



Fee for Service Outpatient Changes

Agenda

- Who is Optum?
- Medi-Cal Managed Care Plans (MCP)
- Fee for Service (FFS) Outpatient Target Population
- Mental Health Severity Analysis
- Authorization Process
- Accessing Forms
- Treatment Philosophy
- Partnership
- Resources
- Contact Information
- Questions/Answers

Who is Optum?

- Optum is the Administrative Service Organization for the County of San Diego, Behavioral Health Division
- Contract includes, but not limited to: Operation of the San Diego County Access and Crisis Line (ACL) and Utilization Management (UM)
- Through the ACL, Optum provides 24 hour crisis intervention, suicide prevention and referrals. Through UM, Optum provide authorizations for Inpatient Psychiatric Hospitalization and Outpatient Fee for Service services



Medi-Cal Managed Care Plans

- There are five Managed Care Plans (MCPs) who provide Health Plan options to San Diego Medi-Cal beneficiaries
- Care1st, Community Health Group, Health Net, Kaiser, and Molina with two additional plans approved to offer services soon: Aetna and United Community and State
- Covers beneficiaries' medical needs and mild to moderate outpatient behavioral health needs and Applied Behavioral Analysis Treatment
- Beneficiaries may change Managed Care Plans, and in rare circumstances, they may not have a MCP; County will assume responsibility if there is no assigned MCP



Fee for Service (FFS) Population

- Clients with serious and persistent psychiatric illness requiring complex biopsychosocial services to maintain stability
- Children with a DSM diagnosis with behavior inappropriate to the child's age according to developmental norms and a substantial impairment in two areas of life functioning
- Children at risk of removal from home/have been removed from home **OR** the impairment has lasted more than six months
- Children presenting with clinical risk: psychosis, suicidal ideation, and/or violence
- Children who meet special education eligibility

The Mental Health Severity Screening/Analysis

- The severity index and other information on target population is available at: optumsandiego.com



Home | County Staff & Providers | Access & Crisis Line

Home > County Staff & Providers

Fee for Service Providers

TERM Providers

Organizational Provider Public Documents

Skilled Nursing Facilities

Healthy San Diego

Forms

Name

HSD MediCal BH IP Guide.doc

HSD MediCalQuickVIDTool.docx

ExpandSeverity FAQ 050514.pdf

More forms below

- The County of San Diego and the Medi-Cal MCPs worked together to develop criteria and tools
- A shared conceptual framework and a useful guide regarding mild, moderate, and severe criteria to assess with clinical perspective
- Uses four elements: Risk, Clinical Complexity, Life Circumstances, and Benefit of Integrated Care
- Use of guide is recommended to ensure assessment alignment across System of Care

Mental Health Severity Analysis – Symptom Examples

FFS and/or other County Providers

- ✓ Acute risk for SI/harm to others
- ✓ Psychosis
- ✓ Cognitive Impairment
- ✓ Impulsive/Aggressive
- ✓ Seriously incapacitated in daily activities
- ✓ Many Mental Health hospitalizations
- ✓ On conservatorship
- ✓ Chronic Mental Health conditions

MCP Behavioral Health

- ✓ Situational issue: loss, break-up, major life change
- ✓ Disruption in relationships resulting in extreme distress
- ✓ Excessive truancy or suddenly failing school
- ✓ Likely to be resolved in 6 mo. or less
- ✓ Stable on meds for 1 yr. or longer

San Diego County Access and Crisis Line 888-724-7240

Operates 24 Hours a day, 7 days per week

Provides Suicide Prevention, Crisis Intervention and Referrals

Adult Medi-Cal Mental Health Severity Analysis

Adult Medi-Cal Mental Health Severity Analysis

Mental Health Plan will follow Medical Necessity Criteria for Medi-Cal Specialty Mental Health Services described in Title 9, CCR

Element	Mild (1)	Moderate (2)	Severe (3)	(0) N/A
Risk (suicidal/violent, high risk behavior, catastrophic illness/loss, criminogenic behavior, impulsivity, insight, ego discordance)	Passive ideation or fantasy—no danger to self/danger to others (DTS/DTO) history Good impulse control Minimal criminal background, Good insight Ego dystonic (refers to thoughts, impulses, and behaviors that are viewed as unacceptable, distressing, or inconsistent with one's self-concept)	Passive ideation or low level active with DTS/DTO history Rare loss of impulse control Mid-level nonviolent arrests, brief jail time Fair insight Ego dystonic	Recent or current active ideation, intent or plan Poor impulse control Violence related arrests, jail or prison time Poor insight Ego syntonic (refers to instincts, ideas, and behaviors that are viewed as acceptable to one's self, are compatible with one's values and ways of thinking or are consistent with one's fundamental personality or beliefs)	
Clinical Complexity (serious & persistent mental illness vs situational/reactive, recovery status, functional & cognitive impairment, treatment resistance, medication complexity, frequent hospitalization, co-occurring medical and alcohol or drug disorder (AOD))	Adjustment reaction Minor depression/anxiety Grief, job loss, marital distress, relationship difficulty No cognitive impairment No prior serious mental illness (SMI) history Limited AOD use	Schizophrenia, major mood or anxiety disorder - stable on medications, baseline function, sustained recovery Prior history of effective treatment, uncomplicated management Minimal cognitive impairment No recent hospitalizations AOD misuse (e.g., multiple emergency room visits at different hospitals)	Schizophrenia, major mood or anxiety disorder, recent instability or worsening function, precarious recovery, cognitive impairment Recent/repeated hospitals AOD dependence Prior history of treatment resistance or complexity (e.g., polypharmacy)	
Life Circumstances (biopsychosocial assessment, availability of resources, environmental stressors, family/social/faith-based support, resilience)	Emotional distress arising in the course of normal life stresses Adequately resourced & supported Resilient	Intermittent emotional distress as a manifestation of a mental illness which is worsened by life stresses Limited resources & support Strained resilience	Persistent emotional distress a manifestation of chronic mental illness Relies on behavioral health system for resources & support Limited resilience	
Benefit of Integrated Care (optimal for stable patients with co-occurring mild to moderate physical and mental illness, limited transportation or unique clinical/cultural needs not well suited for split care)	High (1) Already established, effective care in primary care setting for chronic stable medical + co-occurring mild mental illness/emotional distress	Medium (2) ← High medical, low behavioral High behavioral, low medical →	Low (3) Already established (or pending) care with County provider for complex SMI Relies on behavioral health system for resources & support Low recovery	
Total:	Tier 1 (0-4)	Tier 2 (5-8)	Tier 3 (9-12)	
Referrals	Augmented Primary Care Provider (PCP)-Impact Health Plan Network: -Federally Qualified Health Center (FQHC) -Health Plan Behavioral Health (BH) Network	Health Plan Network: -FQHC -Health Plan BH Network	County Mental Health Plan (MHP): -County Clinics -FQHC -Organizational Provider -Optum Fee-for-Service (FFS) Provider	

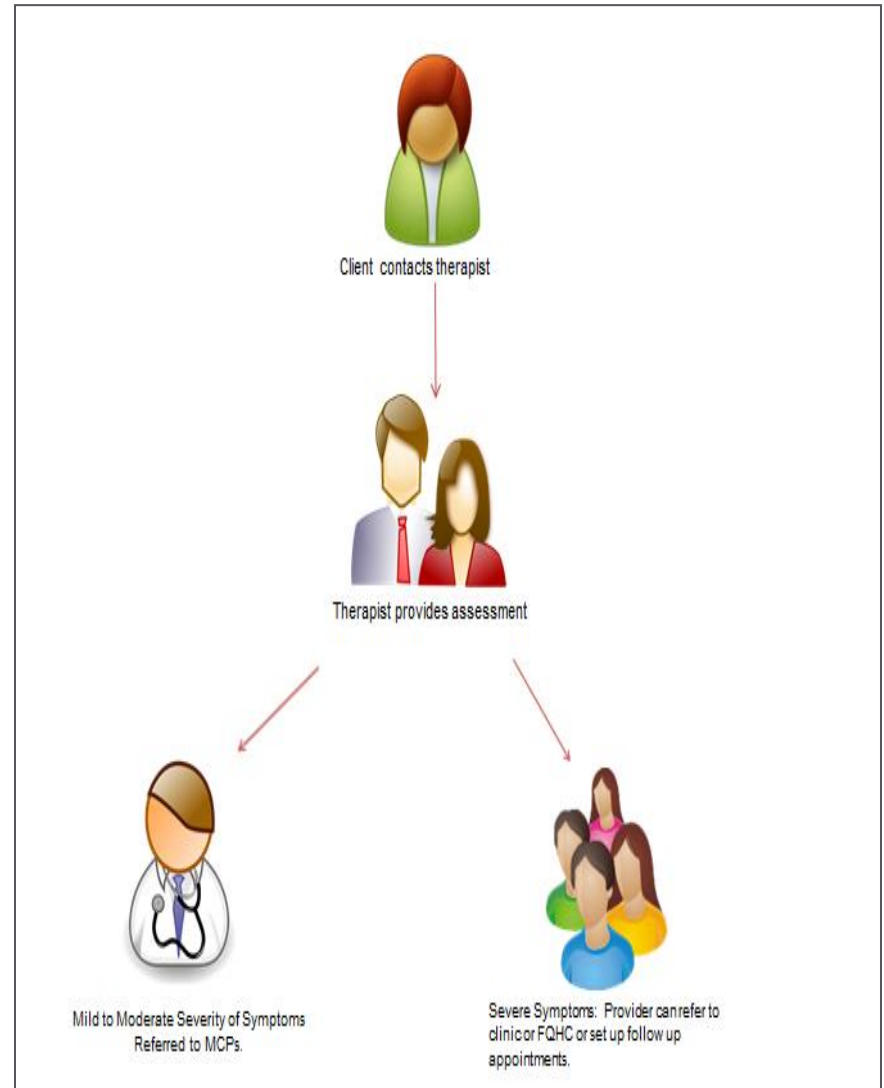
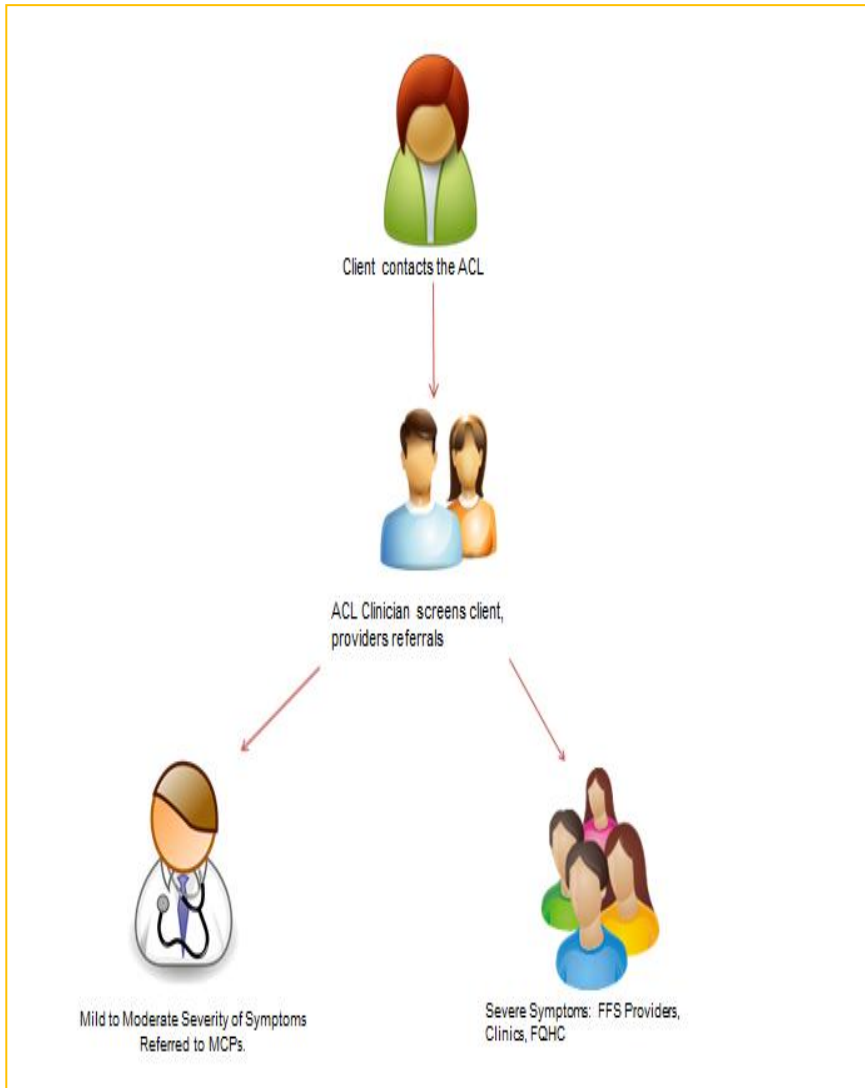
Children's Medi-Cal Mental Health Severity Analysis

Children & Youth Medi-Cal Mental Health Severity Analysis

All standards should be reviewed in the context of a child's age and developmental stage

	Mild (1)	Moderate (2)	Severe (3)	(0) N/A
Risk (suicidal/violent, high risk behavior, catastrophic illness/loss, criminogenic behavior, impulsivity, insight, ego discordance)	Comments about death/dying made in the context of being angry, frustrated No history of DTS/DTO Impulse control poor for age Lapses in judgment/"forgets" to think of consequences Immature choices Decline in educational performance due to mood/behavior	Passive suicidal ideation/non-suicidal self-injury Judgment often immature for age Choices cause impairment in school/family/social settings Little insight; doesn't understand cause/effect Persistent educational decline despite intervention	Current/recent suicidal ideation, intent or plan or recent attempt with clear expectation of death Recurrent psychiatric hospitalizations Unable to consider cause/effect Creates dangerous situations due to impulsive behaviors Intentional choices to harm others/property; carries a weapon Minimal insight At risk of losing educational placement due to mood, behavior Running away overnight and/or multiple attempts New-onset deliberate fire setting	
Clinical Complexity (serious emotional disturbance vs situational/reactive, recovery status, functional & cognitive impairment, treatment resistance, medication complexity, frequent hospitalization, co-occurring medical and alcohol or drug disorder (AOD))	Adjustment reaction Occasionally anxious, fearful or sad No history of psychotic symptoms Uncomplicated ADHD No significant AOD use or use limited to experimentation	Mood/anxiety causing problems with school/family/peers ADHD with comorbid mood, anxiety symptoms AOD misuse Concern for prodromal symptoms	Significant change in emotional or behavioral functioning for which there is no obvious or recognized precipitant Mood/anxiety interferes with daily functioning in all realms (school/family/peers) Emotional/behavioral problems for which outpatient services have not led to significant improvement New onset psychosis AOD abuse and/or dependence	
Life Circumstances (biopsychosocial assessment, availability of resources, family/social/faith-based support, resilience)	Emotional distress arising in the course of normal life stressors Adequately resourced & supported Resilient Occasional conflict with family/school staff/peers	Primary caretaker has serious emotional impairment or substance abuse problem Poor coping skills Known to authority figures for behavior problems Worsening issues with peers (victimized by peers, increased social isolation)	History of abuse, neglect and/or removal from home with current significant symptoms as a result of this action Loss of educational placement for emotional/behavioral disturbance Known to authority figures as a chronic behavioral problem No friends/loner, avoids former friends Frequent problems with the law	
Benefit of Integrated Care (optimal for stable patients with co-occurring mild to moderate physical and mental illness, limited transportation or unique clinical/cultural needs not well suited for split care)	High (1) Already established, effective care in primary care setting for chronic stable medical + co-occurring mild mental illness/emotional distress	Medium (2) ← High medical, low behavioral High behavioral, low medical →	Low (3) Already established (or pending) care with County provider for complex SED Relies on behavioral health system for resources & support Low recovery	
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The Process-Referrals and Screening



The Process, Obtaining Initial Authorization



Therapist assesses client to have severe symptoms and makes follow up appointment



Therapist completes claim, Demographic Information, Initial Outpatient Authorization Request



Paperwork sent to Optum

Optum Care Advocates Review for Title 9 Medical Necessity and Severity



If authorized, Care Advocate will call therapist within 4 business days to provide decision and authorization letter to follow by mail

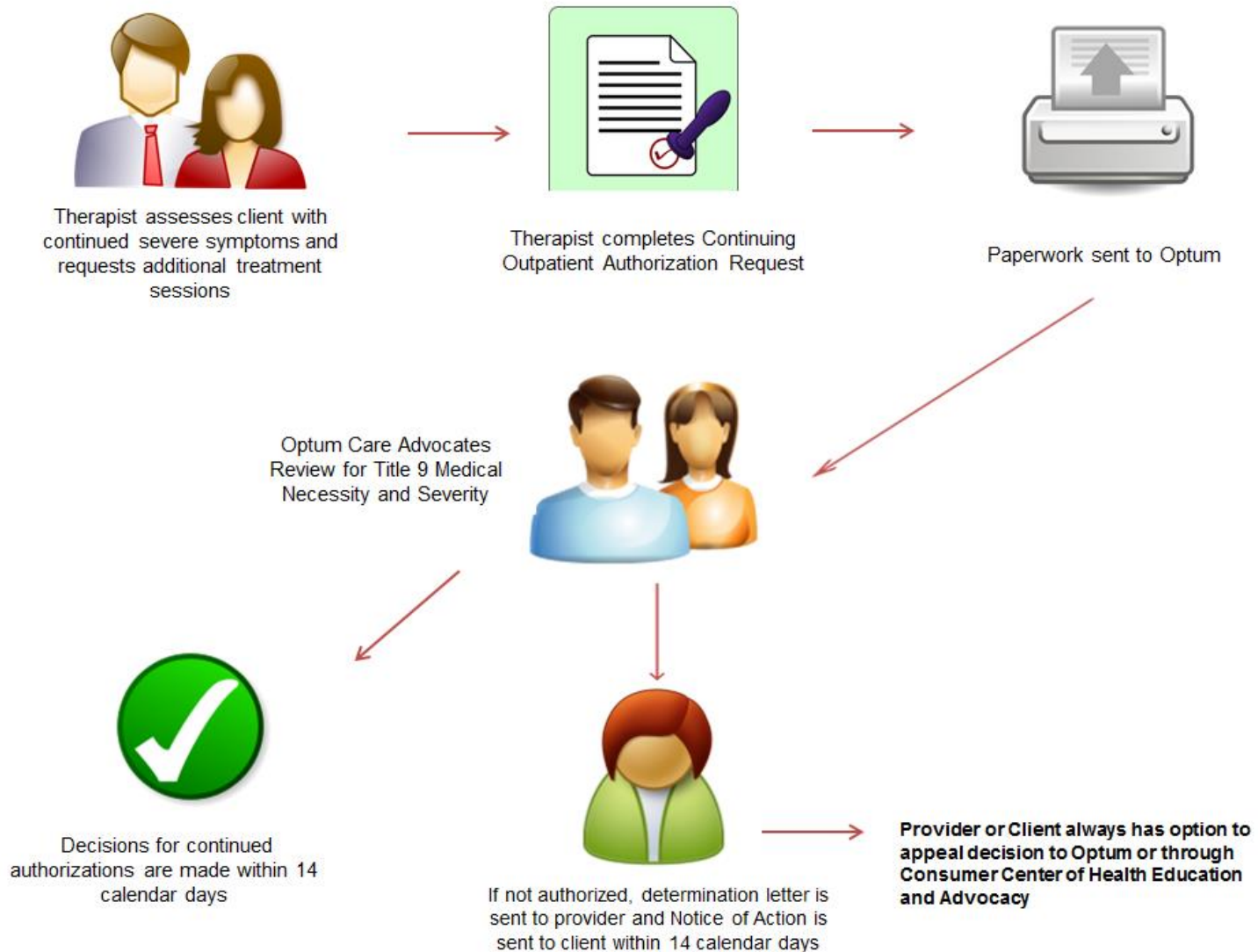


If not authorized, Care Advocate will call therapist within 4 business days, with letter to provider to follow and Notice of Action to client



Provider or Client always has option to appeal decision to Optum or through Consumer Center of Health Education and Advocacy

The Process, Obtaining Continuing Authorization



Accessing Forms

- Website: www.optumsandiego.com
- Select: “County and Staff Providers”
- Then, select: “Fee for Service Providers”
- Click on “Forms”
- Look for Outpatient Authorization Request



OPTUM™ San Diego

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Home > County Staff & Providers > Fee for Service Providers

Fee for Service Providers

This page is utilized by Fee For Service MediCal Providers to obtain documentation related to participation o
[ICD-10_Crosswalk_Version_2-2_with_V_Codes_and_TERM_Supplemental_012516.xls](#)

Applications | Beneficiary Materials | Communications | **Forms** | Manuals | Quick Reference

Name
Advance Health Care Directives.pdf
Authorization To Use or Disclosed PHI Form.pdf

Forms-Demographic Form (At Initial Auth Only)

San Diego County Mental Health Services
Demographic Form

Effective Date: _____ Case #: _____

CLIENT IDENTIFYING INFORMATION New (complete all fields) Update (use RED Ink for changes)

Client Name:

Last Name: _____	First Name: _____
Middle Name: _____	Suffix: _____

Birth Name (if different from above):

Last Name: _____	First Name: _____
Middle Name: _____	Suffix: _____

Mailing Address & Telephone Number(s):

Street Address: _____
 City/State/Zip: _____ County: _____
 Home Phone: _____ OK to call home?: Yes No
 Work Phone: _____ Ext: _____ Cell Phone: _____

Physical Address (if different from above):

Street Address: _____
 City/State/Zip: _____ County: _____

Social Security #: _____ Declines or Unable to provide Social Security #

Gender: M-Male F-Female O-Other U-Unknown **Birth Date:** _____ Actual Estimated

Born in US: Yes No **If No, Country where born:** _____

Born in California: Yes **If Yes, County where born:** _____ No **If No, State where born:** _____

Client Marital Status (Select one only):
 1-Never Married 2-Married 4-Divorced T-Domestic Partner 3-Separated 5-Widowed 6-Unknown

Ethnicity (select one only):
 1-No Hispanic 2-Hispanic - Mexican American/Chicano 3-Hispanic - Cuban 4-Hispanic - Puerto Rican
 5-Hispanic - Dominican T-Hispanic - Salvadoran 3-Hispanic - Other/Latino 2-Unknown/Not Reported

Race Rank 1 to 5 as needed with 1 being primary:

A-White/Caucasian	J-Japanese	S-Samoa
B-Black/African American	K-Korean	T-Turkish
C-Cambodian	L-Latino	U-Unknown
D-Chinese	M-Male	V-Vietnamese
E-Sitka/Alaskan Native	N-Native American	W-Whisper
F-Filipino	O-Other Non-White Non-Caucasian	X-Small
G-Guatemalan	P-Other Pacific Islander	Y-Yoruban
H-Hawaiian Native	Q-Qinghai	Z-Thai
I-Asian Indian	R-Other Asian	2-Unknown/Not Reported

Language (Complete both client languages. If there is a caretaker, complete caretaker language)

Client Primary: _____ Client Preferred: _____ Caretaker Preferred: _____

Interpreter Needed? Yes No (If either preferred language is other than English, an interpreter is needed)

Employment Status (Check only one value. Starting with "A" check the first one that applies to client):

<input type="checkbox"/> A-Comp Job 35+ hrs per week	<input type="checkbox"/> G-Full Time Job Training	<input type="checkbox"/> M-Retired
<input type="checkbox"/> B-Comp Job 20-34 hrs per week	<input type="checkbox"/> H-Part time Job Training	<input type="checkbox"/> N-Unemployed/Seeking Work
<input type="checkbox"/> C-Comp Job < 20 hrs per wk	<input type="checkbox"/> I-Full Time Student	<input type="checkbox"/> O-Unemployed/Not Seeking Work
<input type="checkbox"/> D-Rehab 35+ hrs per wk	<input type="checkbox"/> J-Part Time Student	<input type="checkbox"/> P-Not in the Labor Force
<input type="checkbox"/> E-Rehab 20-34 hrs per wk	<input type="checkbox"/> K-Volunteer	<input type="checkbox"/> Q-Resident/Inmate
<input type="checkbox"/> F-Rehab < 20 hrs per wk	<input type="checkbox"/> L-Homemaker	<input type="checkbox"/> U-Unknown

Living Arrangement (Check only one value from the list below):

<input type="checkbox"/> A-House or Apartment	<input type="checkbox"/> I-With Rehab Ctr (Adult Locked)	<input type="checkbox"/> S-Group Home-Child (Level 1-12)
<input type="checkbox"/> B-House or Apt with Support	<input type="checkbox"/> J-SNFC/INFD	<input type="checkbox"/> T-Residential Tx Ctr-Child (Juvel 13-14)
<input type="checkbox"/> C-House or Apt with Daily Supervision	<input type="checkbox"/> K-Intensive Psych Hospital	<input type="checkbox"/> U-Unknown
<input type="checkbox"/> D-Other Supported Housing Facility	<input type="checkbox"/> L-State Hospital	<input type="checkbox"/> V-Comm Tx Facility (Child Locked)
<input type="checkbox"/> E-Other Supported Housing Program	<input type="checkbox"/> M-Correctional Facility	<input type="checkbox"/> W-Children's Shelter
<input type="checkbox"/> F-Board & Care - Adult	<input type="checkbox"/> O-Other	<input type="checkbox"/> X-Homless/In Shelter
<input type="checkbox"/> F-Residential Tx/Care Ctr - Adult	<input type="checkbox"/> R-Foster Home-Child	<input type="checkbox"/> Y-Homless/Out of Shelter
<input type="checkbox"/> G-Substance Abuse Residential Rehab Ctr		<input type="checkbox"/> Z-Homless/Living w Other(s)

REV 4.1.16

San Diego County Mental Health Services
Demographic Form - Page 2

Client Name: _____ **Case Number:** _____

Currently Pregnant? Yes No Unknown

Number of children less than 18 years of age that the client cares for at least 50% of the time: _____

Number of adults 18 years or older that the client cares for at least 50% of the time: _____

Education (last grade or years completed): _____ **Religion:** _____

Does the client have Regional Center Involvement? Yes No Refuse/Can't Access

Military Service: Yes No Decline Unable to Answer **Branch:** _____

If 18, has client been offered the National Voter's Registration form? Yes No Decline

Mother's First Name: _____

ALIAS(ES) (List other names you have used. A first & last name must be included for each alias)

Last Name: _____	First Name: _____	Middle Initial: _____
_____	_____	_____
_____	_____	_____

LEGAL INFORMATION/LEGAL CONSENT (check only one box in the table below)

Self Consent	Caretaker	Minor	Juvenile Court
Legal/Reg Information not required	<input type="checkbox"/> T-Temporary	<input type="checkbox"/> B-Parental Consent	<input type="checkbox"/> F-Dependent
<input type="checkbox"/> A-Adult / Self Consent	<input type="checkbox"/> J-Permanent	<input type="checkbox"/> C-Guardian/Caretgiver	<input type="checkbox"/> G-Ward Status Offender
<input type="checkbox"/> S-Minor / Self Consent	<input type="checkbox"/> K-Murphy		<input type="checkbox"/> H-Ward Juvenile Offender
<input type="checkbox"/> D-Emancipated Minor	<input type="checkbox"/> U-Probate		

Legal Representative: _____ **Relationship:** _____

Address: _____ **Phone:** _____

City/State/Zip: _____

Employment Phone: _____ **Other information:** _____

PARENTAL & SCHOOL INFORMATION
 Is client under 18: Yes (School & Parental information required) No (Parental information is optional)

Parent Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

City/State/Zip: _____

Employment Phone: _____ **Other information:** _____

School Attending: _____

School District of Residence: _____

JUVENILE FORENSIC

REJIS #: _____

EMERGENCY NOTIFICATION INFORMATION

Name: _____ **Relationship:** _____

Address: _____ **Home Phone:** _____

City/State/Zip: _____ **Work Phone:** _____

Other information: _____

CONTACTS

Name (Last, First MI)	Agency/Title/Relationship	Phone
_____	_____	_____
_____	_____	_____

Staff Completing/Accepting the Assessment:

Signature _____ Printed Name _____ Center ID _____ Date _____

REV 4.1.16



Forms-Outpatient Authorization Request (OAR)

This form should be used by MS provider to request outpatient treatment.

Revised 7.22.16

**COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN
OUTPATIENT AUTHORIZATION REQUEST**

Please check: Initial Request Continuing Request
PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIALS

To request authorization, fax or mail to:
Optum Public Sector
Fax: (888) 220-4492,
PO Box 601340
San Diego, CA 92160-1340
Phone: (302) 792-2254, option #3

CONFIDENTIAL **Client Information** **CONFIDENTIAL**

Client Last Name: _____ First: _____ Middle: _____
 Gender: M F O Birth Date: ____/____/____ Age: _____
 Marital Status: S M O Sp Wid

Client Address (include zip code): _____
 Living Situation: Homelike Alone S* SSC S/M* Other, with whom? _____
 Primary Phone: (____) _____

Medical CN #: _____ Highest Education Level: _____ Current Employment Status: _____ Client Ethnicity: _____

Current Health Plan: _____ If CHS, current ISP: Yes No School District: _____
 Justice System Involvement: N/A Yes If Yes, explain: _____

San Diego Regional Center Client: Yes No If Yes, contact name and number: _____
 Referred by CHS Welfare Services: Yes No If Yes, PSW name and number: _____

If Hx of CVS, when and why? _____

DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations
 Primary Diagnosis: _____ ICD 10 Code: _____
 Other Diagnosis (Mental & Physical Health): _____

Presenting Mental Health Problem, Symptoms, Functional Impairment
 Current Symptoms: _____
 How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis? _____

Hx of Trauma and/or Abuse? Yes No If Yes, explain: _____
 Substance Use: N/A Hx Current Drug(s) of abuse: _____
 Describe current substance use impact on functioning: _____

Current Risk Assessment: Suicidal - N/A Ideation Plan Intent History of harming self
 Homicidal - N/A Ideation Plan Intent History of harming others
 Client Strengths (i.e., motivated, employed, strong social supports): _____

Medications (Psychiatric, Medical, & OTC medications)
 Name of Medication w/ Dose: _____

Page 1 of 2

Treatment
 Proposed Interventions (CST, DBT, behavioral, strength-based, groups, etc.): _____
 If Group Therapy, # Participants: _____ Group Topic/Focus: _____
 Treatment plan with measurable/observable goals addressing diagnosis, functional impairment, and risk (include frequency and duration of treatment goals and separate individual and group if facilitating both): _____

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TSS, Substance Use Tx, Groups, Peer Support): _____

How have you coordinated with these providers? If not, please explain: _____

Progress: N/A (Initial Request) Near completion Improving Stabilizing Regressed due to new stressor Little/no progress
 Expected length of treatment: _____ If Initial Request, date of 1st Appointment/Assessment with you: _____

Referrals made to other community supports and/or aftercare plans for client's recovery: _____

Client Signature
 _____ (print name) _____ participated in the development of the plan and received a copy.
 Client Signature: _____ Date: _____

Provider Requested Authorization Units – Please Sign Below
 On Begin Date of Sessions, Client is: Adult Child

Interpreter needed for these sessions: No Yes. Language(s): _____

CPT Code Group	Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	Per Optum Care Advocate Sign Approved Service
90834	Psychotherapy (max 12)				
90853	Group Psychotherapy (max 12, specify length of session)				
99166/99167	CPT Reading (CVIS only) Team Conference Conference Purpose:				
23820/23821	Care Management Care Management Purpose:				
Other					
Other					

Provider Information
 Name/License#: _____ Phone: _____
 Provider Signature: _____ Date: _____ Fax: _____
 If Group Practice, name of Group: _____

For Optum Care Advocate
 If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature

Page 2 of 2

The Process-Authorization Increments

- Assessments do not require pre-authorization
- Follow up sessions will be given at no more than 12 sessions, to be utilized at a frequency of one time per week or less for children and adults. Exceptions to see client 2 times per week can be made on case by case basis
- Team Conferencing & Case Management Sessions are also available
- Group sessions are also available, but should focus on the client's diagnosis or impairment

Forms-Interpreter Services

- ✓ The MHP covers the cost
- ✓ Request for Interpreter Services Form is available on our website- www.optumsandiego.com, County and Staff Providers, Fee For Service Providers, Forms
- ✓ Must be submitted via fax **AT LEAST 2** business days prior to appt., or as soon as appt. is set
- ✓ Incomplete forms will be sent back and will cause delays in processing
- ✓ Do not sign the document-Optum is the entity approving the service
- ✓ Follow the instructions and fill out **ALL** highlighted areas (2pages)-complete “form fill” online or print out in color
- ✓ Submit form to Optum **before** 1st appt. of new authorization period

Client's Address:	
ZIP Code:	
Medi-Cal Number:	
Date of Birth:	
Gender:	

Client Information:

The County of San Diego, HHSa has authorized the following interpreting services for:

Name(s) of participant(s):	<input type="checkbox"/> Mr. or <input type="checkbox"/> Ms.
If any participants are under age 18, please indicate age of minor(s):	
Language(s) requested:	
Nature of appointment:	
Interpreter gender:	<input type="checkbox"/> Male or <input type="checkbox"/> Female Is gender required?

Service Information:		
Section A:		
Date:	Requested:	
	Start Time	End Time

Requester Information:

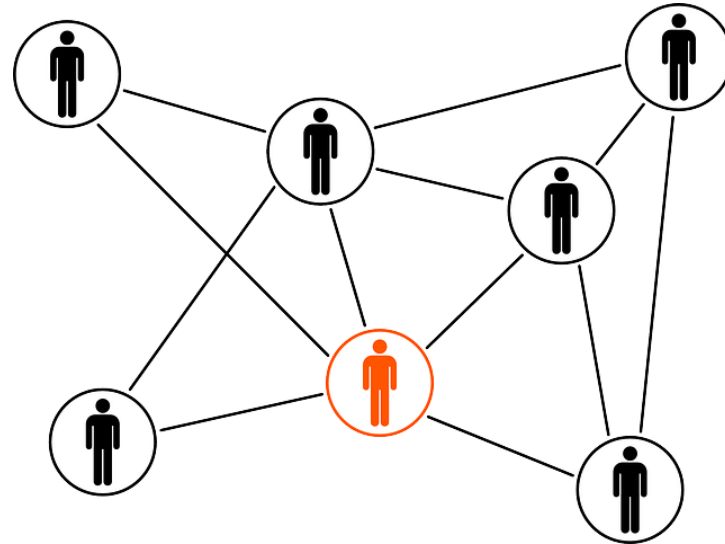
Requester	
Name:	Print Name:
Phone:	Signature:
Fax:	Service Site:
E-mail:	

Treatment Philosophy of the Fee for Service Network

- The Recovery Model: Clinical improvement and self sufficiency is possible, but challenges during the process may occur along the way
- The role of the provider is to stabilize the client by utilizing goal focused treatment targeting the specific mental health condition
- The treatment intervention will diminish the impairment or prevent deterioration
- Authorizations-based on CA Regulation Title 9 Medical Necessity and Severity Rating

Partnership

- Coordination of Care is Essential
 - Managed Care Plans
 - Primary Care Physicians
 - Psychiatrists
 - Case Managers
 - TBS workers
 - Protective Service Workers
 - Probation
 - Teachers



Contact Information-Optum

- Medi-Cal Provider Line 1-800-798-2254
 - Option 2 Claims
 - Option 4 Provider Clinical Questions
 - Option 5 Provider Administrative Questions
 - Option 7 Provider Services

- TERM Provider Line 1-877-824-8376
 - Option 1 TERM Provider Administrative Questions
 - Option 2 TERM Claims
 - Option 3 Provider Services
 - Option 4 TERM Clinical Questions



Contact Information for MCP Behavioral Health

Health Plan	Medi-Cal Managed Care Plan Behavioral Health Services
Care1st Health Plan Care1st.com	Care1st Health Plan (855) 321-2211
Community Health Group Chgsd.com	Behavioral Health Services (800) 404-3332
Health Net HealthNet.com	Managed Health Network (MHN) (888) 426-0030
Kaiser Permanente KP.org	Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare MolinaHealthcare.com	Molina Healthcare (888) 665-4621

Wrap up Reminders

- ✓ We are here to help! Call us! Medi-Cal Provider Line 800-798-2254
- ✓ Mild to Moderate needs can be served by the client's Managed Care Plan, Severe needs Fee for Service, Clinics or FQHCs
- ✓ The role of the provider is to utilize goal-focused treatment targeting the specific mental health condition.
- ✓ There is an array of Recovery focused organizations in our County, please refer to all appropriate community supports.
- ✓ Call Access and Crisis Line 888-724-7240 for additional referrals or resources



Thank you!

Questions?

