Los Angeles County Department of Mental Health

Mental Health Plan Claim Certification for Program Managers (Policy 801.08 - Attachment 4)

Frequently Asked Questions and Sample Form

1. **Where can the Mental Health Plan (MHP) Claim Certification for Program Managers form be found?**

   Form is attached to DMH Policy 801.08 - Mental Health Plan Claim Certification (Attachment 4).

   http://file.lacounty.gov/SDSInter/dmh/1041980_801_08_Att_4.pdf

2. **What does DMH Policy 801.08 – Mental Health Plan Claim Certification entail?**

   For further details regarding DMH Policy 801.08, refer to the hyperlink below.

   http://file.lacounty.gov/SDSInter/dmh/1042086_801_08.pdf

3. **When is the MHP Claim Certification for Program Managers form due?**

   Submission of the complete MHP Claim Certification for Program Managers form to the Compliance Office is due the 15th of each month, indicating compliance for the previous month.

4. **To whom is MHP Claim Certification for Program Managers form submitted for approval?**

   Once the Program Manager completes the MHP Certification for Program Managers form, the form is submitted to the Mental Health Clinical Program Manager III for an approval signature, followed by the Deputy Director's approval signature. Upon completion, the respective Deputy Director is to instruct program liaisons to submit the approved monthly MHP Certification for Program Mangers form to the Compliance Office.

5. **What are common reasons the MHP Claim Certification for Program Managers get rejected upon submission?**

   Rejection of the MHP Claim Certification for Program Managers form can be sole or combination of a) Late submission, b) Incomplete, c) Using outdated form, d) Missing appropriate approval.

   Forms submitted after the deadline/cutoff date for the month, prior to the close of the month being certified, shall not be accepted (e.g., if certifying for July claims, certifications are due no later than August 15th).

6. **How to find support regarding MHP Claim Certification for Program Managers form?**

   Questions, concerns, or any further information regarding MHP Claim Certification for Program Managers form (DMH Policy 801.08 - Attachment 4), contact Compliance Office by telephone at (213) 739-2390 or email compliance@dmh.lacounty.gov.

Provider #:
0101A

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH PLAN CLAIM CERTIFICATION FOR PROGRAM MANAGERS

I John Doe (NAME) Health Program Analyst II (TITLE), hereby certify that all claims submitted for reimbursement under Short-Doyle/Medi-Cal are accurate, complete, and truthful, to the best of my knowledge and belief, and in compliance with all State and Federal statutory and regulatory requirements, specifically:

- An assessment of the beneficiary was conducted in compliance with the requirements established in the MHP contract with the Department.
- The beneficiary was eligible to receive Medi-Cal service(s) at the time the services were provided to the beneficiary.
- The services included in the claim were actually provided to the beneficiary.
- Medical necessity was established for the beneficiary for the service(s), for the timeframe in which the service(s) were provided.
- A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department.
- For each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health service(s) were met, and any reviews for such service(s) were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the Department.

By signing my name below, I certify that all claims submitted from _____ (FULL LEGAL NAME OF SITE)

California Mental Health / 0101A (PROVIDER #)

for the month/year of August 2018 are to the best of my knowledge and belief, in full compliance with the requirements listed above. I further certify that all claims submitted for reimbursement are, to the best of my knowledge and belief, supported by documentation. I agree that I shall notify my appropriate chain of command supervisor in the event that I have any reason to believe that the grounds for certification of claims are no longer valid.

John Doe	John Doe	9/15/2018
PROGRAM MANAGER (PRINT NAME)	SIGNATURE	DATE

As the individuals responsible for the oversight of the above named program(s), to the best of our knowledge and belief processes are in place in the above referenced program(s) that are designed to monitor and ensure compliance with Short-Doyle/Medi-Cal claiming requirements.

Joe Smith	Joe Smith	9/15/2018
MENTAL HEALTH CLINICAL PROGRAM MANAGER III (PRINT NAME)	SIGNATURE	DATE

Jane Doe	Jane Doe	9/15/2018
DEPUTY DIRECTOR (PRINT NAME)	SIGNATURE	DATE

Comments and/or Changes: