confirm that the provider is available to assess the client within 72 hours. The ACL staff may refer the client to one of the County walk-in assessment clinics for evaluation. The ACL staff may contact the clinic in advance to inform the clinical staff of the referral.

Routine Condition

Title 9 defines "Routine Condition" as a condition in which the person is in a relatively stable condition or in need of an initial assessment for Specialty Mental Health Services.

The caller is encouraged to call back to the ACL, if he or she experiences difficulty scheduling an appointment within 28 calendar days of the initial call to the provider. The caller is also reminded of the ACL 24-hour, 7 days a week availability.

Walk-In Cases

Pre-authorization for initial assessments are not required. Please see the *Requesting Authorization Section* of this Handbook.

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Authorization for Reimbursement for Services

Medical Necessity

Optum Public Sector, on behalf of the MHP, authorizes reimbursement for services for all Medi-Cal adult/older adult inpatient care, FFS outpatient care, and certain outpatient services that occur on the same day as another specialty mental health service. For children and adolescents, Optum Public Sector authorizes reimbursement for day program services, certain outpatient services that occur on the same day as the day program services, inpatient care and outpatient FFS services.

Medi-Cal medical necessity criteria for Specialty Mental Health Services are described in Title 9, Section 1830.205, and summarized below. For a complete description of Title 9, Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services, providers may view, though not print, from the State Office of Administrative Law website at www.oal.ca.gov and clicking on California Code of Regulations (CCR) or by accessing the state website they may also be purchased by calling Thomson-West Inc., Barclays Division at (800) 888-3600.

Authorizing Outpatient Services

Medical Necessity for Outpatient Services

Services provided to clients by outpatient FFS providers are reimbursed, if the client meets current criteria in alignment with the Affordable Care Act (ACA) Mental Health Plan population. The FFS Medi-Cal network is part of the Mental Health Plan (MHP) and is intended to serve those that have more severe impairment and meet Title 9 Medical Necessity for Specialty Mental Health Services. Providers should evaluate all new clients to determine if they meet the MHP target population. Providers should refer clients deemed mild or moderate and not meeting Specialty Mental Health Service criteria to services with their Medi-Cal Managed Care Plan (MCP). If the client has no identified MCP, the MHP will support the client's needs as applicable.

The Severity Index Tool can be utilized as part of assessing if criteria are met and is available at www.optumsandiego.com under the Quick Reference tab.

Services provided to new and/or existing clients by outpatient providers are reimbursed, if the following medical necessity criteria are met:

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

AND

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

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- A significant impairment in an important area of life functioning, or
- A probability of significant deterioration in an important area of life functioning.
- For a Child: A reasonable probability the child will not progress developmentally as individually appropriate.

AND

- **All of the following**:
  - The focus of the proposed intervention is to address the impairment or potential impairment identified immediately above.
  - The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning or allow the child to progress developmentally as individually appropriate.
  - The condition would not be responsive to physical healthcare treatment.

Take note:

Expedited authorizations are made within three (3) business days of the request. Providers may call **(800) 798-2254**, **option 4**, for an Expedited authorization.

General Authorization Reminders

Optum Public Sector has worked closely with the County of San Diego Behavioral Health Services to develop an authorization process for the FFS Network that incorporates the following treatment philosophy:

- Recovery from a mental illness is possible.
- The majority of clients are able to improve using treatment that focuses on the specific mental health need of the client.
- Clients are more likely to improve when involved in community services, such as self-help programs, peer support groups, 12 Step programs and Optum Public Sector works closely with these resources.

Therefore, any treatment offered to FFS clients is expected to be consistent with this treatment philosophy.

Please be aware that the number of sessions authorized in the FFS network is assessed on a case by case basis and must meet Title 9 medical necessity. For both adults and children, the maximum authorization is up to 12 sessions per form submitted, typically authorized at one time a week. Initial authorization requests will be processed and the provider notified of determination via telephone within 4 business days of fax received date. Continuing authorization requests will be reviewed within 14 calendar days of fax received date and the provider notified via mail. There is no pre-authorization required for Assessments; simply claim

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for the service provided. Additional sessions past 12 can be requested on an ongoing basis as needed.

Optum Public Sector does not authorize retroactive outpatient authorizations except in extraordinary circumstances. Any exceptions must be requested within 30 days of the date of service and retroactive authorizations that are approved will not go more than 30 days back.

It is the FFS providers' responsibility to verify the client's Medi-Cal eligibility.

Take note:

MD/DO/PNPs only

Ongoing authorization for services that do not exceed twice monthly will be automatically renewed for ongoing clients as long as claims continue to be submitted.

Clients may see only one (1) provider for an ongoing service. Clients may not see two (2) or more providers ongoing for the same service at the same time. It is recommended that providers screen clients for any other Behavioral Health providers that they may be seeing. Clients have the right to change providers at any time. To change providers, clients can call the Access and Crisis Line to request a change in providers and receive referrals. Clients also have the right to a second opinion.

Outpatient Services – Assessment Authorization

The San Diego County MHP defines children/adolescent as 0-17 and adult clients as those between the ages of 18 – 59 years. Older adults are age 60 and above. Pre-authorization for an initial assessment is not required. Assessment authorizations for Medi-Cal eligible clients will be given in increments of one (1) assessment per year. Authorizations will be entered into the designated database after the provider submits the claim for the initial assessment session, and an authorization letter will be sent to the provider.

Optum Public Sector does not authorize retroactive authorizations, except in extraordinary circumstances. Any exception must be requested within 30 days of date of service.

Title 9 requires that authorization decisions be made within 14 days of the receipt of the request; however, providers can also request an expedited authorization for outpatient services. Providers may request an expedited authorization by contacting the Provider Services Line at (800) 798-2254 option 4 and specifically requesting an expedited outpatient authorization. Please have client information available as licensed staff will be requesting specific demographic and clinical information for the authorization.

Take note:

MD/DO/PNPs only

Ongoing authorization requests in excess of two (2) sessions per month require an OAR.

Expedited authorizations will be made within three (3) business days. Once the authorization process is complete, Optum Public Sector mails an authorization letter to the provider. The authorization letter specifies each authorized service by procedure codes and cluster codes and is valid for a given time period.

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Outpatient Services – Initial 12 Sessions and Continuing Sessions

After the Assessment session is complete, the provider should:

Determine if client meets current medical necessity criteria for services for the target population of the Mental Health Plan. The current symptoms, level of impairment, and proposed interventions with treatment plan are to be recorded on the Outpatient Authorization Request Form (OAR) which must be completed and submitted to Optum Public Sector when sessions are requested beyond the initial assessment. A Demographic Form must also be submitted for ongoing clients upon first submission of the OAR and as applicable when updates in the client's Demographics occur. If the client does not meet the MHP target population, the provider can refer clients to their Medi- Cal Managed Care Plan (MCP) for Behavioral Health Services when applicable.

The provider should submit an OAR for up to twelve (12) additional sessions to Optum Public Sector Utilization Management by fax at (866) 220-4495 or mail it to the following address:

Optum Public Sector
PO Box 601340
San Diego, CA 92160-1340

The provider is required to include the client and the client's family (with consent, if applicable), when appropriate, in the treatment planning process. The OAR should reflect the provider's assessment of the client diagnoses, applicable interventions, and a treatment plan that is individualized to meet the client's needs. The provider may request that the client signs the OAR to document client participation in treatment planning, unless it is the clinical judgment of the provider that such a request could adversely affect the therapeutic process or the well-being of the client. A copy of the OAR is located online on the Optum Public Sector Website. The original OAR must be filed in the client's medical record. Each request for authorization of additional sessions must be accompanied by an OAR updated to reflect changes in the client's functioning and treatment plan. Authorization for reimbursement of services will be denied, if the information on the OAR has not been updated from previous requests submitted. An OAR is submitted to Optum Public Sector when the provider is requesting additional services beyond the Initial Assessment. The OAR should be submitted about three (3) weeks prior to the end of the current authorization period.

Any request for authorization of additional sessions must be accompanied by an OAR updated to reflect changes in the client's functioning and treatment plan. Submission of a previously submitted OAR with dates changed does not qualify as updated clinical information and will be returned with a request for an update or possibly clinically denied for further authorization.

Take note:

If a child turns 18 years of age while in treatment and the provider has received authorizations at the child rate, the provider will continue to get paid until the authorization is completed.

If the provider continues to treat the client, the provider will need to request a new authorization at the adult rate and CPT code. A new 90791 will not be approved.

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Fax the updated OAR to Optum Public Sector Utilization Management at (866) 220-4495, or mail it to the following address:

Optum Public Sector
PO Box 601340
San Diego, CA 92160-1340

Authorization letters are mailed to providers within 14 calendar days. If an authorization letter is not received, the provider should call the Provider Line at (800) 798-2254, option 5, to inform a Clinical Administrative Coordinator.

Take note:

Expedited Authorizations:

Optum has up to 14 days to complete authorizations. If a 14 day delay in authorization determination would seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning, please contact Optum and request an Expedited Authorization. Call **(800) 798-2254 option 4**.

Following the assessment of a client, the provider is required to document the results of the assessment and complete a treatment plan. This information, along with session notes, must be placed in the client record maintained by the provider. The record may be audited by the MHP or State or Federal Regulators. The assessment and treatment plan may be recorded on the OAR form if sessions beyond the Assessment are requested.

Note: Psychiatrists who treat children the age 12 and under must be board certified, or eligible to be certified, in Child and Adolescent Psychiatry. Psychiatrists treating children ages of 13-17 may be authorized to do so without board certification or eligibility, but may be required to submit documentation of their experience working with this age group.

Increased Frequency of Sessions for Emergency or Crisis Situations

Outpatient treatment sessions may be increased for any client, adult/older adult, child or adolescent, for a brief period of time to prevent a crisis from occurring or to stabilize a person experiencing a crisis. The process for obtaining authorization in these circumstances is as follows:

- Call the Provider Line at (800) 798-2254, option 4, or
- Fax an OAR with the applicable start date to Optum Public Sector Utilization Management at (866) 220-4495.

The provider should be able to speak to the therapeutic rationale for the increased frequency, the estimated duration of the increased frequent visits, and the expected outcome of the intensified treatment.

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Requesting Authorizations

The following matrix describes the Medi-Cal Fee for Service Provider Network procedures for obtaining authorization for initial (assessment) and continuing outpatient services for Adults, Older Adults, Children and Adolescents.

Assessment Session Completed:	Mild to Moderate	Severe	Request an Increased Frequency in Authorization Sessions for current clients
	No pre-authorization required. After Assessment session is completed, provider submits claim. Providers will receive one assessment session per client per year. Provider refers client to their Medi-Cal Managed Care Plan (MCP) Behavioral Health Services If there is no Medi-Cal Managed Care (MCP) plan, provider is welcome to see client and work with Optum for authorization.	Providers may request up to 12 additional sessions at a time by submitting an OAR. Services will only be authorized up to 30 days retroactively. If an MD/DO/PNP is seeing the client more than 2 times per month, then an OAR will need to be submitted.	Fax or mail an updated OAR to Optum that includes start date for sessions and the therapeutic rationale for increased visits. Or Call the Provider Line at 1 (800) 798-2254, option 4 with the above information.

Requesting Authorizations

Take note:

Submitting Authorization Requests (OARs):

By Fax:
(866) 220-4495 or

By Mail:
Optum Public Sector
PO Box 601340
San Diego, CA 92160-1340

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Authorizing Inpatient Services

Medical Necessity for Adult/Older Adult Inpatient Services

Hospitals are required to notify Optum Public Sector within ten (10) calendar days of a client's admission to the hospital. A hospital may also call Optum Public Sector prior to or at the time of admission for an authorization review.

Adult/older adult inpatient services are reimbursed only when the client meets Medi-Cal eligibility for the dates of service and the following criteria are met, as outlined in Title 9, section 1820.205:

- The client must have a diagnosis included in the Fourth Edition of the Diagnostic and Statistical Manual (DSM) that is reimbursable for inpatient services as described in Title 9, section 1820.205.
- And both of the following are true:
  - The condition cannot be safely treated at a lower level of care.
  - Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 and 2 below:
    1. The symptoms or behaviors:
       a. Represent a current danger to self or others, or significant property destruction
       b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
       c. Present a severe risk to the beneficiary's physical health
       d. Represent a recent, significant deterioration in ability to function

       AND

    2. The symptoms or behaviors require admission for <u>one</u> of the following:
       a. Further psychiatric evaluation, or
       b. Medication treatment, or
       c. Other treatment that can reasonably be provided only if the patient is hospitalized

Psychiatrist professional fees are authorized by Optum Public Sector after the provider submits their claim for services. .

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Medical Necessity for Children's Inpatient Services

Optum Public Sector is also responsible for the authorization of children's inpatient services. In addition, psychiatrist professional fees are authorized by Optum Public Sector after the provider submits their claim for services.

Coordination of Care

With the implementation of the healthcare reform, the coordination of care among inpatient and outpatient services will become even more critical for a mental health system to work effectively. It also supports the clients' efforts to achieve and maintain the highest possible level of stability and independence. Providers are required to coordinate the client's mental health services and refer the client to appropriate community services. The MHP monitors the coordination of care in several ways:

- Chart reviews are conducted at all levels of services. Inpatient reviews include retrospective review of documentation to confirm that upon discharge clients were given referrals to community services such as drug/alcohol or domestic violence support groups, anger management groups, vocational counseling, case management services, socialization centers, or legal services.
- A Consumer Survey may be administered at discharge from an acute inpatient or crisis residential service to assess the clients' perceptions of the degree to which care was coordinated with outpatient providers.
- Individual FFS providers are expected to demonstrate a good faith effort to obtain a signed Consent for Release of Information (ROI), and to obtain relevant mental health records pertaining to any client who has recently been discharged from an inpatient or residential facility, is receiving services from a day program provider or has been transferred from a previous outpatient provider.

Take note:

Providers are expected to coordinate care with the client's health care providers. Please call the **ACL** at **888-724-7240** to obtain information about the full range of community services available for clients.

Coordination with Primary Care Physicians (PCP)

Coordination of care between mental health care providers and physical health care providers is necessary to optimize the overall health of a client. All providers are expected to coordinate mental health care with a client's PCP. Individual FFS providers are requested by the MHP to demonstrate a good faith effort to obtain a signed *Authorization To Use or Disclose PHI Form* from the client during the first visit to facilitate coordination with the client's PCP. The effort to obtain this form is reviewed during the quality chart audit, conducted by the MHP. Included on the Optum Public Sector Website are the *Healthy San Diego Physical and Mental Health Care Coordination Form* and a generic *Authorization To Use or Disclose PHI Form,* which providers may use to facilitate or enhance coordination of care with the client's PCP.

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Pharmacy and Lab Services

Medi-Cal Managed Care Plan (MCP) *Medi-Cal Beneficiaries*

A majority of Medi-Cal beneficiaries are enrolled in one of the Medi-Cal Managed Care Plan (MCP) that are part of Healthy San Diego. Each MCP has contracts with specific pharmacies and laboratories.

Providers prescribing lab tests may refer the client back to his or her PCP for these services. The client's MCP enrollment card also may have a phone number that providers and clients can check in order to identify the contracted pharmacy or lab.

Psychiatrists may order the following lab studies without obtaining authorization from the client's PCP:

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

All other lab studies require authorization from the client's PCP. A provider cannot require a client to use one particular pharmacy or lab; the client may select, based on health plan coverage, where to receive lab or pharmacy services.

The Medi-Cal medication formulary has been incorporated into the MCP medication formulary for the benefit of MCP Medi-Cal clients. Excluded (carved-out) medications are the financial responsibility of Medi-Cal, and are billed directly to Medi-Cal by the pharmacy.

Medi-Cal Beneficiaries Not Enrolled in an MCP

Medi-Cal beneficiaries who are not members of an MCP have the right to use any pharmacy or lab that accepts Medi-Cal reimbursement. A provider cannot require a client to use one particular pharmacy or lab; the client may select where to receive lab or pharmacy services.

Take note:

To assist the provider in coordinating care with PCPs and/or pharmacy/lab services, we have provided a Medi-Cal Behavioral Health Quick Guide containing contact information for the San Diego Managed Care Plans (MCPs) listed online on the Optum Public Sector Website.

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Physical Health Services While in a Psychiatric Hospital

Healthy San Diego MCP Clients

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

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission, and for ordering routine laboratory services. If the psychiatrist identifies a physical health problem, he or she contacts the client's MCP to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted facility must obtain the necessary authorizations from the MCP. The client's MCP contracted providers are to provide these services, unless the contracted facility obtains prior authorization from the MCP to use a provider not contracted with the client's MCP.

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital staff must consult with appropriate MCP staff to arrange transfer from a psychiatric hospital to an MCP contracted hospital, if it is determined that the client requires physical health-based treatment. The Optum Public Sector Medical Director and the MCP Medical Director resolve any disputes regarding transfers.

Healthy San Diego MCPs cover non-emergency medical transportation on a case-by-case basis. MCP members who call the ACL for medical transportation are referred to the Member Services Department of their MCP to arrange for such services.

Beneficiaries Not Enrolled in Healthy San Diego Health Plans

Physical health services provided in a psychiatric facility are reimbursed by the State FFS Medi-Cal program for clients who are not members of one of the Healthy San Diego Health Plans. Providers are expected to coordinate services with the client's FFS physical health care provider.

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Psychiatric Consultation Services While in a Medical Hospital

Psychiatric consult services while in a medical hospital are authorized by Optum Public Sector after the provider submits their claim for services.

Home Health Care

Beneficiaries who are members of one of the Healthy San Diego MCPs must request in-home mental health services from their PCP. The MCP is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of that MCP. The MCP Case Manager and the PCP coordinate on-going in-home treatment.

Clients with No Insurance or Financial Resources

Clients without Medi-Cal eligibility or the means or resources to pay for inpatient services are eligible for realignment funded services. Optum Public Sector refers these Adult clients for services to the San Diego County Psychiatric Hospital and/or the Emergency Psychiatric Unit. Both facilities are located at 3851 Rosecrans Street, San Diego, CA 92110 (619) 692-8200. Optum Public Sector refers child and adolescent clients for services to the Emergency Screening Unit located at 4309 Third Ave., San Diego, CA 92103, (619) 421-6900. The Emergency Screening Unit refers children and adolescents for inpatient services to the Rady's Child and Adolescent Psychiatric Services (CAPS). These County-operated facilities will treat unfunded adult clients who are experiencing psychiatric emergencies. The adult client or the family of the child/adolescent may be financially responsible for services based on a sliding scale fee.

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Quality Management Program

The MHP provides a mental health system for clients with serious mental illness that is:

- Focused on client strengths and recovery from mental illness
- Accountable and outcomes-driven
- Client and family-centered
- Culturally competent

To implement and maintain the goals of this mandate, the County of San Diego's Behavioral Health Services Quality Management unit (BHS QM) has developed a comprehensive Quality Management Program. The BHS QM Program is responsible for assuring that all clients receive high quality and cost-effective mental health care. The BHS QM Program integrates clients, family members, clinicians, mental health advocates, and other stakeholders within its working committees and its monitoring and oversight of MHP processes.

The BHS QM Program adheres to a Quality Improvement Plan that is reviewed and updated at a minimum on an annual basis. The Quality Improvement Plan strives for continuous improvement that does not end once a specified standard or threshold is reached. The quality of the MHP care and service delivery system is evaluated by using standardized, valid, and reliable measures whenever possible.

The aspects of care and service evaluated by the MHP include, but are not limited to:

- Client satisfaction with the delivery and quality of clinical services
- Improving access to services
- Quality, effectiveness, and timeliness of clinical and administrative services
- Complaints and resolutions of complaints about provider services
- Quality of provider documentation of clinical services
- Provider satisfaction with Optum procedures

  Implementation of evidence based practices

Take note:

Questions regarding the Quality Improvement Program, may be emailed to Optum Quality Improvement at SDQI@optum.com Questions regarding County of San Diego Behavioral Health Services Quality Management may be emailed to QIMatters.hhsa@sdcounty.ca.gov

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Quality Management Program Compliance

Providers who contract with Optum agree to the following standards of quality that include, but are not limited to, the following items:

- Compliance with MHP standards for client access to services including distribution of literature at the first face-to-face meeting with a new client. This may include, but is not limited to, Client Rights, County of San Diego Notice of Privacy Practices, Advance Directive Brochure, Grievance and Appeals brochure, etc.
- Compliance with Title 9 medical necessity and MHP and Utilization Management guidelines
- Compliance with Credentialing, Re-Credentialing, and Peer Review Committee activities
- Cooperation and participation in the resolution of client appeals and grievances concerning the provider's services
- Cooperation with the Consumer Center for Health, Education and Advocacy (CCHEA) and Jewish Family Services (JFS) Patient Advocacy Program as they investigate and resolve appeals and grievances
- Completion of any corrective action plans that may occur as a result of an investigation by CCHEA or JFS
- Agreement to report any serious incidents on the County of San Diego Serious Incident Report form. A Serious Incident is defined as any incident that results in a client's death, serious morbidity requiring treatment, injury inflicted on others, serious adverse drug reactions, or evidence of inappropriate or unsafe medical and/ or therapeutic practices involving MHP clients. Such incidents must be reported to the Behavioral Health Services Quality Management unit.
- Cooperation with and participation in the investigation of serious incidents involving a MHP client
- Cooperation with site and treatment record reviews, including the completion of any necessary corrective action plans
- Cooperation with the evaluation of potential quality of care or billing accuracy concerns
- Adherence to Title 9, Federal, State and County regulations, including cultural competence standards for the provision of mental health services

Compliance with California Department of Health Care Services and licensing board record retention procedures, whichever is longer

Take note:

The following documents must be given to clients at the first visit:

- Guide to Mental Health Services
- Grievance and Appeal Procedures
- MHP's Notice of Privacy Practices
- Advance Directives Recovery Happens brochures

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Refusal to comply with the Behavioral Health Services Quality Management unit and/or Optum Public Sector's Quality Improvement procedures can result in disciplinary action up to and including termination from the network.

Client Satisfaction

The MHP is committed to assessing client satisfaction with the delivery and quality of clinical services. Title 9 requires an assessment of clients' perceptions of this care. The MPH conducts an ongoing survey of client satisfaction with inpatient services. Providers are strongly encouraged to conduct client surveys to determine client satisfaction with their services.

Provider Satisfaction

Every two years, the MHP will send a survey to all contracted providers and groups measuring their satisfaction with Optum. These results are provided to Optum where they are reviewed by the leadership team to develop and implement changes aimed at improving provider satisfaction.

Quality of Care

Optum facilitates a process to address concerns related to the quality of care rendered by FFS providers. Quality of care concerns are addressed by Optum Quality Improvement, reviewed by the Optum Medical Director, and may be presented to the Optum Clinical Quality of Care Committee. In some instances, FFS providers will be requested to submit copies of treatment documentation which includes progress notes. Optum may follow up with questions regarding the information received or not received in the documentation which will be relayed via a letter. Based on the outcome of the review, providers may be required to complete a plan of correction to address quality of care concerns. In certain cases, information related to the quality of care may be referred to the Credentialing Committee for disciplinary action up to and including termination from the network.

Peer Review Committee

Optum facilitates a peer review process. This process includes Optum employees, network providers, and other professionals in the community. The peer review process reviews cases involving the suicide of a client or other serious provider issues. FFS providers may be requested to submit copies of treatment documentation, including clinical notes.

This information is reviewed internally by the Optum Quality Improvement clinicians. After development of the case history, the clinical documentation is reviewed with the Peer Review Committee. All identifying client and provider information is removed.

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The Peer Review Committee may develop questions regarding treatment, which will be relayed to the provider via a letter. Based on the outcome of the review, providers may be required to complete a plan of correction to address quality of care concerns. In certain cases, information related to the quality of care may be referred to the MHP Credentialing Committee for disciplinary action up to and including termination from the network.

Outpatient Provider Reviews

The MHP requires review of providers' practice site and documentation of services to determine that County, State, and Federal guidelines and standards are met regarding the quality and effectiveness of clinical services and the accuracy of provider claims.

Monitoring is accomplished through a review of clinical records, billing practices, and an inspection of provider offices. Optum Quality Improvement employees conduct site and treatment record reviews for each provider during the three year credentialing period.

Providers may also be selected for review in response to a complaint or quality of care issue. Providers may also be selected for review at the request of the County of San Diego or the Credentialing Committee. Reviews are scheduled in advance. Copies of the site review tool and treatment record review tool are available on the Optum website at www.optumsandiego.com. Providers are required to cooperate with the review process and comply with any resulting corrective action plans.

Site Reviews

FFS provider sites are reviewed to ensure that providers maintain a safe office, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a QI Quality Improvement Clinician will review:

- Physical facility
- Licenses and Permits (as applicable)
- Required Documents
- Personnel (if applicable)
- Medication Service (if applicable)
- Cultural Competence
- Consumer Orientation
- Provider/staff knowledge of Client Rights, Grievance & Appeals Process and Advance Directives
- Treatment Records

Take note:

Please review the online form *Record Keeping and Treatment Record Requirements.*

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- Verification of the safe storage and dispensing of medications in compliance with State and Federal laws and regulations (physicians only)
- Accessibility of the facility for individuals using wheelchairs
- Availability of Guide to Medi-Cal Mental Health Services, client complaint/grievance brochures and complaint filing forms in English, Spanish, Vietnamese, Arabic, and Tagalog in common areas that preclude the need for a verbal or written request by the client
- Access and Crisis Line posters displayed and Access and Crisis Line brochures available to clients

Treatment Record Reviews

Providers are urged to review the online form *Record Keeping and Treatment Record Requirements*. Competent record keeping not only documents the client's history and treatment, but also acts as a protection for providers against recoupment of payments or legal action. During the treatment record review, a Quality Improvement clinician will review clinical records for:

- Assessment/Appropriateness of Treatment
- Medical Necessity
- Clinical Quality
- Client Treatment Plan and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge Plan and Summary

Outcome Reports and Plans of Correction

Problems and areas of non-compliance noted during a site visit and/or treatment record review are summarized into an outcome report, which is sent to the provider. A score of 85% is required to pass. Optum may require the provider to submit a plan of correction based on the areas of non-compliance; a re-review may be incorporated into a plan of correction. Providers have 30 days to submit a plan of correction in writing to Optum Quality Improvement. Quality Improvement clinicians are available to discuss problem areas and assist with developing plans of correction. Optum Quality Improvement reviews and approves plans of correction and monitors providers for compliance achievement.

Take note:

The CPT code submitted on a claim form and the amount of time a provider spends face to face with a client must match the amount of time associated with that CPT code in the provider's and/or group's contract fee schedule and the most current version of the American Medical Association Procedural Codebook.

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The MHP is committed to working with providers to help address and correct any areas of concern that may be identified during site visits and treatment record review; however, repeated deficiencies in documentation or quality of care can result in disciplinary actions up to and including termination of the provider contract.

Recoupment and Recoupment Appeals Process

It is the policy of the MHP to disallow provider billing that does not meet the documentation standards and to recoup payment in accordance with the current County of San Diego MHP policy and procedures. Per the current California Department of Health Care Services Reasons for Recoupment, the MHP is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes

Providers are responsible for ensuring that all treatment records comply with Federal, State, and County documentation standards when billing for reimbursement of services. At the conclusion of a treatment record review, the provider may receive a Medi-Cal Fee for Service Recoupment Report, listing any claims that have been disallowed based on the Medi-Cal recoupment criteria.

If the provider disagrees with a recoupment, the MHP has a process for the provider to appeal the Medi-Cal recoupment decision. Providers are required to submit their appeal in writing to Optum Quality Improvement within required timelines.

Please email Optum Quality Improvement at SDQI@optum.com for information on the appeals process.

Inpatient Professional Service Reviews

The MHP requires annual review of providers of inpatient professional services to ensure documentation is present for claims to be substantiated. A minimum of ten percent of all paid services per provider shall be reviewed by Optum Quality Improvement employees. The MHP may require additional reviews of providers at any time if deemed necessary.

Monitoring is accomplished through a review of inpatient progress notes and paid claims. A copy of the inpatient review tool is available on the Optum website at www.optumsandiego.com. An outcome report with a summary of the results including feedback on any deficiencies will be sent to the provider. Optum may require the provider to submit a plan of correction based on the areas of deficiency. If documentation does not support claims payment, payment for the services may be recouped. Providers are required to cooperate with the review process and comply with any resulting corrective action plans.

Take note:

Effective 07/01/2016 Providers are required to complete the "Understanding Medi-Cal Documentation Standards: An e-Learning Course by the County of San Diego and Optum" Documentation Training Course available through the Behavioral Health Education & Training Academy (BHETA) as a pre - requisite to contracting.

Instructions for creating an account can be found on the Optum Public Sector Website

Take note:

Providers are required to meet MHP documentation requirements.

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The MHP is committed to working with providers to help address and correct any areas of concern that may be identified during inpatient professional service reviews; however, repeated deficiencies can result in disciplinary actions up to and including termination of the provider contract.

Documentation Standards for Outpatient Client Records

The following information is required to be included in the client's treatment record. Documentation must be timely, legible, and support the claims information submitted to Optum for provider reimbursement. Providers are urged to review the online form *Record Keeping and Treatment Record Requirements* for additional information.

Client Record Documentation Requirements

- Documentation that client/guardian received the following: Client Rights, Grievance and Appeals brochure/form, Advance Directive brochure, County of San Diego Notice of Privacy Practices, right to have services provided in their primary language, etc.
- Informed Consent/Agreement for Services
- Relevant physical health conditions reported by the client must be prominently identified and updated as appropriate
- Presenting problems and relevant conditions affecting the client's physical health and mental health status must be documented; for example, living situation, daily activities, cultural issues, and social support
- Documentation must include and describe client strengths in achieving client plan goals
- Special status situations that present a risk to client or others must be prominently documented and updated as appropriate
- Documentation must 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 must be clearly documented
- For children and adolescents, prenatal and perinatal events and a complete developmental history must be included
- Documentation must include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs
- A mental status examination must be documented
- A diagnosis must be documented, consistent with the presenting problems, history, mental status evaluation, and/or other assessment data

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- Document the amount of time spent with the client. Time spent face to face with the client must match CPT code and contracted rate schedule
- Provider signature, including professional degree and licensure for each note (if applicable, an electronic signature is acceptable)

Client Treatment Plans

Each client record must contain a treatment plan completed within 30 days of the initial assessment session that is updated at least annually. The treatment plan must be developed in partnership with the client or, for children/adolescents, with the client's family. Providers are expected to review the plan with the client and request the client signs off on the plan.

Client Treatment Plans must:

- Identify specific observable and/or specific quantifiable goals
- Identify the proposed type(s) of intervention
- Include a proposed duration of intervention(s)
- Be signed (or electronic equivalent) by the person providing the services

Take note:
A progress note is required for each service rendered by a provider.

In addition, client plan clinical data must be consistent with the diagnosis/ diagnoses, and the focus of intervention must be consistent with the client plan goals. Documentation of the client's participation in developing, and agreement with the treatment plan is expected. Examples of documentation include, but are not limited to: reference to the client's participation and agreement in the body of the plan, client signature on the plan or a description of the client's participation and agreement in progress notes.

The client signature on the plan will be used as the means by which the MHP documents the participation of the client when the client is a long term client as defined by the MHP, and when the client is receiving more than one type of service from the MHP. When the client's signature is required on the client plan and the client refuses or is unavailable for signature, the provider must include a written explanation of the refusal or unavailability.

Progress Notes

The following items related to the client's progress must be entered in the client record at every service contact:

- Timely and legible documentation of relevant aspects of client care
- Amount of time spent face-to-face with client
- Client encounters, including relevant clinical decisions and interventions
- Signature of the provider providing the services (or electronic equivalent); the provider's professional degree and licensure
- Date services were provided

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- Referrals made to community resources and other agencies
- Follow-up care, or as appropriate, a discharge summary

Take note:

A progress note is required for each service rendered by a provider.

Documentation Standards for Inpatient Client Records

Inpatient professional service progress notes must, at minimum, have the following elements:

- Client name or identifier is present in the progress note
- Provider identifier is present in the progress note
- The progress note is legible
- The diagnosis or diagnosis code is indicated
- The progress note supports the code billed

Medical Necessity

Admission

- Documentation in the medical record must establish that the beneficiary has a Title 9 covered diagnosis.
- Documentation in the medical record must establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
- Documentation in the medical record must establish that, as a result of a mental disorder the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:
  - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction;
  - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
  - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health;
  - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function; or
  - Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized.

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Continued Stay Criteria

- Documentation in the medical record must establish the continued presence of a Title 9 covered diagnosis
- Documentation in the medical record must establish that the beneficiary could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion
- Documentation in the medical record must establish that, as a result of a mental disorder the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:
    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
    - Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized
    - Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
    - Presence of new indications that meet medical necessity criteria
    - Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital

Administrative Day Requirements

- Documentation in the medical record must establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay
- Documentation provided by the MHP must establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:

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- The MHP or its designee may waive the requirement of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be fewer than one contact per week
    - The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:
        - The status of the placement option
        - The date of the contact
        - Signature of the person making the contact

Client Plan

- The medical record must contain a client plan
- The client plan must be signed by a physician

Access Standards

The MHP also has identified standards for access to services. These access standards refer to the acceptable timelines for face-to-face initial assessment:

Emergency Cases:	Face-to-face assessment within one (1) hour of client request or referral
Urgent Cases:	Face-to-face assessment within 48 hours of client request or referral
Routine Cases:	Face-to-face assessment within 10 business days of client request or referral

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Provider Contracting

Optum Public Sector, on behalf of the MHP, is responsible for developing and maintaining a network of Fee-for-Service (FFS) providers. All FFS and TERM providers must be contracted with Optum Public Sector, either individually or within a group in order to receive reimbursement for professional services rendered to clients. Both the Optum Public Sector individual and group-based provider contracts contain:

- General terms applicable to all contracts delivering County reimbursable services.
- A description of work or services to be performed.
- Exhibits specific to FFS and/or TERM network requirements.
- Attached CPT codes and reimbursement schedules as approved by the County of San Diego MHP.
- Statutes and/or regulations particular to Medi-Cal managed mental health care and/or TERM network participation.
- This handbook is included by reference in the contract; the requirements, workflows protocols are part of the contract. .

All providers whether individual or group-based FFS and/or TERM providers are required to follow the contract requirements. Please contact Optum Public Sector Provider Services at (800) 798-2254, option 7, with any questions related to the contract.

Take note:

Optum Public Sector cannot contract with providers who are employed by the County or public agency for which the Board of Supervisors is a governing body.

Take note:

Provider are asked to read the contract carefully

The contract should be in a place where providers can easily refer to it.

For any questions regarding the contract with Optum Public Sector, providers may call **Provider Services** at:

(800) 798-2254, Option 7.

Credentialing

Credentialing Standards

Optum Public Sector, on behalf of the MHP, contracts with Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Marriage and Family Therapists, Licensed Clinical Social Workers and Licensed Professional Clinical Counselors to provide specialty Medi-Cal mental health services to Adults/Older Adults, and Children and Adolescents.

All providers are required to complete an Optum Public Sector practitioner application and complete a site review as part of the initial contracting process. Credentialing is completed per National Committee of Quality Assurance (NCQA) guidelines and is facilitated by Optum Public Sector Provider Services. It includes approval by the MHP Credentialing Committee and a documentation review or primary source verification (PSV) of the following:

- Education and medical residency, if applicable
- Professional license
- Board certification from American Board of Medical Specialties (ABMS) or equivalent osteopathic certification, if applicable

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- DEA certificate, if applicable
- Professional liability insurance
- Malpractice history and complaints documented with the National Practitioner Data Bank (NPDB), Regional Medicare/ Medi-Cal offices, and the State medical boards or other appropriate State agency
- Evidence of Participation with State Medi-Cal (not applicable for LMFT). This is the Medi-Cal State provider number.
- Medicare provider number, if applicable
- Individual Provider NPI (National Provider Identifier) and Taxonomy Code
- Group NPI and Taxonomy Code, if applicable
- Clinical privileges in good standing at an institution, as applicable
- Any certifications, additional training/ areas of specialty, service location, telephone, and office hours
- Review of Board Certification, CME hours and experience for psychiatrists that wish to treat children or adolescents. Psychiatrists who treat 12 years old children and under, must be board certified in Child & Adolescent Psychiatry. Psychiatrists treating children ages 13-17 may be authorized to do so without board certification; however, may be required to submit documentation of their experience with this population to the MHP Credentialing Committee.

Take note:

Please refer to the *TERM Provider Handbook* for additional specific requirements necessary to be paneled onto the Optum Public Sector TERM Network. All providers contracting with TERM must attest to specific experience and/or training prior to rendering services to the TERM Network population.

In order to ensure that providers meet minimum qualification standards, Optum Public Sector, San Diego, adheres to the credentialing policies and qualification standards developed by Optum Public Sector, as well as sections 1810.436 and 1810.438 of Title 9, and County of San Diego malpractice coverage requirements. Credentialing policies and qualification standards may be obtained by contacting Optum Public Sector Provider Services at (800) 798-2254, option 7.

Recredentialing

A recredentialing process occurs at a minimum of every 36 months from the most recent credentialing or recredentialing date. Providers receive a recredentialing application to complete and return to Optum Public Sector. This recredentialing process enables Optum Public Sector to update demographic information and verify that providers continue to meet the credentialing criteria required to continue a contract with Optum Public Sector.

Recredentialing of all providers is facilitated by Optum Public Sector Provider Services and includes approval by the MHP Credentialing Committee and includes documentation review and primary source verification of documents reviewed during the original credentialing process.

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Additional areas reviewed during the recredentialing process include:

- Provider data such as complaints or grievances, results of client satisfaction surveys, quality management reviews and site and chart reviews, in addition to compliance with the goals of the MHP
- Compliance with contract obligations and the Optum Public Sector authorization procedures, standards established in the MHP QI Plan, and cultural competency standards established by the County and the State
- Medi-Cal Sanctions Report (*This report is reviewed monthly, as well as at the time of provider credential and recredentialing - If a provider is identified as on the Exclusion and Debarment list, the provider shall not receive a contract, or contract that is in effect shall be reviewed for termination."*).

Providers can help avoid delays at recredentialing time by updating credentials on an on-going basis. Providers who delay updating documentation may be unable to obtain ongoing authorizations, referrals or claims reimbursement until all documentation is up to date. A provider may be required to furnish additional background information or to authorize a background investigation based upon new or additional information. Providers who do not submit the required recredentialing documentation shall have their contracts terminated.

Mental Health Plan (MHP) Credentialing Committee

The MHP Credentialing Committee reviews and recommends for approval providers who meet the credentialing or recredentialing requirements. In addition, the MHP Credentialing Committee is responsible for recommending disciplinary actions or terminations of providers from the network. The MHP Credentialing Committee membership includes but is not limited to the following:

- County Clinical Director, or designee
- Optum Public Sector Medical Director or designee
- Optum Public Sector Director of Behavioral Health Network and Quality Improvement or designee
- Optum Public Sector Director of Clinical Operations or designee
- Optum Public Sector Manager of Provider Services
- Optum Public Sector Manager of TERM team or designee
- Director of Adult/ Older Adult Mental Health Services or designee
- Director of Quality Improvement of County of Behavioral Health Services
- Director of Child, Youth and Family Services or designee
- A contracted FFS psychiatrist and psychologist

A quorum of 50% of committee members must be present in order to conduct business. A majority consensus is required for implementation of credentialing and contracting decisions.

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Disciplinary Actions

The MHP Credentialing Committee may restrict or suspend the participation of a Provider and/or may recommend any action deemed appropriate to improve and monitor performance. In addition, Optum Public Sector or the County of San Diego Behavioral Health Director may, at their sole discretion, take corrective action, discipline, suspend or restrict any provider's participation for failure to follow participation agreement terms, the FFS Provider Handbook, the Plan or any other reasons set forth in the participation agreement, Plan or under applicable law.

Examples of such disciplinary actions include, but are not limited to the following:

- Monitoring of the provider
- Requiring peer consultation
- Requiring additional training
- Limiting the scope of practice in treating clients
- Submission by the provider, and adherence to a plan of correction and/or corrective action plan
- Ceasing referrals or authorization of any new or existing clients
- Temporarily restricting, limiting or suspending the provider's participation status
- Referral to the Peer Review Committee
- Terminating the provider's contract/agreement

Contract Termination

Contracts may be terminated at the request of the provider, by Optum Public Sector or at the request of the County MHP. To review the conditions, responsibilities, and provider rights upon termination, please refer to Section 11, Term and Termination, in the provider contract.

Providers, who wish to terminate their contract to provide mental health services to MHP Medi-Cal beneficiaries, must notify Optum Public Sector in writing 30 days prior to the date of termination. The provider contract requires completion of authorized episodes of treatment for current clients unless clinically contra-indicated. Optum Public Sector can assist the client in locating a new provider.

There may be occasions when a provider's contract is terminated by Optum Public Sector. The provider is notified by mail. The provider may have the right to appeal the termination and request a hearing. Please contact Provider Services at (800) 798-2254, option 7 to obtain more information about the provider disciplinary, termination and termination appeals processes.

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If Optum Public Sector chooses to terminate a provider's contract, the provider is required to complete authorized episodes of treatment with current clients unless it is clinically contra-indicated. The provider must work with Optum Public Sector to transition the clients to a new provider in a clinically appropriate manner.

Reporting Requirements – 805 Reports and National Practitioner Data Bank (NPBD)

Optum Public Sector re[ports all adverse Actions designated as reportable adverse actions, pursuant to applicable state and federal to state licensing boards, the Medical Board of California and the National Practitioner Data Bank (NPBD) in the event that a provider's network participation is restricted or terminated due to quality issues.

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Provider Obligations

To ensure that clients receive the highest quality care, contracted providers are required to maintain a safe facility and practice within ethical and legal guidelines. Obligations include storing and dispensing medications in compliance with State and Federal laws and regulations, and promoting effective clinical treatment and service responsiveness that results in positive outcomes.

The following pages outline the provider's contractual obligations as a MHP provider of Medi-Cal funded services.

Take note:

It is important that all providers are familiar with the Recovery Model of Psychosocial Rehabilitation. The client's self-determination and recovery from mental illness is the foundation of this model.

Clinical Orientation

Recovery Model of Psychosocial Rehabilitation

Providers are encouraged to become familiar with psychosocial rehabilitation as well as the principles and procedures of cost-effective, outcomes-oriented behavioral healthcare. The Recovery Model of Psychosocial rehabilitation is designed to empower individuals with severe and persistent mental illness to achieve improved levels of competence, independence and involvement in their community. It provides people who have a psychiatric illness with the opportunities, abilities, and support to achieve their own goals within their cultural context. Recovery, as defined by the client, is the ultimate goal of psychosocial rehabilitation.

The MHP embraces the Recovery Model of psychosocial rehabilitation. Self-determination, empowerment, and recovery form the foundation of a recovery-based system. Research has demonstrated that consumers who have the most opportunity to control their own care have the greatest potential for recovery. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. For still others, recovery is the ability to make choices concerning their own lives and future.

Coordination of Care

Coordination of care is essential for a mental health system to work efficiently. Coordination of care includes inpatient and outpatient services and providers of mental health, physical health, and substance abuse services. Coordination supports clients' efforts to achieve and maintain the highest possible level of stability and independence. In addition, providers are required to inform consumers about community based opportunities to maximize recovery. For more information about community based services and opportunities for clients, including substance abuse information, please contact the Access in Crisis Line at (888) 724-7240.

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Providers are required to coordinate the client's mental health services with other professionals treating the client and to refer the client to appropriate community services when indicated, based on the client's goals, a clinical assessment and the response or lack of response to the treatment provided. Please review the Authorization of Services section for more information on provider obligations in coordination of care and how to get authorization for these services.

Acceptance of Contracted Rate

Providers agree to the MHP negotiated rate for services as payment in full. This means that the client/family may not be "balance billed" for the difference between the contracted rate and the provider's usual and customary fees. In addition, Medi-Cal does not reimburse providers for "no show" appointments. If a provider is being reimbursed for services rendered to a Medi-Cal client by CWS, he/she agrees to the CWS negotiated rates and, may not bill the client/family.

Full Scope Medi-Cal

Clients with Full Scope Medi-Cal are not required to pay the provider co-pay. There are Medi-Cal clients that do not have Full Scope Medi-Cal. These clients have Share of Cost Medi-Cal and the required co-payment is determined by the Uniform Method for Determining Ability to Pay (UMDAP) process, which is based on their financial resources. Refer to the Claims section of this manual for detailed information on Share of Cost Medi-Cal.

Availability

The MHP has identified standards for access to emergency, urgent, and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for a face-to-face assessment as follows:

Emergency Services

Title 9 defines an "Emergency Psychiatric Condition" as a condition in which the person, due to a mental disorder, is a current danger to self or others, or is gravely impaired in the ability to provide for or utilize food, shelter, or clothing. These situations require psychiatric inpatient hospital or psychiatric health facility services.

There may be an occasion in which one of a provider's current Medi-Cal clients presents (in person or by telephone) in an emergency condition. In that situation, the provider is responsible for scheduling the necessary emergency services for that client.

The standard that must be met for emergency services is: **Face-to-face clinical assessment within one (1) hour of initial client request or referral.**

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Urgent Services

Title 9 defines an “Urgent Condition” as a condition that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

The standard that must be met for urgent services is: **Face-to-face clinical assessment within 48 hours of initial client request of referral.**

Routine Services

This is a situation in which a person is relatively stable and in need of initial assessment for Specialty Mental Health Services.

The standard that must be met for routine services is: **Face-to-face clinical assessment within 10 business days of initial client request or referral.**

Providers are expected to arrange coverage for emergencies, after-hours inquiries, and when the provider is ill or on vacation. If a provider is treating a client in an acute care setting, the provider must arrange for another contracted provider to follow the client’s care in his/her absence. If the provider is unable to take on any additional clients for a period of time, he/she must notify Optum Public Sector Provider Services to stop/prevent referrals. Likewise, when the provider becomes available again, Provider Services must be re-contacted to open/commence referrals once more. Provider Services can be reached at (800) 798-2254, option 7.

Hours of Service Availability

Providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial and private pay clients. If the provider serves only Medi-Cal clients, the hours of service availability must be the same for fee-for-service and managed care plan clients. Providers are also expected to ensure that hours of operation are convenient to the cultural and linguistic needs of clients in the surrounding geographic area.

Wait Time Attestation

In order to ensure compliance with Senate Bill 1135 standards of 48 hours for Urgent appointments and 10 business days for Non-Urgent Appointments providers are required to complete a Wait Time Attestation twice a year to reflect the time a client must wait to get an appointment at each office in which the provider renders services. This attestation is available online and can be completed in conjunction with the required Practice Information Verification and Validation attestation. Providers whose wait times exceed the standards must close themselves to new referrals until the wait times are back within standards. Providers may close an office to new referrals by contacting Provider Services at sdu_providerserviceshelp@optum.com.

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Verification of Providers Demographic and Practice Information

Fee For Servicers (FFS) Medi-Cal beneficiaries may be referred to you by the Access and Crisis Line (ACL) or through self-referral based on a review of information available in the FFS Providers Directory on the Consumer & Families section of the Optum Public Sector Website or Optum Public Sector Online FFS Provider Directory (07/01/2017). Referrals, timely access to appropriate services, and your receipt of claim payments rely on the information you provide. It is critical that this information be kept current and accurate.

As a network provider, you must notify us when there is a demographic change pertaining to your practice, your specialties change, when you practice is full, or when you are not able to accept new FFS clients/patients for any reason.

Take note:

Providers are required to notify Provider Services:

- If providers are not accepting new referrals
- If a provider's location has changed
- If a provider's phone number or answering service has changed
- If a provider acquires any additional training or new credentials for clinical and cultural specialties.

Requirement to Notify in Case of Incident

Providers are required to notify Optum Public Sector Provider Services in writing within 10 business days of the occurrence of any of the following:

- Action which may result in the revocation, suspension, restriction, probation, termination, voluntary relinquishment of, sanction condition, limitation, qualification or material restriction on Provider's licenses, certifications or permits
- Any legal action pending against Provider for professional negligence
- Any indictment, arrest, or conviction for a felony or for any criminal charge related to the practice of Provider's profession
- Any judgments against Provider which might materially impair Provider's ability to carry out responsibilities under this Agreement
- Any change in name or ownership or Federal Tax I.D number
- Any lapse or material change in liability insurance required by this Agreement
- Any limitation on, restriction, suspension, revocation, voluntary relinquishment of or any other adverse action taken against Provider's medical staff membership or clinical privileges at any health care facility. Provider need not notify of any action which lasts thirty (30) days or less.

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Requirement to Notify in Case of Status and Practice Changes

Providers are required to notify Optum Public Sector Provider Services within 10 business days of changes to the status of their practice and demographics including:

- Name (legal change)
- Practice Address
- Phone number(s)
- Area of specialty/expertise, including board certification(s), if applicable
- Office email address (for client use), if applicable (NOTE: must be "Secure" and HIPAA compliant)
- Business email address (If this email is also used by client's it must be "Secure" and HIPAA compliant)
- (MD Only) Hospital admitting privileges, if applicable *(County contracted facilities)*
- * Accepting New Patients/Clients
    - (* *Accepting new referrals through the Access and Crisis Line (ACL), FFS Providers Directory on the Consumer & Families section of the Optum Public Sector Website and/or Optum Public Sector online FFS Provider Directory [07/01/2017]).*

Practice Information Verification and Validation

Optum Public Sector will be outreaching to providers semi-annually to verify the accuracy of their demographic and clinical specialty information as well as whether or not new referrals are being accepted by the provider through the Access and Crisis Line and Provider Directory. The regulations require that we obtain a response from the provider in 30 days, either verifying that the information is accurate or providing any needed updates.

Optum Public Sector requires that all providers cooperate fully with the outreach efforts and respond promptly and thoroughly to the outreach efforts. Failure of providers to validate/attest to the accuracy and status of their practice information may result in a delay of payments and administrative termination from the network.

Submitting Changes, Updates and Validation Attestations

Currently, each provider has a unique link that has been set up to display his/her personal provider profile including office locations, contact information and clinical expertise/specialties. Providers can attest to the accuracy of the information or request updates/changes at this link.

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Providers may also submit changes/updates by electronic mail, at sdu_providerservicesehelp@optum.com, by fax to Provider Services at (877) 309-4862, or by USPS mail to:

Optum Public Sector
Attn: Provider Services
P.O. Box 601370
San Diego, CA 92160-1370

Coming Soon: A New Provider Portal is in progress at this time. Once completed this portal will allow each provider to individually register and access his/her information online to make updates/changes and completed the required attestations. Providers will be notified via email blast with registration instructions once the portal is available.

Information Privacy and Security Provisions

The provider must protect the privacy and security of Optum Public Sector and County information that the provider may create, receive, access, store, transmit and/or destroy. In addition to the below responsibilities the provider shall be in compliance with the following rules, regulations, and agreements as applicable:

- Health Insurance Portability and Accountability Act, specifically, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, 42USC section 17921 et seq., and 45CFR Parts 160 and 164, collectively referred to as "HIPAA;"
- Title 42 Code of Federal Regulations, Chapter 1, Subchapter A, Part 2

Definitions

Terms used, but not otherwise defined, in this Article shall have the same meaning as defined by HIPAA.

- PHI - Shall have the sane meaning as PHI under HIPAA, specific to PHI under the provider's contract/agreement
- "Breach" of Protected Health Information (PHI) shall have the same meaning given to the term "breach" under HIPAA

Responsibilities of Provider

- Use and Disclosure of PHI: Providers shall use the minimum PHI required to accomplish the requirements of their Agreements or as required by Law. Provider may not use or disclose PHI in a manner that would violate HIPAA or any other applicable the State Agreement(s).

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- Safeguards: Providers shall develop and maintain a HIPAA-compliant information privacy and security process to prevent use or disclosure of PHI, other than as required by their Contract/Agreements.
- Mitigation: Provider shall mitigate any harmful effects caused by violation of these requirements, as directed by the Optum Public Sector.
- Cooperation with Optum Public Sector and the County:
  - Providers shall provide access to Optum Public Sector to PHI, at the request of Optum within ten (10) calendar days.
  - Providers will assist Optum Public Sector regarding a client's success, copy, amendment, accounting of disclosure, and other requests for PHI in a time and manner designated by Optum Public Sector.
- Breach Reporting: Providers shall report breaches and suspected security incidents to Optum Public Sector's Quality Improvement Department via email at SDQI@optum.com to include:
  - Initial Report:
    - Immediately Upon Discovery – An incident that involves information related to the Social Security Administration
    - Within one (1) Business Day of the Discovery: Any suspected security incident or suspected breach of PHI.
      - Additionally, the provider shall complete and submit a "Privacy Incident Report" which is posted on Optum Public Sector's website within one (1) business day.
- Data Security: Provider shall comply with data security requirements as specified by HIPAA and any applicable State Agreement(s), including but not limited to:
  - Complete privacy and security training to include a signed certification within thirty (30) days contracting, and at least annually thereafter

Take note:

MHP clients are entitled to receive the same clinical treatment and service delivery that is provided to privately funded clients. Providers also are expected to meet the cultural competence requirements developed by the MHP to ensure that the clinical needs of clients from diverse backgrounds are met.

Take note:

The CPT code submitted on a claim form and the amount of time a provider spends face-to-face with a client must match the amount of time associated with that CPT code in the provider's contract, fee schedule and the most current edition of the American Medical Association Procedural CPT Codebook.).

Clinical Records and Documentation

All providers are required to prepare and maintain appropriate medical records on all clients receiving services in compliance with Title 9, Chapter 11 and 42 CFR guidelines. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. Medical records are to be kept in a locked storage area to assure confidentiality and safety. Providers are expected to meet minimum requirements for records retention as designated by the Department of Health Care Services or their licensing body, whichever is longer.

Providers are required to take reasonable precautions to ensure that billing and/or coding of client services are prepared and submitted accurately, timely,

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and in compliance with all applicable federal, State, local laws, rules and regulations and HHSA's policies and procedures.

Providers must only bill for eligible services actually rendered and fully documented. When coding for services, only billing codes that accurately describe the services and the time spent on delivering the services provided shall be used. Providers may not engage in billing for services rendered by another individual (e.g. an LMFT/LCSW/LPCC intern or psych assistant). In addition, providers are expected to act promptly to report and correct problems, if errors in claims or billings are discovered.

In accordance with the documents referenced above, it is the provider's responsibility to provide and document the following for services delivered:

- Client data and identifying information
- An initial assessment identifying target symptoms
- A Client Treatment Plan, completed in collaboration with the client or parent/ guardian and family, which sets realistic treatment goals and provides clear expectations for treatment and outcomes
- Progress Notes that reflect progress towards treatment goals and the appropriate level of treatment intensity
- Administrative or legal documentation reflecting collaboration with other social service providers
- Evidence of cultural competence when necessary to meet the needs of a client

If co-existing substance abuse or medical problems exist, the provider is expected to make collateral referrals, and coordinate care with other providers working with the same client. Providers should coordinate ongoing treatment with the client's PCP and other behavioral health providers involved in the client's care.

Please refer to the forms section on the Optum Public Sector website for additional details including a *Documentation Tip Sheet* regarding medical record documentation requirements.

Take note:

MHP clients are entitled to receive the same clinical treatment and service delivery hat is provided to privately funded clients. Providers also are expected to meet the cultural competence requirements developed by the MHP to ensure that the clinical needs of clients from diverse backgrounds are met.

Take note:

The CPT code submitted on a claim form and the amount of time a provider spends face-to-face with a client must match the amount of time associated with that CPT code in the provider's contract, fee schedule and the most current edition of the American Medical Association Procedural CPT Codebook.).

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Ethical, Legal and Billing Issues Hotline

The County of San Diego's MHP has created a hotline to report concerns about a variety of ethical, legal, and billing issues. The confidential hotline is toll-free and available 24 hours per day, seven days per week. Callers may remain anonymous, if they wish. The number of the Compliance Hotline is (866) 549-0004.

Non-Discrimination and Cultural Competence Requirements

Optum Public Sector makes every effort to refer to providers with the ethnic and cultural background requested by the client. A client has the right to a second opinion and referral to a new provider, if the client is not satisfied with the cultural expertise of a provider.

The State and County requires cultural competency requirements to be met in the provision of the following services:

- Interpreter services
- Culturally appropriate assessments and test interpretation (as indicated)
- Utilization of peer consultants (as indicated)

To this end, all providers are required to obtain a minimum of four hours of cultural competence training per calendar year on the effect of ethnicity and culture on mental health issues and treatment.

Written materials pertaining to client rights (e.g., Complaint and Grievance brochures, complaint filing forms, Beneficiary Handbooks, NOA-As and NOA-Bs) are available in English, Spanish, Vietnamese, Arabic, Farsi, and Tagalog. Please refer to the Beneficiary Rights section of this handbook for further information regarding these materials.

Interpreter Services

Providers requiring initial authorization for interpreter services, including American Sign Language should complete an Interpreter Request form located online at www.optumsandiego.com. Providers must complete the required fields on both pages of this form and fax it to Optum at (866) 220-4495 at least two (2) days prior to the initial appointment. Optum will issue an authorization and set up the interpreter services for the initial appointment ONLY. This authorization will cover all subsequent visits with that particular provider if ongoing sessions are authorized after submission of the OAR. The provider is responsible for requesting interpreter services for ongoing sessions directly with the interpreter services. The interpreter services agency will receive the Service Authorization Request form, which includes the authorization number and dates of service authorized.

Take note:

Providers are required by Title 9 to give each client a MHP beneficiary handbook at the client's first appointment, or upon request. To obtain a copy of the beneficiary handbook, contact the Strategic Planning and Administration Unit at (619) 563-2713.

Providers are required to obtain at least four (4) hours of cultural competency training per year.

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Interpreter Services - Continued

The MHP covers the cost of interpreter services. Providers are not permitted, per Title 9, to use family members to interpret for other family members. In addition, clients must be informed, in a language they understand, that they have the right to free language assistance services. Clients cannot be billed for interpreter services. Questions regarding provider cultural competence requirements may be directed to MHP QI Department at (619) 563-2713.

Serious Incident Reporting (SIR)

All providers are required to report unusual occurrences or "serious incidents" involving clients in active treatment to San Diego County Behavioral Health Services (BHS), in accordance with policies and procedures established by the MHP. Serious incidents are identified below:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet).
- Death of a client by suicide, under questionable circumstances or by homicide.
- Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or significantly injurious.
- Alleged homicide committed by or attempted by a client, alleged homicide attempt on a client.
- Injurious assault on a client (client is victim) occurring on the program's premises resulting in severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Injurious assault by a client (client is perpetrator) occurring on the program's premises resulting in severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Tarasoff Notification is made by or received by provider or program.
- Serious allegations of or confirmed inappropriate staff behavior, such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.
- Serious physical injury resulting in a client experiencing severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Adverse medication reaction resulting severe physical damage or loss of consciousness, respiratory, or circulatory collapse.

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Serious Incident Reporting (SIR) – Continued

- Medication error in prescription or distribution resulting severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Apparent overdose, whether fatal or injurious, requiring medical attention.
- Major confidentiality breach (lost or stolen laptop, large number of client files/ records accessed, etc.)
- Use of physical restraints only during program operating hours (applies to CYF mental health clients and excludes ADS programs, Hospitals, Long-Term Care Facilities, San Diego Psychiatric Hospital/EPU, ESU and PERT).

For a **Level One** Serious Incident Providers are required to call the BHS Serious Incident Report Line **immediately at 619-563-2781 and fax the Level One SIR within 24 hours (FAX: 619-236-1953).** A **Level One** Serious Incident is the most sever type of indicant and must include one of the following:

- The vent has been reported in the media or has the potential for significant **adverse media involvement**, i.e. TV, newspaper, internet.
- The event has resulted in a death or serious physical injury ion the program premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health.

All other serious incidents are reported as Level Two incidents.

Providers are required to fax the Level Two (2) Sir within 72 hours of the occurrence, using the *Confidential BHS Serious Incident Report (SIR)* found in the forms section on the Optum Public Sector website. This report should be faxed to the County of San Diego Behavioral Health Services (BHS) at (619) 236-1953. Questions regarding the reporting of serious incidents may be directed to the QM Program Manager at (619) 563-2747.

A Root Cause Analysis (RCA) is required for any serious incident that results in 1) a completed suicide or 2) a major breach of confidentiality. The RCA shall be completed within 30 days of a reported serious incident. The program COR, in consultation with the QM unit, may ask the provider to complete an RCA for other serious incidents.

Additionally, Title 9 requires that FFS providers maintain a log of any serious incidents involving their MHP clients. This log may consist of photocopies of all serious incidents reported by the provider to the MHP QI Department, kept in a binder. The log may be requested for review by the MHP at any time, including at the time of a site review.

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Serious Incident Reporting (SIR) – Continued

Second Opinions

In accordance with Title 9, Section 1850.210, a client has the right to a second opinion, if he/she disagrees with a decision by the MHP or a provider to deny, reduce, or modify services.

An Optum Public Sector Utilization Manager will arrange for an assessment by a Second Opinion provider. The Second Opinion provider conducts an assessment and forwards a recommendation to Optum Public Sector Utilization Management. Optum Public Sector informs the client and original provider of the second opinion decision by letter via certified mail.

NOAs, Appeals and Grievances, State Fair Hearings

Please review the Beneficiary Rights section of this manual for a description of beneficiary rights and provider responsibility to protect those rights in accordance with Title 9 of the California Code of Regulations.

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Claims and Billing

Optum Public Sector, on behalf of the MHP, is responsible for the reimbursement of claims for Specialty Mental Health Services rendered by FFS network providers. The billing procedures found in this section are to be followed for all Specialty Mental Health Services provided to:

- Medi-Cal clients with no share of cost
- Medi-Cal clients with a share of cost
- Clients with both Medicare and Medi-Cal (Medi-Medi)
- Clients with Medi-Cal and other insurance coverage
- Clients with no Medi-Cal or a restricted Medi-Cal benefit
- Out-of-County Clients

In accordance with Title 9, Section 1830.205, the diagnoses below are covered under Outpatient Specialty Mental Health Services. If a client does not have one of the following as a primary diagnosis, medical necessity criteria are not met and services delivered to the client cannot be reimbursed per Title 9 regulations. Title 9 covered diagnoses for outpatient services include:

http://www.dhcs.ca.gov/services/MH/Documents/Title9MedicalNecessityCriteria.pdf

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia and other Psychotic Disorders, except Psychotic Disorder due to a General Medical Condition
- Mood Disorders, except Mood Disorders due to a Medical Condition
- Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilia
- Gender Identity Disorder
- Eating Disorder
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

Take note:

When requesting treatment authorization and submitting claims, providers are asked to only use the MHP approved CPT Codes included in the provider contract. Providers are asked to refer to their contract fee schedule for the official listing of the CPT Codes, the client service minutes associated with each code and the reimbursement amount for the provider's licensure.

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The following diagnoses are ***not covered*** **under** Title 9 Specialty Mental Health Services, unless they are secondary to a covered primary diagnosis:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communications Disorders
- Autism (other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnesic and other Cognitive Disorders
- Mental Disorders due to a general medical condition
- Substance Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorders
- Other conditions that may be a focus of clinical attention, except medication induced movement disorders, which are covered

Verification of Medi-Cal Eligibility

Network providers are required to verify Medi-Cal eligibility prior to the provision of services. The state eligibility system is updated on the 1st of each month; therefore, Medi-Cal eligibility must be verified monthly. Verifying eligibility provides critical information including:

- Medi-Cal coverage type (Aid Code)
- Share of Cost (SOC), if applicable
- County of Residence (must be 37 to bill San Diego Medi-Cal)
- Other insurance coverage
- Ineligible Aide Code

Take note:

San Diego County is code **37** in **AEVS**.

It is the responsibility of the provider rendering services to verify eligibility by calling the Automated Eligibility Verification System (AEVS) at (800) 866-AEVS (2387), or using the website http://www.medi-cal.ca.gov. Providers must have a valid PIN/User ID to access AEVS and may call (800) 541-5555 for assistance obtaining a temporary PIN.

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Providers may use the Medi-Cal Aid Code Master List link provided below to identify the types of services for which Medi-Cal and Public Health Program recipients are eligible.

http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx

LMFT/LPCC Providers Medi-Cal Eligibility Verification

The County of San Diego Behavioral Health Services is contracted with Optum Public Sector to verify Medi-Cal eligibility for Marriage and Family Therapists (LMFT) and Licensed Professional Clinical Counselors (LPCC).

The following outlines the process for LMFT/LPCCs to verify a client's Medi-Cal eligibility. Providers are required to take the following into consideration when verifying Medi-Cal eligibility:

- Providers who intend to verify eligibility for more than one client at one time are asked to use the Fax Request option outlined below.
- Eligibility can only be verified up to one (1) year from date of service.
- A client's Medi-Cal eligibility can change retroactively; therefore, the information provided by Optum Public Sector is based on the client's eligibility status in the Medi-Cal Eligibility Verification System at the time of the request. Medi-Cal eligibility may change by the time services are rendered of the claim submitted for payment.
- A client's Medi-Cal eligibility can change from month-to-month; therefore, providers must verify eligibility for each month of service.

The following information must be provided to Optum Public Sector at the time of the request:

1. Provider's name
2. Provider's phone number
3. Provider's fax number
4. Client's name
5. Client's Medi-Cal ID, BIC, CIN (only one is required)
6. Client's date of birth
7. Month(s) of service

There are two (2) eligibility verification options available:

Fax Request:

Providers may fax the Medi-Cal Eligibility Verification Request Form to Optum Public Sector Claims Representative at (619) 641-6975. Providers are asked to ensure all of the required information on the request form is complete.

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Faxes will be retrieved routinely between 8:00 a.m. and 5:00 p.m. each business day. Upon receipt of the request form, Optum Public Sector will fax back an eligibility verification response to the provider's fax number provided on the request. Optum Public Sector will respond to all requests within one (1) business day.

Phone Request:

Providers may call the Optum Public Sector Provider Line at (800) 798-2254, option 2 to speak to a Claims Representative who will ask for the required information outlined above. Eligibility will be verified during the call and a verbal response will be provided. Optum Public Sector will also fax an eligibility verification response to the provider's fax number provided. Optum Public Sector will respond to all requests within one (1) business day. A Claims Representative will complete the Eligibility Verification Response Fax and fax it to the provider who is requesting confirmation of client eligibility.

Providers may call Optum Public Sector Claims Department at (800) 798-2254, option 2 for any questions.

Submitting Claims for Medi-Cal Services

Providers are required to use ICD-10 codes for all claims. The International Classification of Disease, 10th Revision (ICD-10) is the diagnosis and procedure coding system that replaced the ICD-9 coding system. The use of the ICD-10 Clinical Modification (CM) and Procedure Coding System (PCS) codes is expected to improve the ability to govern reimbursement, monitor a population's health, track trends in disease and treatment, and optimize health care delivery.

Take note:

Providers are required to submit claims no later than 60 days after the date of service.

Providers are required to mail ALL Medi-Cal FFS claims to the following address:

Optum Public Sector Claims
P.O. Box 601340
San Diego, CA 92160-1340

The following outlines the claims submission procedures for various Medi-Cal eligible groups:

1. Claims must be submitted within 60 days from the day of service.
2. All claims must be submitted using an original form CMS-1500. Form CMS-1500 may be purchased at Staples or by calling (888) 212-7219.
3. The following data elements must be included on the form CMS-1500. Claims submitted without these data elements will be denied.
    a. **Box 1a** – Medi-Cal Benefits Identification Card (BIC) number. The BIC number is the 14 digits number, located on the front of clients' Medi-Cal card.

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b. **Box 2** – Client's name

c. **Box 3** – Client's date of birth and gender

d. **Box 5** – Client's complete address

e. **Box 12** – Signature of authorizing party or signature on file

f. **Box 13** – Signature of authorizing party or signature on file

g. **Box 21.1** – Diagnosis using ICD-10, DSM-IV or DSM IV-TR

h. **Box 24 A** – Date(s) of services – one (1) date of service per line

i. **Box 24 B** – Place of service code (office = 11, home = 12, inpatient = 21)

j. **Box 24 D** – CPT Code for service rendered

k. **Box 24 F** – Charge for the service rendered

l. **Box 25** – Federal Tax ID number of the billing provider (Social Security Number or Employee Identification Number)

m. **Box 31** – Name of Rendering Provider of Rendering Provider (or designee) and Date

n. **Box 32** – Service facility location information

o. **Box 33** – "Pay To " Provider/Agency's Name, Address and Telephone Number

Important notes:

- The diagnosis code entered in box 21 must be a Medi-Cal covered diagnosis code and contain ALL of the required digits. Optum Public Sector is required to deny claims with a diagnosis code that does not contain all the required digits.
- The Department of Health Care Services and Optum Public Sector recognize the importance of protecting the identity and the health information of clients; therefore, providers must not include the clients' Social Security Numbers (SSN) on claims. Claims submitted with a SSN will be denied.
- Provider NPI must be on file with Optum Public Sector, and if the provider is associated with a group, the group's NPI must also be on file in order for the claim to be processed.

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Claims Clusters

When an authorization is created, the provider will receive a letter indicating a CPT Code for the authorized service. Some CPT Codes listed on the authorization letter include authorization for associated, or clustered, CPT Codes. The chart below lists these associations.

Providers must bill using the CPT Code, which corresponds to the provided service.

CPT Code/ Group Listed on Authorization	CPT Codes Within Cluster that the Provider Can Bill
90791	90791
90792	90792
IT/CIT	90832, 90834, 90846, 90847, 99341, 99343
MDT/ CMDT	90832, 90834, 99211, 99212, 99213, 99214, 99215, 90846, 90847, 99201, 99202,99203, 99204,99205, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349,99350
ADAT/ CDAT	90833, 90836
X6220	X6220
90853	90853
90870 Outpatient	90870
IPADM/ CIADM	99221, 99222, 99223
IPFUP/ CIFUP	99231, 99232, 99233, 99238, 99239, 90870 (Inpatient)
IDAT/ CIDAT	90833 (Inpatient), 90836 (Inpatient)
CONSU/ CCONS	99251, 99252, 99253, 99254, 99255
ER, CER	99281, 99282,99283, 99284, 99285
96101	96101
MTC (child and adult) (Note: 99366 is child only)	99366, 99367
TCE, CTE	99495, 99496
CM, CCM	Z5831, Z5820

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Share of Cost

Share of Cost (SOC) is a monthly client liability amount (determined by the state) that is based on a client's ability to pay. The SOC must be paid by the client each month for services received during the month, prior to the client accessing Medi-Cal benefits, and prior to the provider being reimbursed by the MHP. A client is not Medi-Cal eligible until his or her entire SOC has been paid. The MHP does not reimburse providers for any SOC. Eligibility verification via AEVS includes the SOC amount. It is the provider's responsibility to certify and clear the SOC through the AEVS by contacting (800) 866-AEVS (2387).

Medi-Cal Clients with Share of Cost (SOC)

- If the client's SOC is greater than the provider's customary charge for the service, the claim may not be filed with Optum Public Sector since the client is responsible for the full amount.
- If the client's SOC has been completely cleared for that month by other services received, the claim should be submitted with the statement "Share of Cost (SOC) Cleared" in box 19 of form CMS-1500.
- If the client's remaining SOC is less than the rate in the provider contract for the service, the remaining SOC should be deducted from the contracted Medi-Cal rate, and the balance should be shown in box 24F, and the statement "SOC Balance" must be written in box 19 of form CMS-1500.

For more information on clearing Medi-Cal Share of Cost, providers may refer to the following document: Share of Costs

Clients with Medicare and Medi-Cal (Medi-Medi)

Providers who serve clients with Medicare and Medi-Cal must bill Medicare before billing Medi-Cal.

Any Medicare deductibles and/or co-payments billed to Medi-Cal on behalf of the client are considered Medicare/Medi-Cal crossover claims and must be billed to ACS directly. These claims may crossover automatically from the Medicare Part B fiscal intermediary or the provider may be required to submit the hard copy crossover claim to ACS at the following address:

Department of Health Care Services (DHCS) Fiscal Intermediary
Attn: Crossover Unit
P.O. Box 15700
Sacramento, CA 95852-1700

Phone: 1-800-541-5555

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Optum Public Sector is responsible for reimbursement of services provided to Medi-Medi clients whose Medicare benefits have been exhausted or denied. When a client's Medicare benefit has been exhausted/ denied, providers must attach a copy of the Medicare Explanation of Benefits (EOB), reflecting the benefits are exhausted or denied, to the Medi-Cal claim that is submitted to Optum Public Sector for payment. Providers are asked to contact Optum Public Sector to obtain an authorization when Medicare benefits are close to exhaustion.

Providers who are not enrolled Medicare providers will not be authorized and reimbursed for seeing clients with both Medicare and Medi-Cal.

Providers serving Medi-Medi clients are required to be Medicare providers. Optum Public Sector cannot reimburse providers for serving Medi-Medi clients when the Medicare denial reason is that the provider is not a Medicare participating provider.

Medi-Cal clients who also have Medicare-contracted Health Maintenance Organization (MCP) or Medicare Advantage plan coverage must seek medical treatment through the plan; neither the plan, nor Medi-Cal/ Optum Public Sector pay for services rendered by non-plan providers.

To bill Optum Public Sector for services not covered by the Medicare MCP or Medicare Advantage plan, providers must submit a hard copy claim to Optum Public Sector, accompanied by the plan denial letter or Explanation of Benefits (EOB) documenting that the plan does not cover the service. These claims are not considered Medi-care/Medi-Cal crossover claims.

If Medicare has made a partial payment or has applied co-insurance / deductible, these claims are submitted directly to Medi-Cal State at the following address:

Department of Health Care Services (DHCS) Fiscal Intermediary
Attn: Crossover Unit
P. O. Box 15700
Sacramento, CA 95852-1700

Take note:

Federal Medicaid regulations state that Medi-Cal is the payer of last resort.

All other health insurance must be exhausted before Medi-Cal can reimburse a provider.

Providers are required to bill Medicare and all other insurance prior to billing Medi-Cal.

Clients with Medi-Cal and Other Health Plan Coverage

When a client's primary insurance/coverage is NOT Medi-Cal the provider must be contracted with that specific Health Plan (the primary insurer) in order to render services to the client. The provider is required to obtain authorization from the client's primary Health Plan and follow that plan's policies and procedures for payment prior to submitting a claim to Optum.

Per Federal Regulations providers must bill all other insurances (Health Plans) prior to billing Medi-Cal. In order for Optum Public Sector to pay any appropriate amount (residual) that may be due to the provider following the payment by the primary Health Plan the provider must obtain a treatment authorization for the client from Optum.

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Optum will not reimburse for services when:

- A claim to the primary Health Plan has been denied because a provider did not follow the required policies for reimbursement (*The provider is responsible to know the reimbursement policies for any health plan he/she has a contract*).
- A claim is denied because a provider is not contracted with the primary Health Plan; this applies to all other Health Plans including Medicare.

When submitting Medi-Cal claims for clients with other Health Plan coverage, Optum Public Sector must receive the claim within 60 days of the provider's receipt of the primary Health Plan's Explanation of Benefits (EOB), but no later than six (6) months from the date of service. Claims must be submitted to the primary Health Plan in a timely manner in order for the provider to submit the claim to Optum Public Sector within six (6) months of the date of service.

Take note:

To apply for a **Medi-Cal PIN**, providers may call the Medi-Cal Provider Support Center at **(800) 541-5555**.

The Explanation of Benefits (EOB) from the primary Health Plan must be attached to the form CMS-1500 when claiming a residual Medi-Cal amount.

Providers are asked to mail Medi-Cal FFS claims to the following address:

Optum Public Sector San Diego
P.O. Box 601340
San Diego, CA 92160-1340

Clients with No Medi-Cal Insurance, or Restricted Medi-Cal Benefit

At the present time, non-Medi-Cal eligible clients will not be referred to FFS providers. However, some clients may have restricted or partial Medi-Cal benefits as indicated by the Aid Codes. If those Aid Codes do not cover the services requested, then the client should be considered a non-Medi-Cal client. If a client's Medi-Cal Aid Code does not cover mental health treatment and claims are denied by the State, recoupment of paid funds will be made through the MHP.

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Out-of-County Clients

Financial responsibility for a Medi-Cal client rests with the client's County of residence, as specified by the County code, with the exception of children in the Adoption Assistance Program (AAP) & KIN GAP. Please contact Provider Services at (800) 798-2254, option 7 for information on the AAP. The county code for San Diego County is 37.

If the person requesting service is not a resident of San Diego County, it is the provider's responsibility as the provider of services to contact the appropriate County for authorization and billing information.

Out-of-State Clients

The MHP may be responsible for paying claims for out-of-State Specialty Mental Health Services when the recipient resides in a "border community". A border community is a community located outside the State of California, which is not considered to be out-of-State, because of its proximity to California and historical usage of California providers by Medi-Cal beneficiaries of that community. Examples of border communities include, but are not limited to: Ashland, Oregon; Carson City, Nevada; Yuma, and Arizona. A complete list of border communities is found in Title 9, Section 1810.205.1.

Claims Processing Procedures

All claims must be submitted within 60 days from the date of service. Clean claims will be processed within 30 days from the receipt of the claim. Processing means paid or denied.

A denied claim that has been corrected must be resubmitted within 45 days from the date of the Explanation of Benefits (EOB), but no later than four (4) months from the date of service.

All payments will be made based on the approved fee schedule in effect at the time service is delivered.

Overpayment

Overpayments may be offset against future claims payments. This includes claims reimbursed by Optum Public Sector and subsequently denied by Medi-Cal. In such cases, the provider will be notified of the action and given 30 days to appeal. Appeals should be submitted as described in the Issue Resolution section of this handbook.

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Should a provider choose to return excess funds on his or her own check, the check must be made payable to "County of San Diego" and mailed to Optum Public Sector/ Claims Department at the address below for processing:

Optum Public Sector San Diego
Claims/Refunds
Attn: Claims Manager
P.O. Box 601340
San Diego, CA 92160-1340

How to Submit Billing Inquiries

Providers may submit specific questions regarding claims to Optum Public Sector via phone or facsimile.

Providers may call (800) 798-2254, option 2 for all claims related inquiries.

Providers may also submit questions via facsimile to (619) 641-6975.

Written inquiries may be sent to:

Optum Public Sector San Diego
Claims Services
Attn: Claims Manager
P.O. Box 601340
San Diego, CA 92160-1340

Ethical, Legal and Billing Issues Hotline

The County of San Diego's MHP has created a Hotline to report concerns about a variety of ethical, legal, and billing issues. The confidential Hotline is toll-free and available 24-hours per day, seven days per week. Callers may remain anonymous, if they wish. The number of the County of San Diego's MHP Compliance Hotline is (866) 549-0004.

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Issue Resolution

At times a provider may disagree with Optum Public Sector regarding a clinical or administrative issue. Providers are encouraged to communicate any issues or concerns regarding clinical decisions or claims and billing procedures to Optum Public Sector. Optum Public Sector is committed to responding in an objective and timely manner. Optum Public Sector will attempt to resolve the issue informally through direct discussion with the provider. However, if the problem is not resolved to the satisfaction of the provider, a formal appeal process is available.

All provider problem resolution and appeals processing is governed by Title 9, Chapter 11, Section 1850.305. Providers may contact Provider Services at (800) 798-2254, option 7, for any questions regarding the timelines or regulation of the process.

Provider Appeals Process

Providers who wish to pursue an appeals process regarding authorization for reimbursement of services, or processing and payment of claims, have the right to access the provider appeals process at any time.

A provider may appeal a denied or modified request for payment authorization. The written appeal shall be submitted to Optum Public Sector within 90 calendar days of the date of receipt of the non-approval of payment notification.

Providers are asked to submit a letter of appeal along with any relevant documents that support medical necessity of the services requested. Appeal requests must be sent to the following address:

Optum Public Sector
Attn: Appeals
P.O. Box 601340
San Diego, CA 92160-1340

A psychiatrist who was not involved in the initial denial or modification of a payment authorization request shall determine the appeal decision.

Optum Public Sector shall have 60 calendar days from receipt of the written appeal to inform the provider in writing of the decision.

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Claims and Billing Issues

Clean claims will be processed within 30 days of receipt of the claim. Processing means paid or denied. In the event of a denial, providers may appeal the decision by contacting the Claims Provider Service Representative at (800) 798-2254, option 2. The Claims Provider Services Representative will forward the information to the Senior Claims Examiner who will assist the provider in resolving the appeal informally. The provider may be asked to submit written documentation justifying the request to overturn the denial.

Should the outcome of the informal problem resolution process result in a decision that the provider feels is not satisfactory, the provider may submit a claims appeal in writing with supporting documentation to:

Optum Public Sector San Diego
Attn: Claims Provider Services
P.O. Box 601340
San Diego, CA 92160-1340

Acknowledgment of written appeals will be mailed to providers within two (2) business days of receipt. Providers are asked to make sure to have the client name, Medi-Cal BIC number, date(s) of service and authorization number with supporting documentation available when calling. A written response will be sent to the provider within 30 days of receipt of the claims appeal.

Provider Complaints about Administrative and Contract Issues

Provider complaints about Optum Public Sector administrative procedures, referral authorizations, forms, response or lack of response by an Optum Public Sector employee, as well as other general questions and concerns about policies and procedures, can be discussed with any Optum Public Sector staff person with whom the provider comes in contact. Optum Public Sector documents the content of the complaint and is obligated to come to a resolution within 30 days of receiving the complaint. The participation of providers in this process is viewed as a reflection of the providers' genuine commitment to improve the quality of care and service. Providers are protected from any form of retaliation, because of complaints about denied authorizations or claims. Optum Public Sector tracks and trends the data gathered from complaints and appeals and uses this information to focus quality improvement initiatives.

Providers may present complaints, issues, or concerns to Optum Public Sector by contacting the Provider Line at (800) 798-2254, option 7, or by calling the MHP QI Department at (619) 563-2713.

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Telephone/ E-mail/ Website Directory

Optum Public Sector Access and Crisis Line	(888) 724-7240
Provider Line	(800) 798-2254
Crisis Calls	Press 1
Claims/ Medi-Cal Eligibility Verification	Press 2
Hospital Authorization	Press 3
Outpatient Authorization	Press 4
Authorization/ Correspondence Questions	Press 5
Clinical Questions	Press 6
Provider Services	Press 7
Provider Services E-mail	sdu_providerserviceshelp@optum.com
Term Provider Line	(877) 824-8376
Status of Authorization or Reports	Press 1
CWS Claims/ Billing Questions	Press 2
Joining TERM provider network or credentialing or contracting questions	Press 3
Clinical questions regarding psychological or Psychiatric or treatment plans	Press 4
Claims Provider Services e-mail	psclaims@Optum.com
Fax Numbers	
Clinical Operations	(866) 220-4495
Secure Facility/ Long Term Care (SF/LTC)	(888) 687-2515
Provider Services	(877) 309-4862
Treatment Evaluations and Resource Management	(877) 624-8376
Business Operations/ MIS/ Finance & Claims	(619) 641-6975

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Optum Public Sector	(619) 641-6800
Management Phone Numbers:	
Executive Director	(619) 641-6818
Medical Director	(619) 641-6807
Director of Business Operations	(619) 641-6252
Director of Clinical Operations	(619) 641-5302
Director of Behavioral Health Network and Quality Improvement	(619) 641-6285
Manager of Access and Crisis Line	(619) 641-6218
Manager of Utilization Management	(619) 641-6831
Manager of Provider Services	(619) 641-6832
Manager of Claims	(619) 641-6668
Manager of Quality Improvement	(619) 641-6813
Manager of Administrative Operations	(619) 641-6241
Sr. Manager of Management Information Services	(619) 641-6868
Sr. Manager of Business Analysis/ Operations	(619) 641-6225
Important Phone Numbers:	
CA Automated Eligibility Verification System (AEVS)	(800) 456-2387
Consumer Center For Health, Education, and Advocacy (CCHEA)	(877) 734-3258
Jewish Family Services Patient Advocacy	(800) 479-2233
County of San Diego Behavioral Health Services Quality Management	(619) 563-2747
San Diego Mental Health Plan Administration	(619) 563-2700

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Directory

Websites

Optum Public Sector – Provider Website www.optumsandiego.com

County of San Diego www.co.san-diego.ca.us

California Department of Mental Health www.dhcs.ca.gov

California Medi-Cal Homepage www.medi-cal.ca.gov

California Medi-Cal Provider Manuals

http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

Behavioral Health Education and Training Academy (BHETA)

http://theacademy.sdsu.edu/programs/BHETA/index.htm

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