COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
LOCAL MENTAL HEALTH PLAN

MEDI-CAL SPECIALTY
MENTAL HEALTH SERVICES
FEE-FOR-SERVICE NETWORK
PROVIDER MANUAL
SIXTH EDITION
DECEMBER 2018

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DMH Intensive Care Division

INTRODUCTION

Welcome to the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP).

On June 1, 1998, under a State mandate, the LMHP implemented Phase II Consolidation of Medi-Cal specialty mental health services. Phase II consolidated specialty mental health services delivered by private fee-for-service network providers with the Short Doyle/Medi-Cal Community Mental Health System under the umbrella of the LMHP.

This revised County of Los Angeles Department of Mental Health Local Mental Health Plan Medi-Cal Specialty Mental Health Services Provider Manual, Sixth Edition, December 2018 replaces, in its entirety, the Provider Manual, Fifth Edition, July 2014. As updates, changes and additions to the current manual are required, you will receive Provider Bulletin publications which will supersede or augment the specified content in the Provider Manual, Sixth Edition, December 2018.

The Provider Manual and all subsequent Provider Bulletins have the same authority as the Medi-Cal Professional Services Agreement which stipulates that providers shall perform Specialty Mental Health Services in accordance with the terms and conditions of the legal agreement and the requirements in the LMHP Provider Manual and Provider Bulletins.

For your convenience the Provider Manual is located on the LMHP website at http://dmh.lacounty.gov/. Select “For Providers.” Then select “Provider Manuals & Directories.”

We trust that you will find the Provider Manual to be a valuable and useful resource. If you have any questions, or need additional information please feel free to contact the Provider Support Office at (213) 738-3311.

We look forward to working with you to ensure the delivery of quality Specialty Mental Health Services to Los Angeles County Medi-Cal beneficiaries.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
LOCAL MENTAL HEALTH PLAN

Important Phone Numbers

ACCESS Center	(800) 854-7771
Patients' Rights/Beneficiary Services Program	(213) 738-4949
Help Desk	(213) 351-1335
Individual and Group Provider Contracts	(213) 738-2841
Over-Threshold Services	(213) 738-4889
Psychological Testing	(213) 738-4889
Provider Credentialing	(213) 738-2814
Provider Support Office	(213) 738-3311

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal Provider Telephone Service Center

(800) 541-5555

LOS ANGELES MEDI-CAL FIELD OFFICE

311 S. Spring St.
P.O. Box 60172, MS 4513
Los Angeles, CA 90060-0172

Call (213) 897-0745
for
Medi-Cal Case Management
Hospital Services Section
Allied Health Services/Appeals

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SECTION I – PURPOSE, PRINCIPLES AND GOALS

PURPOSE

The purpose of the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) is to administer all Medi-Cal and State grant funds for Specialty Mental Health services that are in compliance with the Health Insurance Portability and Accountability Act (HIPAA), and designed to ensure availability and accessibility of quality mental health care for Los Angeles County Medi-Cal beneficiaries. These services include, but are not limited to, mental health assessment; individual, collateral group and family therapy; mental health services in inpatient, outpatient, and residential settings; medication support and psychological testing.

The LMHP is responsible for informing fee-for-service network providers of the specialty mental health services provided by the LMHP, referring Medi-Cal beneficiaries to qualified mental health network providers, maintaining a HIPAA-compliant information system, providing quality management services, processing submitted claims, reimbursement, and evaluating clinical outcomes of mental health services.

PRINCIPLES

The LMHP is governed by the following principles:

- Services are provided to any Medi-Cal eligible individual meeting medical necessity criteria for specialty mental health services;
- Culturally sensitive services are delivered to ethnically diverse populations in the communities in which they are located;
- Services are client-centered, family-focused and culturally competent;
- Treatment is provided to the greatest extent possible in the individual's own community and at the least restrictive but most effective level of care;
- Innovative treatment approaches and clinical practices are utilized to optimize the clinical outcome;
- Possibilities for relapse are reduced through the identification and coordination of ongoing mental health services; and
- Medi-Cal beneficiary's treatment preference and selection of a network provider are honored.

GOALS

- Establish working relationships in a public-private partnership with network providers to provide quality specialty mental health services;
- Maintain a network of skilled and effective network providers selected and retained based on demonstrated clinical performance;
- Match treatment needs to a network provider with specialized skills to address the needs of the Medi-Cal beneficiary; and
- Maintain a comprehensive well-managed mental health system to relieve clinical and symptomatic distress and improve the quality of life for Medi-Cal beneficiaries.

SECTION II – THE PROVIDER NETWORK

The Local Mental Health Plan (LMHP) Provider Network is comprised of licensed mental health professionals whose scope of practice permits the practice of psychotherapy independently. Network providers may be psychiatrists (MD/DO), psychologists (PhD/PsyD), licensed clinical social workers (LCSW), licensed marriage and family therapists (MFT), or registered nurses (RN) who are board certified with a master's degree in psychiatric/mental health nursing as a clinical nurse specialist or as a nurse practitioner. Nurses and Nurse Practitioners must be certified by the American Nurses Credentialing Center (ANCC) or the American Association of Nurse Practitioners (AANP) in behavioral health.

All mental health providers must be credentialed and contracted with the LMHP to receive reimbursement for specialty mental health services provided to Los Angeles County Medi-Cal beneficiaries. Credentialed providers may contract with the LMHP as an individual provider or render services as part of a contracted group. A group is comprised of two or more licensed, credentialed mental health providers.

CREDENTIALING

Credentialing is the formal process of collecting and verifying the professional credentials and qualifications of licensed providers and evaluating them against the standards and requirements established by the LMHP to determine whether such licensed providers meet these standards and requirements. Before an LMHP network applicant can be offered a LAC-DMH contract, he or she must apply for enrollment in the State Medi-Cal program, and be free and clear of any Medi-Cal related adverse actions.

Network providers are required to re-credential every three years in order to continue to participate in the LMHP Provider Network. Providers will be sent an email reminder or letter and an application to re-credential approximately four months prior to the expiration of their credentials. A certified letter with return receipt will be mailed to the provider if the re-credentialing application is not submitted within a month of the expiration date

> Note: It is the network provider's responsibility to maintain current credentials. A network provider's failure to maintain current credentials will result in the termination of reimbursement privileges for specialty mental health services rendered to Medi-Cal beneficiaries. Dates of service upon which a network provider has experienced a break in active credentialing status will not be subject to retroactive reimbursement. Even if a contract is in place at the time credentials lapse, the contract is considered in default, and claims will not be reimbursed until the provider's credentials are renewed.

APPLICATION

Mental health providers may request a credentialing application by contacting the Provider Credentialing Unit at (213) 738-2814. A request may also be faxed to (213) 487-9658. When requesting credentialing applications, mental health providers should provide the following information: 1) full name, discipline, mailing address, and email address (please include a 9 digit zip code); 2) telephone and fax number(applicants must provide a phone number that would allow direct contact); 3) whether the requested application is to provide specialty mental health services as an individual or as a group provider; and 4) if the provider will be providing services within the geographic boundaries of Los Angeles County. Applications will be mailed within 2-3 working days.

The application packet contains the credentialing application form entitled *Application to Participate as a Provider in the Los Angeles County Department of Mental Health Local Mental Health Plan* and all the necessary information for completing the application requirements (Attachment II).

The following documents are required in addition to the completed credentialing application form:

- General Administration Profile Self-Assessment (Attachment I)
- Psychiatrist are to include a copy of their current Drug Enforcement Agency (DEA) Certificate, a current curriculum vitae, a Certificate of Professional Liability Insurance, and a *Consent To Release Information To Biller* form, if applicable.
- Psychiatrists must be either board certified or board eligible in order to provide services under the LMHP. Psychiatrists who are not board certified must include a copy of their certificate of completion of psychiatric residency training.
- Psychologists, LCSWs and MFTs are to include a curriculum vitae, a Certificate of Professional Liability Insurance, and a *Consent To Release Information To Biller* form, if applicable.
- Clinical nurse specialists and nurse practitioners are to include a curriculum vitae, a Certificate of Professional Liability Insurance, and a *Consent To Release Information To Biller* form if applicable.
- Clinical nurse specialists are also to submit proof of graduation from a master's degree program in psychiatric/mental health nursing as a clinical nurse specialist or a master's degree within a scope of practice that includes psychotherapy
- Nurse practitioners are also to submit a DEA certificate and proof of graduation from a master's degree program in psychiatric/mental health nursing as a nurse practitioner (the quality of graduate program's curriculum as well as applicant's experience will be included in the overall decision).

All affirmative answers to any professional liability or attestation questions on pages five through seven of the application require a detailed explanation including supporting documents from the court(s) or attorney(s). Documentation from the appropriate licensing board is required if disciplinary action has been taken, or is pending, against a provider. Applicants will also be required to attest that they have downloaded and read the LMHP Provider Manual. The manual can be downloaded at: http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals

GROUP APPLICATION

Group network providers must include two or more credentialed mental health providers. A group provider may request a *Group Network Provider Application* form (Attachment III) by contacting the Provider Credentialing Unit at (213) 738-2814. A request may also be faxed to (213) 487-9658. The following information will be required on the group application:

- The name and address of the group;
- The group Medi-Cal provider and NPI numbers;
- The names of the rendering providers in the group and their Medi-Cal provider and NPI numbers; and
- The name of the person in the group authorized to enter into legal agreements on behalf of the group.

To add new group members after the group has been contracted, submit a *Group Network Provider Application* form and include page 2 of the application with an updated list of the group members.

The completed application form for individual and group providers, including all the required documents, is to be submitted via mail or fax to:

Department of Mental Health
Provider Credentialing Unit
550 S. Vermont Ave., Room 703B
Los Angeles, CA 90020
Fax: (213) 487-9658

Note**:** The County shall not be responsible to provide or arrange and pay for Specialty Mental Health Services provided by Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

CONTRACT WITH THE LMHP

After completion of credentialing, the Contracts Development and Administration Division (CDAD) will send credentialed individual providers an individual provider legal agreement. The agreement is to be signed and returned to CDAD for processing with all the required documents.

Group providers will be sent a group provider legal agreement, which must be signed by the legally authorized representative of the group.

When contract processing is successfully completed the individual or group provider will be sent a signed, dated, executed legal agreement signed by the Director of the Department.

Note: Reimbursement may only occur after the legal agreement is executed and only for specialty mental health services delivered on or after the effective date of the legal agreement. Retroactive reimbursement for services delivered prior to the completion of an executed contract will not be authorized.

CREDENTIALING POLICIES AND PROCEDURES

Credentialing policies and procedures are included at the end of this section to provide detail regarding credentialing, re-credentialing, due process requirements for the limitation and termination of a provider's privileges and a provider's right to an independent review of any decisions to deny or restrict participation in the Provider Network (Refer to Attachments IV to VII).

CREDENTIALING REVIEW COMMITTEE

The purpose of the LMHP Credentialing Review Committee (CRC) is to ensure that the initial and ongoing credentials of the applicants and Network Providers are evaluated and maintained in accordance with the credentialing standards established by the LMHP.

New Applicants and existing Network Providers may be referred to the CRC according to established criteria. The CRC shall review cause for concern and recommend action to the Medical Director of DMH. Network Providers shall be notified and due process shall be given for any recommended adverse action.

NATIONAL PROVIDER IDENTIFICATION AND TAXONOMY

As of 2008, all providers are required to obtain a National Provider Identifier (NPI) prior to applying to the LMHP. Providers who do not have a NPI will be unable to receive reimbursement for specialty mental health services. To apply to a National Provider Identifier, go to the National Provider and Plan Enumeration System (NPPES) website at:
https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

During the process of obtaining a NPI, providers will need to submit a taxonomy which is related to the license or certification they possess. It is necessary to ensure that all licensure and certification properly reflect eligibility to render specialty mental health services.

The following taxonomies are applicable to Fee-for-Service Network Providers:

Discipline	Taxonomy
M.D. / D.O.	2084P0800X
Ph.D. / PsyD	103TC0700X
L.C.S.W.	1041C0700X
M. F.T.	106H00000X
R.N.	163WP0808X
N.P.	363LP0808X
CNS (child)	364SP0807X
CNS (adult)	364SP0809X

INDIVIDUAL VS. INCORPORATION PROVIDERS

Individual providers are considered sole practitioners whom shall have a Type I NPI in the NPPES system, and a contract and credentialing application stating as such. Incorporations are considered sole practitioners; however, they must have a Type I and Type II NPI in the NPEES system, as well as, a contract and credentialing application stating they are to be recognized as an incorporated entity. Even though a provider has a Type I and Type II NPI in NPPES, if they have not contracted with DMH and the LMHP as an incorporation, they will still be considered as an individual provider.

REGISTRATION AS A COUNTY OF LOS ANGELES VENDOR

All newly contracted individual and group network providers who provide a Federal Tax ID Number to the LMHP must register with the County of Los Angeles as a vendor in order to receive payments.

Registration as a vendor may be completed online via the internet by accessing the County of Los Angeles homepage and vendor registration website address at: http://camisvr.co.la.ca.us.webven/.

Provider Vendor information must be correct and current in order to continue to receive payments. Contact ISD Vendor Relations at (213) 267-2725 or (213) 323-881-3613 if assistance is needed to modify the information in the system.

ON-LINE VENDOR REGISTRATION REQUIREMENT

In order to receive payments, network providers who have contracted with the LMHP using a Federal Employment Identification Number (FEIN) are required to register as a vendor with the County of Los Angeles, Internal Services Department (ISD) at the following website address: http://camisvr.co.la.ca.us/webven/.

Do not register as a vendor if the network provider contracted with the LMHP using a social security number only and did not provide a FEIN. It is recommended that network providers confirm in the system, via the “Vendor Search” link, whether a registration has already been completed before starting the registration process. Registrants should also be prepared to enter the network provider’s FEIN.

Click on the “New Registration” link at the website listed above. Enter Your FEIN or SSN to begin the process.

Note: The network provider's name and address must be exactly the same as the billing address used on their credentialing application and contract to avoid reimbursement delays. In the event that a change of billing address becomes necessary, network providers must also update their ISD vendor registration by selecting "Change Registration" at the website listed above in a timely manner to avoid reimbursement delays.

Please contact ISD Vendor Relations at (323) 267-2725 or (323) 881-3613 for questions regarding vendor registration.

CHANGES IN PROVIDER STATUS AND CONTACT INFORMATION

It is very important to advise the LMHP of any changes that would affect a network provider's contract or ability to receive payment, such as changes in name; a request to terminate the contract; a change in corporate status; changes in mailing, billing or service location addresses; or changes in required insurance coverage. The *Contractor Address* form (Attachment VIII) is to be completed to report address changes.

Submit all changes via mail or fax to:

Department of Mental Health
Contracts Development and Administration Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020
Fax: (213) 381-7092

CONTRACT TERMINATION

When the Network provider's contract is terminated, the provider is responsible for notifying current clients in writing that they are no longer a Medi-Cal provider in the LMHP Provider Network effective the date of contract termination. The Provider shall make a good faith effort to give written notice of termination of a contract within 15 calendar days after the termination date, to each beneficiary who was seen on a regular basis (42 C.F.R. Section 438.10 (f)(1)). The notification letter is to advise clients they may contact the ACCESS Center or the Patients' Rights Office to receive referrals to other LMHP network providers, directly operated providers or contract providers. Network providers may elect to utilize the sample notification letter (Refer to Attachment IX). The Beneficiary Services Program Specialist will provide assistance to the client in transferring clients to another mental health provider.

The network provider is to send one copy of the client notification letter and a list of clients that were sent the notification letter to:

Department of Mental Health
Patients' Rights Office
550 S. Vermont Ave., 6th Floor
Los Angeles, CA 90020

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH

The General Administrative Profile is a mandatory self-assessment tool sent to the Network Providers triennially. Network providers are to utilize these tools to review their administrative procedures and clinical practices to evaluate compliance with the LMHP legal agreement and Medi-Cal requirements. Please complete this assessment in its entirety and submit it with your application.

Note: Information on the Self-Assessment Tool will be verified during the biennial chart review.

GENERAL ADMINISTRATIVE PROFILE
Self-Assessment
Individual and Group Network Providers
Page 1 of 8

PROVIDER INFORMATION

Provider Name:_____
Provider Discipline: ☐MD, ☐DO, ☐PhD, ☐PsyD, ☐LCSW, ☐MFT, ☐NP, ☐CNS
Provider License/Certification Number:_____

Provider Medi-Cal Number:_____
Provider's LMHP Status: ☐ Individual Contract ☐ Group Contract

Primary Office Address:_____

_____

Is this a ☐private residence, or ☐office building?

Phone Number:_____ Fax Number:_____ E-mail:_____
Services provided at this location to: ☐ Children, ☐ Adolescents, ☐ Adults, ☐ Older Adults (65+)

Secondary Office Address:_____

_____

Is this a ☐private residence, or ☐office building?

Phone Number:_____ Fax Number:_____ E-mail:_____
Services provided at this location to: ☐ Children, ☐ Adolescents, ☐ Adults, ☐ Older Adults (65+)

Tertiary Office Address:_____

_____

Is this a ☐private residence, or ☐office building?

Phone Number:_____ Fax Number:_____ E-mail:_____
Services provided at this location to: ☐ Children, ☐ Adolescents, ☐ Adults, ☐ Older Adults (65+)

(Attach additional addresses if more than three. Please complete the succeeding pages of this assessment separately for each of the addresses.)

Name of Individual Completing Form:_____

Date Completed:_____

No Outpatient Services Provided ☐

A. ADMINISTRATION

1. PHYSICAL ENVIRONMENT

a. Is your office maintained in a manner that provides for the physical safety of beneficiaries, visitors and personnel? ☐Yes ☐No

b. Is your office clean, sanitary and in good repair? ☐Yes ☐No

c. Does your office meet federal requirements of the Americans with Disability Act? Does it have:

1) Ramps for accessibility? ☐Yes ☐No
2) Bathrooms that can accommodate wheelchairs? ☐Yes ☐No
3) Handicapped parking? ☐Yes ☐No

2. ADMINISTRATIVE PROCEDURES

a. In accordance with your contract, are you aware of the provisions of Article 9, Chapter 4, Section 6150 of the Business and Professions Code related to Unlawful Solicitation? ☐Yes ☐No

b. Do you maintain a Drug-Free workplace?

c. Do you maintain a smoke-free workplace? ☐Yes ☐No

d. In accordance with your contract, are you knowledgeable about the child, dependent adult and elder abuse reporting laws and the reporting requirements? ☐Yes ☐No

e. In accordance with your contract, do you ensure there is no evidence of discrimination on the basis of ethnic group identification, race, creed, religion, age, sex, or physical and mental disability in the provision of services to clients? ☐Yes ☐No

f. Do you maintain appropriate Health Insurance Portability and Accountability (HIPAA) policies, including: ☐Yes ☐No

1) Informing clients about HIPAA upon admission; ☐Yes ☐No

2) Use and Disclosure of Protected Health Information Requiring Authorization; ☐Yes ☐No

3) Use and Disclosure of Protected Health Information (PHI) without Authorization; ☐Yes ☐No

4) Clients Right to Access Protected Health Information. ☐Yes ☐No

g. Do you inform clients about the need for an Advance Health Care Directive? ☐Yes ☐No

3. CONFIDENTIALITY

a. Are beneficiary records accessible only to authorized personnel? ☐Yes ☐No

b. Describe how you protect the confidentiality of client records and govern the disclosure of information in the records. (W&I Code 5328; Calif. MH Confidentiality Laws; Title 22)

c. Are you taking necessary steps to ensure the continuous security of all computerized data systems containing PHI ☐Yes ☐No

d. Have you educated and/or trained all your office staff on maintaining beneficiary confidentiality at all times? ☐Yes ☐No

1. MAINTENANCE OF RECORDS

a. Where are clinical records maintained?

b. Do you fulfill your responsibility to safeguard and protect clients records against loss, unauthorized alteration or disclosure of information? ☐Yes ☐No

c. Are you in compliance with the following consent standards stipulated in the current Medi-Cal Specialty Mental Health Services Provider Manual? ☐Yes ☐No

1) A signed Consent for Services is obtained at first contact with beneficiary ☐Yes ☐No

2) An appropriately executed Consent of Minor is obtained at first contact with a beneficiary who is a minor. ☐Yes ☐No

3) A signed Informed Consent for Psychotropic Medication is obtained from the beneficiary when prescribing psychotropic medication. ☐Yes ☐No

4) A signed Authorization to Release Information is obtained from the beneficiary as to what information is released from the beneficiary's record. ☐Yes ☐No

d. Are you in compliance with the minimum requirement of clinical records/documentation standards stipulated in the Medi-Cal Specialty Mental Health Services Provider Manual? ☐Yes ☐No

1) Are clinical records retained at least seven years from the time of discharge for clients who are at least eighteen years of age or legally emancipated at the time of discharge? ☐Yes ☐No

2) Are records that have audit or legal action pending retained 3 years after the issues have been settled or seven years from the date of

discharge, whichever is longer? ☐Yes ☐No

2) If the client is a minor or not legally emancipated at the time of discharge, are clinical records retained at least one year after such minor has reached the age of 18, but never less than seven years? ☐Yes ☐No

B. ACCESS/AUTHORIZATION

1. How many Medi-Cal clients were referred to you last Fiscal Year, either through a DMH directly operated or contracted agency? _____
2. Of this number, how many were you able to serve? _____
3. Are you familiar with the DMH directly operated or contracted agencies in the area(s) where you practice? ☐Yes ☐No
   - Identify the Mental Health agencies you communicate/coordinate with the most frequently. ☐Yes ☐No
4. Describe the type of relationship you have with the mental health agencies in your area(s).

C. NOTIFICATION

Is Notice of Action-A (NOA-A) issued when services are denied based on medical necessity criteria? ☐Yes ☐No

1. Are notices informing beneficiaries of their access to specialty mental health services and the LMHP complaint and grievance procedures posted in an area in ready view of the beneficiaries? ☐Yes ☐No
2. Are Patients' Rights brochures in appropriate languages? ☐Yes ☐No
3. Are Patients' Rights brochures in the appropriate languages, displayed in an area in ready view of the beneficiaries? ☐Yes ☐No
4. Are Grievance, Appeal Procedures and State Fair Hearing pamphlets in appropriate languages? ☐Yes ☐No
5. Are Grievance Appeal Procedure and State Fair Hearing pamphlets in appropriate languages, displayed in an area in ready view of the beneficiaries? ☐Yes ☐No
6. Do you provide a copy of the Beneficiary Booklet (Informing Material) to the beneficiaries upon first receiving Specialty Mental Health Services and upon request? ☐Yes ☐No

D. MEDICATION COMPLIANCE

***Use only if you store and dispense medications*.**

1. DISPENSING DRUGS

a. Are drugs ordered and dispensed only by persons lawfully authorized to do so? ☐Yes ☐No

b. Is the medication supply at your office under the direct responsibility of a physician or staff whose professional license include dispensing, and administration of medication ? ☐Yes ☐No

c. Are medications administered only by persons whose scope of professional license include dispensing and administration of medication? ☐Yes ☐No

d. For each medication administered at your office, are the following data recorded on a Medication Log Sheet?

1) Date ☐Yes ☐No
2) Patient's name ☐Yes ☐No
3) Amount dispensed ☐Yes ☐No
4) Signature-and license of the person administering the medication ☐Yes ☐No

e. Are multi-dose vials dated and initialed when opened? ☐Yes ☐No

2. PHARMACEUTICAL SAMPLES

a. Are "Samples" stored in a locked cabinet or other storage container, under lock and key? ☐Yes ☐No

1. Is a log maintained for each "sample" kept and does it include the following:
   - Date dispensed ☐Yes ☐No
   - Patient's name ☐Yes ☐No
   - Amount dispensed ☐Yes ☐No
   - Name of authorizing physician ☐Yes ☐No
   - Initials of person dispensing ☐Yes ☐No
   - Balance of remaining inventory ☐Yes ☐No

b. Are medication "samples" dispensed in the original manufacturer's packaging with directions on how to take the medication affixed to the package? ☐Yes ☐No

3. LABELING AND STORING OF DRUGS

a. Are prescription and non-prescription drugs labeled in compliance with state and federal laws? ☐Yes ☐No

b. Do you ensure that prescription labels are altered only by persons legally authorized to do so? ☐Yes ☐No

c. Are drugs intended for external use only stored separately? ☐Yes ☐No

d. Do you have a means to monitor the room temperature of the storage area where medications are kept? ☐Yes ☐No

e. Is a log maintained to show the date, time, temperature and signature of the person responsible for the weekly monitoring function? ☐Yes ☐No

f. Are drugs stored at proper temperatures, i.e., room temperature drugs at 59-86 degrees F (15-30 degrees C)? ☐Yes ☐No
refrigerated drugs at 36-46 degrees F (2-8 degrees C)? ☐Yes ☐No

g. Are drugs stored separately from foodstuff and other agents, and are drugs clearly labeled? ☐Yes ☐No

h. Are drugs stored in an orderly manner, in a secure area with access limited to authorized personnel, and controlled by policy and practice, including "sample" drugs? ☐Yes ☐No

i. Are drugs retained after the expiration date? ☐Yes ☐No

j. Do you keep drug containers that are cracked soiled or poorly secured? ☐Yes ☐No

4. DISPOSAL OF DRUGS AND INJECTABLE MATERIALS

a. Do you dispose of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws? ☐Yes ☐No

b. Is a log maintained of drugs that have been disposed of, including "sample" drugs? ☐Yes ☐No

c. Are needles and syringes disposed of in accordance with the Center for Disease Control guidelines? ☐Yes ☐No

F. CLIENT INFORMATION (FOR MEDI-CAL CLIENTS SEEN THROUGH YOUR CONTRACT WITH THE DEPARTMENT OF MENTAL HEALTH ONLY)

		Primary Location	Secondary Location	Tertiary Location
1.	Indicate the total number of cases presently open at each of your provider locations	_____	_____	_____
2.	How many clients are dually diagnosed, substance abuse/mentally ill?	_____	_____	_____
3.	How many clients are dually diagnosed, mental retardation/mentally ill?	_____	_____	_____

4.	How many clients are wards or dependents of the courts?			
5.	How many forensic clients are part of your caseload?			
6.	Please provide the following specific client data ◆ The ethnicity percentages of clients at each provider location.			
	1) Caucasian			
	2) Hispanic			
	3) African-American			
	4) Asian/Pacific Islander			
	5) Native American			
	6) Other (Please specify)			

		Primary Location	Secondary Location	Tertiary Location
9)	What is the age range of the clients you serve?			
10)	How many clients do you refer to an emergency room each month for psychiatric hospitalization?			

11) Are beneficiary telephone numbers and addresses updated when there is a change? ☐ Yes ☐ No

Credentialing Application Instructions

Individual providers and group rendering providers are licensed or certified (registered nurses only) to practice psychotherapy independently and must be credentialed by the Local Mental Health Plan (LMHP). Non-psychiatric physicians may not be credentialed with the LMHP.

- Credentials will be renewed every three years.
- The credentialing application must be typed or printed legibly.
- Applicants must provide a phone number and an email address that allows direct contact
- All providers must report their DUNS (Dun & Bradstreet) number, which uniquely identifies providers in the claims submission processing. The following website allows you to register for the DUNS number: http://www.sba.gov/content/getting-d-u-n-s-number. In addition to including your DUNS number in the application, please submit your DUNS number via email to CPTT@dmh.lacounty.gov.
- Visit the National Plan & Provider Enumeration System (NPPES) website and ensure your primary taxonomy matches your discipline, as illustrated in the following chart and include a copy of your NPI Registry (required document).

Discipline	**Taxonomy**
M.D. / D.O.	2084P0800X
Ph.D. / PsyD	103TC0700X
L.C.S.W.	1041C0700X
M. F.T.	106H00000X
R.N.	163WP0808X
N.P.	363LP0808X
CNS (child)	364SP0807X
CNS (adult)	364SP0809X

- The provider application must be completed in its entirety.
- If the answer to any professional liability question is “yes”, provide full details on an attached separate sheet and include all pertinent documents from the court and/or attorneys.
- If the answer to any attestation question is “yes”, provide full details on an attached separate sheet. Documentation is required from the professional licensing board if any action has been taken against your license. Additionally, documentation is required from Medi-Cal or Medi-Caid authorizing final disposition on any adverse actions.
- Psychiatrists are to include a copy of their current Drug Enforcement Agency (DEA) certificates, a current *curriculum vitae*, copies of their Medical Degrees, a *Certificate of Professional Liability Insurance*, a completed *Consent to Release Information to a Biller* form (if applicable) and a completed *Rendering Provider* form. Psychiatrists must be either board certified or board eligible in order to provider services under the LMHP. Psychiatrists who are not board certified must include a copy of their certificate of completion of psychiatric residency training.

Psychologists, LCSWs and MFTs are to include a *curriculum vitae*, copies of applicable Graduate Degrees, a *Certificate of Professional Liability Insurance,* a completed *Consent to Release Information to a Biller* form (if applicable) and a completed *Rendering Provider* form.

- Clinical nurse specialists and nurse practitioners are to include a *curriculum vitae*, a *Certificate of Professional Liability Insurance,* Proof of ANCC or AANP certification in behavioral health, a completed *Consent to Release Information to a Biller* form (if applicable) and a completed *Rendering Provider form*. Clinical nurse specialists are to submit proof of graduation from a master's degree in psychiatric/mental health nursing as a clinical nurse specialist. Nurse practitioners are to submit proof of graduation from a master's degree program in psychiatric/mental health nursing as a nurse practitioner and a DEA certificate.

- Malpractice insurance liability requirements are $1,000,000 per occurrence and $3,000,000 aggregate.

- The Credentialing Unit will query the following websites to confirm licensure/certification, and obtain information regarding limitations or sanctions and malpractice claims.
    - State licensing boards and Medical Specialty Boards
    - National Provider Data Bank and Healthcare Integrity and Protection Data Bank
    - Office of the Inspector General exclusion list
    - Department of Health Care Services Medicaid/Medicare Suspended and Excluded List

- Other Required Documents: W-9 Form, Articles of Incorporation (if incorporated), Fictitious Business Name Statement (if Doing Business As)

Please mail or fax the completed application with the required documents to:

Department of Mental Health
Provider Credentialing Unit
550 S. Vermont Avenue, Room 703B
Los Angeles, CA 90020
Fax: (213) 487-9658
Credentialing Unit Telephone Numbers: (213) 738-2814

Helpful Resource Links:

1) National Plan and Provider Enumeration System (NPPES)
   https://nppes.cms.hhs.gov/NPPES/Welcome.do
2) D&B D-U-N-S® Number
   http://www.dnb.com/duns-number.html
3) Los Angeles County Vendor Registration (WEBVEN)
   http://camisvr.co.la.ca.us/webven
4) Enter address to look up the full address with the 9-digit ZIP Code™
   https://tools.usps.com/go/ZipLookupAction!input.action or http://www.unitedstateszipcodes.org/
5) LA County District Locator for Service Areas and Supervisorial District
   http://gis.lacounty.gov/districtlocator/

Application to Participate as a Provider in the Los Angeles County Department of Mental Health Local Mental Health Plan

PROVIDER INFORMATION

Last Name:	First Name:	Middle Initial:

Gender:	Birth date:	Ethnicity:	Degree:

Social Security Number: _____ **Direct Contact Phone Number:**_____

Fax Number:_____ **Email Address (required):**_____

National Provider Identifier (NPI): _____
https://nppes.cms.hhs.gov/NPPES/Welcome.do **Please attach a copy of your NPI number**

Medicare Number:_____
Explanation if no Medicare Number:
☐ **Opted out** ☐ **Excluded**

☐ **Other (explain)** _____

DMH Medi-Cal Provider Billing Number:_____ **(re-credentialing only)**

Is /are there any other name(s) under which you have been known?
Name(s):

DMH Office Use Only	Performed by	Date	Reviewed by	Date
Application completed w/ req. docs				
Credentials verified				
Contract/Amendment requested				
Contract/Amendment executed				

PRACTICE INFORMATION

INDIVIDUAL PRACTICE INFORMATION

Only one of the listed Individual Practices is acceptable. Attach a copy of the IRS Form W-9

☐ **Individual Practice as a sole proprietor under individual name.**

☐ **Individual Practice and doing business as (DBA); attach a copy of Fictitious Business Name Statement**

Business name:_____

NPI Organization Number of the business:_____

☐ **Individual Practice and incorporated; attach a copy of Articles of Incorporation**

Corporation name:_____

NPI Organization Number of the corporation:_____

Federal Tax Identification Number (EIN) of DBA/corporation : _____

Name Affiliated with the above EIN : _____

For Services Reimbursement purposes:

Data Universal Numbering System (DUNS) number: _____
http://www.dnb.com/duns-number.html

LA County Vendor Registration Number (WEBVEN or ECAPS) number:_____
http://camisvr.co.la.ca.us/webven

GROUP PRACTICE INFORMATION

☐ **Group Practice as a member of a group.**

Name of the Group: _____

NPI Organization Number of the Group:_____

DMH Contract Number of the Group (only completed by existing contracted groups): _____

Federal Tax Identification Number (EIN) of the Group :_____

Name Affiliated with the above group EIN : _____

OTHER PRACTICE

Are you currently a County of Los Angeles employee? ☐ **Yes** ☐ **No**

If the answer is yes, please provide the following information: ☐ **Full-time** ☐ **Part-time** ☐ **Consultant**

Name of Department: _____

Work Location: _____

Position: _____

Job Responsibilities: _____

MAILING ADDRESS: Address to which all official notices will be sent. Address must match the NPI Registry.

Street:	Suite Number:	Post Office Box Number:
City:	State:	9 Digit Zip Code (required): http://www.unitedstateszipcodes.org/
Phone:	Fax Number:	Email Address (required):

PRACTICE LOCATIONS and ASSOCIATED BILLING INFORMATION: Practice location address will be listed in the LMHP Directory of Network Provider).

PRIMARY PRACTICE LOCATION (must match the NPI Registry) Street:		Suite Number:
City:	State:	9 Digit Zip Code (required):
Phone:	Fax Number:	Is this office wheelchair accessible? ☐ Yes ☐ No

Medi-Cal Provider Billing Number: _____

NPI number associated to this primary practice location address on NPI registry: _____

Service Area (Circle one) : 1 2 3 4 5 6 7 8 Other
http://gis.lacounty.gov/districtlocator/

Supervisorial District (Circle one) : 1 2 3 4 5
http://gis.lacounty.gov/districtlocator/

OTHER PRACTICE LOCATION (if any) Street:		Suite Number:
City:	State:	9 Digit Zip Code (required):
Phone:	Fax:	Is this office wheelchair accessible? ☐ Yes ☐ No

Service Area (Circle one) : 1 2 3 4 5 6 7 8 Other
http://gis.lacounty.gov/districtlocator/

Supervisorial District (Circle one) : 1 2 3 4 5
http://gis.lacounty.gov/districtlocator/

PAY TO ADDRESS: Reimbursements will be mailed to this address and must match the IRS Form W-9

Street:		Suite Number:	Post Office Box Number:
City:		State:	9-digit Zip Code (required):
Phone:	Fax Number:	Contact Person (please print):	Billing E-Mail Address (required):

PROFESSIONAL EDUCATION

Educational Institution		Degree	From (mm/yy)	To (mm/yy)
Graduate School/ Medical School	**Institution:** **Address:** **City, State, Zip:**			
Internship *(for MD and DO only)*	**Institution:** **Address:** **City, State, Zip:**			
Residency *(for MD and DO only)*	**Institution:** **Address:** **City, State, Zip:**			
Fellowship *(for MD and DO only)*	**Institution:** **Address:** **City, State, Zip:**			

If you are an international medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)? ☐ **Yes** ☐ **No**

For Non-Board Certified Physicians please include Residency completion Certificate

PROFESSIONAL LICENSE (S):

Include a copy of your license(s) with your application materials

Licensing Board Name	State	Specify Active or Inactive	License Number	Expiration Date

DEA CERTIFICATE: M.D.s'/D.O.'s/Nurse Practitioners

Include a copy of your current certificate with your application materials

DEA Certificate Number:	Expiration Date:

BOARD CERTIFICATION: M.D.'s/D.O./CNS

Name of Board	Certification Date	Expiration Date (If Applicable)

HOSPITAL PRIVILEGES: List all hospitals at which you have privileges

Hospital	City	Appointment Date

PROFESSIONAL LIABILITY COVERAGE:

Insurance Carrier	Per claim amount	Aggregate amount	Expiration Date

Please answer either "yes" or "no" after each question. If you answer "yes" to any question, please provide a detailed explanation on a separate sheet. Documentation is required if you have any malpractice actions pending or settled within the past seven years. The documentation must be from an attorney or the entity that issued the judgment.

Have you ever been denied professional liability insurance?	☐ **Yes**	☐ **No**
Has your professional liability insurance ever been canceled, denied renewal or subject to restriction (e.g. reduced limits, surcharged)?	☐ **Yes**	☐ **No**
Within the past seven years have you been a party to any malpractice actions?	☐ **Yes**	☐ **No**
Within the past seven years has any malpractice action been settled or has there been an unfavorable judgment(s) against you in a malpractice action?	☐ **Yes**	☐ **No**
To your knowledge, is any malpractice action against you currently pending?	☐ **Yes**	☐ **No**

ATTESTATION QUESTIONS:

Please answer "yes" or "no" after each question. If you answer yes to any question, please provide a detailed explanation on a separate sheet. Documentation is required from the professional licensing board if any action has been taken against your license.

LICENSURE

1. Has your professional license in any state ever been limited, suspended, revoked or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you?..... ☐ Yes ☐ No
   a. Have you ever voluntarily surrendered your license?..... ☐ Yes ☐ No
   b. Are formal charges pending against you at this time?..... ☐ Yes ☐ No

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

2. Have you ever had an application for membership or privileges at a hospital or other health care facility denied, granted with limitations, suspended, revoked, not renewed or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you, or ever been recommended by a standing medical staff committee or governing board of a hospital, other health care facility or any medical organization? …… ☐ Yes ☐ No
3. Have you ever voluntarily or involuntarily relinquished a medical staff membership, your clinical privileges, a professional license, or a narcotics permit under threat of disciplinary action, threat of censure, restriction suspension or revocation of such privileges?..... ☐ Yes ☐ No
4. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?..... ☐ Yes ☐ No
5. Have your medical staff membership, your clinical privileges, a professional license, or a narcotics permit ever been limited or subjected to disciplinary action of any kind?..... ☐ Yes ☐ No
6. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? …….. ☐ Yes ☐ No
7. Are you currently the subject of any investigation by any hospital, licensing authority, DEA, or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?..... ☐ Yes ☐ No
8. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever be revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?..... ☐ Yes ☐ No

EDUCATION, TRAINING AND BOARD CERTIFICATION

9. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?..... ☐ Yes ☐ No
10. Has your specialty board certification or eligibility ever been limited, suspended, revoked, denied, relinquished, not renewed, or reduced or subjected to probationary conditions, or have proceedings toward any of those ends ever been instituted? (MD/DO only)…… ☐ Yes ☐ No

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

11. Has your DEA certificate or any other controlled substances authorization, ever been suspended, revoked, limited, denied renewal, or have any proceedings toward any of those ends ever been instituted against you?(M.D./D.O./ Nurse Practitioners only)…… ☐ Yes ☐ No

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PARTICIPATION

12. Do you have any pending disciplinary action, or are you currently sanctioned, expelled, or suspended from any federally funded programs, including but not limited to, Medi-Cal, or Medicare?..... ☐ Yes ☐ No
13. Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid?..... ☐ Yes ☐ No
14. Have you ever been sanctioned, expelled, suspended from, or had criminal charges brought against you by any federally funded programs, including but not limited to, Medi-Cal, or Medicare?..... ☐ Yes ☐ No

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

15. **Has your professional liability insurance ever been terminated, or not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your liability insurance or its coverage of any procedure? ……** ☐ Yes ☐ No

MALPRACTICE CLAIMS HISTORY

16. **To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data bank or Healthcare Integrity and Protection Data Bank?.....** ☐ Yes ☐ No
17. **Has any malpractice lawsuit and/or arbitration been filed against you in the last 10 years?.....** ☐ Yes ☐ No
18. **To your knowledge, do you have any pending malpractice suite, arbitrations or judgments?.....** ☐ Yes ☐ No

CRIMINAL/CIVIL HISTORY

19. **Have you ever been court-martialed for actions related to your duties as a medical professional?(M.D./D.O./N.P.s only) ……** ☐ Yes ☐ No
20. **Have you ever been a subject of charges related to moral or ethical turpitude?.....** ☐ Yes ☐ No
21. **Have you ever been convicted of any crime, other than a traffic violation, or pled nolo contendere?** ☐ Yes ☐ No
22. **Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?.....** ☐ Yes ☐ No
23. **Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last 10 years for sexual harassment or other illegal misconduct?.....** ☐ Yes ☐ No

ABILITY TO PERFORM JOB

24. **Do you have a history of alcohol and/or chemical dependency/substance abuse?.....** ☐ Yes ☐ No
25. **Do you have a current problem with alcohol and/or chemical dependency/substance abuse?.....** ☐ Yes ☐ No
26. **Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?.....** ☐ Yes ☐ No
27. **Do you have any physical or mental impairment which would render you unable, with or without reasonable accommodations, to provide professional services within your areas of practice, without posing a direct threat to the health and safety of others?.....** ☐ Yes ☐ No
28. **Are you able to perform all the services required by your agreement with, or professional bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodations, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?.....** ☐ Yes ☐ No

PRIOR LOS ANGELES COUNTY EMPLOYMENT

29. **Have you ever been employed in any capacity by Los Angeles County?.....** ☐ Yes ☐ No
30. **If yes, were you terminated of did you resign because of a performance issue or in the midst of any kind of investigation?.....** ☐ Yes ☐ No

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I do hereby certify that the information contained in this application is accurate and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission from this application constitutes cause for denial of credentialing and enrollment as a network provider in the County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP). I agree to notify the LMHP promptly if there are any material changes in the information provided in this application.

I authorize the LMHP to consult orally, electronically, and in writing with the state licensing board(s), the American Medical Association, the National Technical Information Service, educational institutions, malpractice insurance carriers, specialty boards, Educational Commission for Foreign Medical Graduates, hospitals, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my professional competence and qualifications. Applicants are hereby advised that the LMHP participates in the National Practitioner Data Bank, The Office of the inspector General, California Licensing Boards, American Board of Medical Specialties, and the Department of Health Care Services Medi-Cal Suspended and ineligible Provider list, and the Healthcare Integrity and Protection Data Bank. Applicants acknowledge that adverse actions taken by the LMHP may be reported to these agencies and/or other disciplinary boards/authorities as necessary.

I consent to the release by any person to the LMHP of all information that may be relevant to an evaluation of my professional competency and qualifications, including any information relating to any disciplinary action, suspension or curtailment of privileges. I release the LMHP and all those whom the LMHP contacts from any and all liability for their acts performed in good faith in obtaining and verifying such information and in evaluating my application.

I agree to obtain and maintain in effect all licenses, permits, registration, accreditations and certificates as required by all Federal, State and local laws, ordinances, rules and regulations, and policies of the LMHP. I agree to immediately notify the LMHP upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my DEA number, furnishing certificate, professional license, professional liability insurance, participation in federally funded programs such as Medi-Cal or Medicare or other certification and/or other credentials authorizing me to practice my profession. I also agree to immediately notify the LMHP upon termination, suspension or revocation of my staff privileges at any hospital or health care facility.

I understand that I must meet any requirements set forth in this credentialing application and that this credentialing application implements the LMHP credentialing policy, all of which apply to the application and any decision made by the LMHP with respect to it.

I certify under penalty of perjury that I have downloaded and read the LMHP Provider manual.

_____ _____

Signature of Applicant **Date**

PROVIDER PRACTICE PROFILE

MEDI-CAL REFERRALS

Do you wish to receive new outpatient Medi-Cal client referrals? ☐ **Yes** ☐ **No**
Do you wish to be included in the LMHP Directory of Network providers? ☐ **Yes** ☐ **No**

Please notify Provider Credentialing at (213) 738-2814 or to close or open your practice to new referrals.

Note: The County does not guarantee referrals

What age groups of clients do you serve? (Please check only those that apply)

Children 0 through 5..... ☐
Children 6 through 13 ..... ☐
Adolescents 14 through 17 ..... ☐
Transition Youth 18 through 20..... ☐
Adults 21 through 59..... ☐
Adults 60 and over ..... ☐

Services you provide:

Brief Psychotherapy..... ☐
Medication Services..... ☐
Inpatient..... ☐
Consultation and Liaison ..... ☐
Psychological Testing ..... ☐
Family Psychotherapy..... ☐
Neuropsychological Testing ..... ☐
Group Psychotherapy ..... ☐

Psychological testing that considers the influence of medication on test results ..... ☐

Practice settings in which you provide services: For each practice setting that you check, please indicate the Service Area (SA) in which you are available to provide these services. **Example:** You have offices in both Hollywood and Santa Monica. Check **Office** and **SA 4** and **5**. You provide services to group homes, but only in Hollywood. Check **Group Home** and **SA Area 4**. You may refer to the map attached to this application to assist you in determining which cities are in which SA.

	Practice Settings		**Service Area**							
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1.	Office ***For each Service Area you check, please complete the practice location information on page 2.	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Inpatient	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Youth Group Home/Residential/Schools	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Residential Facilities	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Probation Facilities	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Nursing Facilities	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Clients' Homes	☐	☐	☐	☐	☐	☐	☐	☐	☐

SA 1 Antelope Valley
SA 2 San Fernando/Santa Clarita Valley
SA 3 San Gabriel Valley
SA 4 Metropolitan/Hollywood
SA 5 Santa Monica/ West Los Angeles
SA 6 South Los Angeles
SA 7 Southeast Los Angeles
SA 8 Harbor /Long Beach

MFTs, LCSWs, and RNs are not reimbursed by the LMHP for services in inpatient settings.

Identify any foreign language(s) or sign language in which you are sufficiently proficient to provide competent mental health services without the assistance of a translator:

- ☐ Afghan, Pashto, Pusho
- ☐ Afrikaan
- ☐ American Sign Language
- ☐ Amharic
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bulgarian
- ☐ Burman or Burmese
- ☐ Calo
- ☐ Cambodian
- ☐ Cantonese
- ☐ Cebuano
- ☐ Chinese, other specify:_____
- ☐ Choctaw
- ☐ Creole
- ☐ Czech
- ☐ Danish
- ☐ Dutch
- ☐ English
- ☐ Ethiopian
- ☐ Farsi
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Hindustani
- ☐ Hmong
- ☐ Hungarian
- ☐ Ibonese
- ☐ Igorot
- ☐ Ilocano or Iloko
- ☐ Ilongot
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Konkani
- ☐ Korean
- ☐ Lao
- ☐ Lingata or Ngata
- ☐ Lithuanian
- ☐ Mandarin
- ☐ Marathi
- ☐ Mie
- ☐ Native American Dialects Norwegian
- ☐ Pakistani
- ☐ Pangasinan
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Romanian
- ☐ Samoan
- ☐ Serbo-Croatian
- ☐ Sinhalese
- ☐ Swahili
- ☐ Swatowese
- ☐ Swedish
- ☐ Russian
- ☐ Sign Language, Specify:_____
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Taiwanese
- ☐ Telegu
- ☐ Temne
- ☐ Thai
- ☐ Toisan
- ☐ Tonga
- ☐ Turkish or Ottoman
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Visayan
- ☐ Yao
- ☐ Yiddish
- ☐ Yoruba
- ☐ *Other, specify*_____

Cultural competence is an awareness, understanding, and acceptance of the dynamics of cultural differences. It involves the ability to adapt practices to the cultural context of the consumer. The culturally competent practitioner utilizes the universal similarities present in all of us in order to engage the individual(s) and transcend barriers.

Areas of Cultural Competency:

- ☐ African-American
- ☐ American Indian
- ☐ Armenian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Gay/Lesbian/Bisexual/Transgender
- ☐ Hispanic/ Latino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Persian
- ☐ Russian
- ☐ Samoan and other Pacific Islanders
- ☐ Turkish
- ☐ Vietnamese
- ☐ Other, specify_____

Clinical Expertise: From the list below select the areas for which you have training and expertise.

- ☐ Abuse Survivors
- ☐ Adjustment Disorders
- ☐ Adoption
- ☐ AIDS/HIV
- ☐ Anxiety Disorders
- ☐ Attention-Deficit/Hyperactivity Disorder
- ☐ Developmental Delays
- ☐ Disorders of Adolescence
- ☐ Disorders of Childhood
- ☐ Disorders of Infancy
- ☐ Dissociative Disorders
- ☐ Domestic Violence Perpetrators
- ☐ Domestic Violence Victims
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Elder Care Abuse
- ☐ Family Therapy
- ☐ Gang Members
- ☐ Gay/Lesbian
- ☐ Gender Identity Disorders
- ☐ Grief/Bereavement
- ☐ Group Therapy
- ☐ Hearing Impaired
- ☐ Homeless
- ☐ Mobility Impaired
- ☐ Mood Disorders
- ☐ Norm-Referenced Psychological Testing
- ☐ Personality Disorders
- ☐ Psychotic Disorders
- ☐ Sex Offenders
- ☐ Severe and Persistent Mental Illness
- ☐ Sexual Abuse Victim
- ☐ Substance Abuse
- ☐ The Use of American Psychological Association Guidelines in Child Protection Matters
- ☐ Visually Impaired
- ☐ Other, specify_____

Hours of Operation: Select the days and indicate the hours of your practice.

- ☐ Monday _____AM to _____PM
- ☐ Tuesday _____AM to _____PM
- ☐ Wednesday _____AM to _____PM
- ☐ Thursday _____AM to _____PM
- ☐ Friday _____AM to _____PM
- ☐ Saturday _____AM to _____PM
- ☐ Sunday _____AM to _____PM

Please note that according to 42 C.F.R. section 438.206(c)(1)(ii), the regulation requires providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

January 2, 2019

To: Group Provider Applicant

Thank you for applying to become a group provider in the County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP). In order to enroll as a group provider and receive reimbursement for specialty mental health services provided to Medi-Cal beneficiaries, the legally authorized official of your group must sign a Group Provider Contract with the LMHP.

Please provide the information requested below:

Name of Official: _____

Address: _____

Service Location Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Official Group Name: _____

Group Medi-Cal Provider Number: _____ Tax ID: _____

Vendor Number (if already assigned): _____

NPI Number: _____

Do you wish to receive new outpatient Medi-Cal client referrals? ☐ Yes ☐ No

Note: the County does not guarantee referrals

Are you a Federally Qualified Health Center (FQHC): ☐ Yes ☐ No

Note: The County shall not be responsible to provide or arrange and pay for specialty mental health services provided by FQHCs, Indian Health Centers, and Rural Health Clinics.

Please mail or fax or mail the requested information to:

Department of Mental Health
Provider Credentialing Unit
550 S. Vermont Ave., 7th Floor, Room 703B
Los Angeles, CA 90020
Fax: (213) 487-9658

You cannot be enrolled in the LMHP as a group provider until we have received the above information and have credentialed the individual providers in your group. If you have any questions, please contact the Provider Credentialing Unit at (213) 738-2814.

Sincerely,

Michael Tredinnick, Ph.D.
Mental Health Clinical Manager III
Medi-Cal Professional Services and Authorization Division

Please return this completed form with the Group Provider Application to:

Department of Mental Health
Provider Credentialing Unit
550 S. Vermont Ave., Room 703B
Los Angeles, CA 90020
Fax: (213) 487-9658

Group Provider Name: _____

Group Medi-Cal Provider No: _____

Address: _____

City/State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Please list the individual providers in the group who provide Medi-Cal specialty mental health services. Each provider must complete an individual provider application and be credentialed.

Individual Provider Name	9 Digit Provider No.	NPI No.	Request Type	Eff. Date
			New __ Terminate __Change__	
			New __ Terminate __Change__	
			New __ Terminate __Change__	
			New __ Terminate __Change__	
			New __ Terminate __Change__	
			New __ Terminate __Change__	

You may attach a separate sheet to list additional provider names

Signature: _____Date: _____

Name _____ Title: _____

DEPARTMENT OF MENTAL HEALTH

Intensive Care Division

POLICY/PROCEDURE

SUBJECT: **CREDENTIALING OF PROVIDERS**	POLICY NO. **313.51**	EFFECTIVE DATE **12/28/2018**	PAGE **1 of 9**
APPROVED BY: Robert Burchuk, Medical Director	SUPERSEDES **01/13/2016**	ORIGINAL ISSUE DATE **11/01/98**	DISTRIBUTION LEVEL(S) **1**

PURPOSE

1.1 To outline the standards, requirements and guidelines for the credentialing of licensed mental health providers to participate as network providers in the Los Angeles County Department of Mental Health Plan Local Mental Health Plan (LMHP).

POLICY

2.1 Licensed mental health professionals whose scope of practice permits the practice of psychotherapy independently, who meet the credentialing standards and contracting requirements established by the LMHP and who have a signed and executed contract, will be approved to provide specialty mental health services to Los Angeles County Medi-Cal beneficiaries.

DEFINITION

3.1 Credentialing: The formal process of collecting and verifying the professional credentials and qualifications of licensed individual providers and evaluating them against the standards and requirements established by the LMHP to determine whether such individual providers meet these standards and requirements.

3.2 Credentialing Timeframe: The process of completing credentialing must occur within 180 days of the LMHP receipt of the provider's complete application.

3.3 Providers: The following mental health providers who are licensed or certified and recognized by the State of California to practice independently may apply to participate as network providers in the LMHP.

3.3.1 Board eligible or board certified psychiatrists

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3.3.2 Licensed clinical psychologists

3.3.3 Licensed clinical social workers

3.3.4 Licensed marriage and family therapists

3.3.5 Registered nurses with a master's degree in psychiatric/mental health nursing as a clinical nurse specialist (CNS) or Psychiatric Mental Health Nurse Practitioner (PMHNP).

PROCEDURES

4.1 Upon receipt of a request for an application to participate in the LMHP, the provider's name, discipline, address, phone number and fax number are to be entered in the Application Request Log.

4.1.1 Each entry in the Application Request Log is to be dated and include the initials of the Credentialing Unit staff member who recorded the request.

4.1.2 The application packet will be sent to the provider within five working days of the request.

4.1.3 The packet contains the application, credentialing requirements and direction for completing the application.

4.1.4 The date the application is sent and the initials of the staff member who processed the application request are to be entered on the Application Request Log.

4.1.5 Completed logs are to be retained for 60 days for future reference.

4.2 Upon receipt of a completed application, it is date stamped on page 1 of the application indicating the date of receipt of the application materials.

4.3 A Credentialing Unit staff member will review the application within two weeks of receipt of the application and determine if the application materials are complete and current.

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4.3.1 A Mental Health Provider Application Checklist is to be completed recording the outcome and date of the review.

4.3.2 The application form must be completed, signed and dated. If the application form is incomplete and/or the documents required are not included or are not current, the provider will be contacted via telephone or letter. A copy of the notification letter will be retained in the provider file. The incomplete application form is returned to the provider and a copy is retained in the provider file.

4.3.3 A detailed explanation is required for an affirmative answer to liability or attestation questions. A history of all professional liability claims which resulted in settlements or judgments paid on behalf of the provider is required.

4.3.4 The following documents are required for credentialing and must be included with the application form:

1) A copy of the certificate of completion of Psychiatric Residency Training (physicians who are not board-certified in psychiatry).

2) Documentation of completion of a graduate nursing program in Psychiatric/Mental Health Nursing (clinical nurse specialists and nurse practitioners). For Clinical Nurse Specialist (CNS), an advanced practice registered nurse (APRN), documentation with graduate preparation (earned master's or doctorate) from an approved program that prepares CNSs. For Psychiatric Mental Health Nurse Practitioner (PMHNP), documentation indicating a master's degree in nursing from an accredited college or university with a specialty in Psychiatric Mental Health Nursing and completion of an approved Adult, Child, or Family Nurse Practitioner program, or documentation of completion of an approved master's level Psychiatric Mental Health Nurse Practitioner Program issued by an accredited college or university.

3) A copy of a current DEA certificate (physicians and nurse practitioners only)

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4) A current curriculum vitae or work history

5) Evidence of current malpractice insurance with liability requirements of $1,000,000 and $2,000,000 aggregate. Other evidence of insurance required by LAC DMH Board of Supervisor.

6) National Provider Identifier Number

4.4 The Credentialing Unit staff member will complete a query of the National Provider Data Bank and the Healthcare and Integrity Protection Data Bank. A copy of the results of the query will be added to each provider's file.

4.5 The Credentialing Unit staff member will verify that the provider is not on any federal or state list excluding the provider from Medicare or Medicaid payment. The results will be documented in the provider's file. Specifically, history of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in Plan's provider network. This list is available at http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and history of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

4.6 Verification of Professional License/Physician Board Certification

4.6.1 M.D.: License status is verified directly with the Medical Board of California via the internet. The verification is printed and retained in the provider's file. Completed a residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

4.6.2 Board certification by the American Board of Psychiatry and Neurology is verified directly via the Internet. The search results are printed and retained in the provider's file. Possesses a valid and active license issued by the California Medical Board, has completed an ACGME accredited residency training program, an dis certified by the American Board of Psychiatry and Neurology in general psychiatry, a psychiatric sub-specialty, or certified by the American Board of Medical Specialties (ABMS).

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4.6.3 D.O.: License status is verified with the Osteopathic Medical Board of California via the Internet. The verification is printed and kept in the provider's file.

4.6.4 Board certification by the American Osteopathic Board of Psychiatry and Neurology is verified directly via the internet. The search results are printed and retained in the provider's file.

4.6.5 Psychologists: License status is verified directly with the California Board of Psychology. The verification is printed and kept in the provider's file.

4.6.6 Licensed Clinical Social Workers and Licensed Marriage and Family Therapists: License status is verified directly with the California Board of Behavioral Sciences via the Internet. The verification is printed and kept in the provider's file.

4.6.7 Registered Nurses with a master's degree License status is verified directly with the California Board of Registered Nursing via the internet. The verification is printed and kept in the provider's file. Clinical Nurse Specialist (CNS) is an advanced practice registered nurse (APRN), with graduate preparation (earned master's or doctorate) from an approved program that prepares CNSs. The Psychiatric Mental Health Nurse Practitioner (PMHNP) possesses a master's degree in nursing from an accredited college or university with a specialty in Psychiatric Mental Health Nursing and completion of an approved Adult, Child, or Family Nurse Practitioner program, or completion of an approved master's level Psychiatric Mental Health Nurse Practitioner Program issued by an accredited college or university.

4.7 Criteria for Accreditation into the LMHP Provider Network.

4.7.1 Minimum criteria must be met for an applicant to be considered for enrollment as a LMHP Network Provider. These minimal criteria are indicated in the provider application. Applicants who fail to meet the minimum criteria shall be notified by the Credentialing Unit staff member in writing of those criteria that are not met and that further consideration of the application will not occur until such criteria are met. Applicants have no

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right of appeal when the application is denied due to failure to meet minimum credentialing criteria. Minimum criteria are as follows:

1) Practice location meets the following standards for individual and group practice sites:

   a) Practice site is maintained in a manner that provides for the physical safety of beneficiaries, visitors and personnel.

   b) Practice site is clean, sanitary and in good repair.

   c) Medications are securely stored and dispensed according to State and Federal regulations.

   d) Clinical records are maintained sect rely and confidentially.

2) Graduation from an accredited professional school at the time of attendance, and/or highest training program applicable to the academic degree, discipline, and licensure of the provider.

3) Physicians must have attained Board certification or be eligible for examination to receive certification by the American Board of Psychiatry and Neurology. A. copy of the certificate of completion of psychiatric residency training must be submitted with the application materials for those physicians who are not Board certified.

4) Valid, current California license.

5) Valid, current, unrestricted Drug Enforcement Agency (DEA) Certificate, where applicable.

6) Submission of a completed, signed and dated application form with all required documents as indicated on the application.

7) Absence of falsification of the provider application or material omission of the information requested in the provider application.

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8) Current professional liability insurance that meets or exceeds the Department's minimum limits of $1 million per incident/ $2 million annual aggregate per clinician. The Contracts Development and Administration Division will conduct current and additional imposed insurance verification in accordance with the Board of Supervisor.

9) Absence of current sanctions (i.e., exclusions or suspensions) by federal or State agencies in the National Plan Provider Enumeration System (NPPES) and the Excluded Parties List System (EPLS), Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and National Practitioner Data Bank (NPDB).

10) Verification that the clinician is not in the Social Security Administration's Death Master File.

4.8 Additional Credentialing Criteria: Applications that meet the minimum credentialing criteria listed in Section 5.1.1 of this policy will be reviewed by the credentialing specialist for the following additional criteria. Applications will be referred to the Credentialing Review Committee (CRC) if the additional criteria are not met which may result in a determination to deny credentialing.

1) Absence of a history of involvement in a malpractice suit, arbitration or settlement in the past five years in accordance with the criteria set forth below. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.

   a) No more than three malpractice suits, arbitrations, or settlements within the last five years greater than $100,000 in aggregate.

   b) No single judgment, arbitration or settlement within the last five years that is greater than $100,000.

   c) The CRC reviews all open cases.

2) Absence of a history within the past 10 1/ears of disciplinary actions affecting the applicant's professional license, Board standing, DEA certification, or

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other required certification. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.

3) Absence of felony or misdemeanor convictions, other than traffic violations. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such conviction does not adversely affect the applicant's ability to perform his/her professional duties.

4) Absence of a history of sanctions by regulatory agencies including Medicare/Medicaid and any other public regulatory agency. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.

5) Absence of a history of alcohol and chemical dependency/substance abuse. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.

6) Absence of a physical or mental impairment which would make the applicant/provider unable, with or without reasonable accommodations, to provide professional services within his/her area of practice, without posing a direct threat to the health and safety of others. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such condition does not adversely affect the applicant's ability to perform his/her professional duties.

7) If the CRC denies waiver for one of the situations addressed in this section an applicant may not apply for a credential for two years or until such a time as the situation requiring waiver is resolved.

4.9 In situations where currently credentialed providers would be excluded by changes in credentialing policies or changes in application of the policies, such providers may be excluded from the policies and their application reviewed on a case by case basis.

DEPARTMENT OF MENTAL HEALTH
Intensive Care Division
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AUTHORITY

42 C.F.R. Section 438.214
MHSUDS Information Notice No: 18-019

DEPARTMENT OF MENTAL HEALTH

Intensive Care Division

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APPROVED BY: Robert Burchuk, Medical Director	SUPERSEDES **1/13/2016**	ORIGINAL ISSUE DATE **02/01/1999**	DISTRIBUTION LEVEL(S) **1 & 2**

PURPOSE

1.1 To outline the structure, composition and functions of the Credentialing Review Committee (CRC).

POLICY

2.1 The Credentialing Review Committee shall review and consider the applications of all mental health provider whose credentials present special issues that require further consideration and who do not clearly meet the standards for credentialing in the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) Provider Network.

DEFINITIONS

3.1 Credentialing is the formal process of collecting and verifying the professional credentials and qualifications of licensed providers and evaluating them against the standards and requirements established by the LMHP to determine whether such providers meet these standards and requirements.

3.2 The CRC is a confidential, multi-disciplinary body appointed by the Director or its designee. The purpose of the CRC is to ensure that the initial and ongoing credentials of applicants and network providers are evaluated and maintained in accordance with the credentialing standards established by the LMHP.

PROCEDURES

4.1 **CRC Meetings**

4.1.1 The CRC meeting is scheduled monthly.

4.1.2 Prior to each meeting the credentialing specialist will notify committee members of the scheduled meeting.

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4.1.3 The credentialing specialist will prepare a meeting agenda prior to each scheduled meeting.

4.1.4 The credentialing specialist will distribute the minutes of the previous committee meeting to the committee members for review prior to each scheduled meeting.

4.1.5 The credentialing specialist prepares and presents documentation for consideration by committee members. Prior to each meeting, the redacted credentialing documents scheduled for review will be distributed to the committee members. The application materials will be marked **CONFIDENTIAL**.

4.1.6 The credentialing specialist will prepare CRC minutes. The minutes will reflect the discussion of the relevant issues presented and consideration of the provider's credentialing documents before a credentialing decision is made. The committee minutes will be marked **CONFIDENTIAL**.

4.1.7 Approved committee minutes will be kept in a binder in the Medi-Cal Professional Services and Authorization Division.

5.1 **Applicants will be referred to the CRC under the following circumstances:**

5.1.1 Falsification or misrepresentation of any information on the application.

5.1.2 A pending or previous malpractice claim that reflects quality of care or clinical practice problems.

5.1.3 More than two professional malpractice actions within the past five years.

5.1.4 Applicants who are currently on probation with the professional licensing board.

5.1.5 Applicants with a disciplinary action(s) pending before the professional licensing board.

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5.1.6 Applicants whose professional license or narcotic registration has previously been revoked, suspended or limited.

5.1.7 Applicants who have been the recipient of adverse actions by Medicare, Medi-Cal or any other public program.

5.1.8 Applicants who have been the recipient of adverse actions by a specialty board, professional organization, hospital medical staff, clinical group, independent practice association or other health delivery system.

5.1.9 Applicants who have been convicted of a felony.

5.1.10 Applicants who have a physical or mental impairment which might render him/her unable, with or without reasonable accommodations, to provide professional services within his/her area of practice, without posing a direct threat to the health and safety of others.

5.1.11 Applicants who raise concern regarding clinical practice outside the professional standard of care.

6.1 **Network providers will be referred to the CRC under the following circumstances:**

6.1.1 A disciplinary action concerning a network provider is brought before the professional licensing board.

6.1.2 The professional licensing board enforces a disciplinary action against a network provider.

6.1.3 A malpractice claim is brought against a network provider that reflects quality of care or clinical practice problems.

6.1.4 The network provider becomes the recipient of an adverse action by Medi-Cal, Medicare or any other public agency.

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6.1.5 The network provider becomes the recipient of an adverse action by a specialty board, professional organization, hospital medical staff, clinical group, independent practice association or other health delivery system.

6.1.6 Felony criminal charges are filed against a network provider that raises concern about clinical practice and quality of care.

6.1.7 The network provider has developed a physical or mental impairment which might render him/her unable, with or without reasonable accommodations, to provide professional services within his/her areas of practice, without posing a direct threat to the health and safety of others.

6.1.8 A complaint(s) raises concern regarding professional standard of care.

7.1 **Responsibilities and functions of the CRC are as follows:**

7.1.1 To serve as an advisory panel in the development of standards for the credentialing of mental health providers.

7.1.2 To serve as an advisory panel in the development of credentialing policies and procedures.

7.1.3 To review and evaluate the credentials of mental health providers whose application and/or credentials present special issues or indicate adverse events that require further consideration.

7.1.4 To review and evaluate the credentials of network providers who no longer appear to meet the established criteria for credentialing during the term of an existing contract or at the time of contract renewal.

7.1.5 To review and evaluate the credentials of network providers at the time of re-credentialing who no longer appear to meet the established criteria for credentialing.

7.1.6 To advise the Director or its designee of the Department of the committee's recommendations for the denial of credentialing of mental health providers.

DEPARTMENT OF MENTAL HEALTH
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8.1 **The CRC Evaluation of Application and Credentials are as follows:**

8.1.1 The CRC will review all documents pertaining to the evaluation of the professional credentials of a provider presented to the committee.

8.1.2 The CRC may request additional information from the provider or pertinent organizations that may assist the committee in the evaluation process.

8.1.3 The CRC may request a personal interview with providers to clarify any questions related to the approval/denial of credentialing.

8.1.4 Upon completion of the review, the CRC will recommend a decision regarding the qualifications of the provider to participate in the LMHP Provider Network. Recommendations may include, but are not limited to full approval, approval with specific restrictions and monitoring and denial.

8.1.5 A recommendation by the CRC to deny credentialing to deny re-credentialing or to recommend the termination of an existing contract will be reviewed with the Director or its designee of the Department.

8.1.6 The Director or its designee will notify providers in writing, via certified mail, of a decision to place a provider on probation, to deny credentialing, to deny re-credentialing or to recommend termination of an existing contract.

9.1 **A recommendation by the CRC to deny credentialing, deny re-credentialing or recommend termination of an existing contract may be made under the following circumstances:**

9.1.1 Falsification or misrepresentation of information required for credentialing or re-credentialing.

9.1.2 Failure to supply current information when requested for credentialing.

9.1.3 Failure to attest, explain or provide accurate information regarding the following:

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9.1.3.1 Past and/or current professional liability claims and settlements.

9.1.3.2 Past and/or current denial, termination, restriction, or modification of professional liability insurance.

9.1.3.3 Past and/or current suspension, limitation or termination of professional license or narcotic registration.

9.1.3.4 Current sanction activity by a professional licensing board or Drug Enforcement Administration.

9.1.3.5 Past and/or current sanction activity or adverse actions by Medicare, Medi-Cal, a specialty board, hospital medical staff, health faculty, clinical group, independent practice association or other health delivery entity or system.

9.1.3.6 A felony conviction.

9.1.3.7 A physical or mental impairment, which would render the provider unable, with or without reasonable accommodation, to provide professional services within his/her area of practice, without posing a direct threat to the health and safety of others.

9.1.4 Inability to verify credentials submitted by provider.

9.1.5 Excessive or egregious past or current malpractice claims and/or settlements.

9.1.6 Excessive or significant beneficiary or provider complaints as verified by primary source and/or internal quality management information,

9.1.7 Excessive or egregious administrative non-compliance as determined by internal quality management information.

9.1.8 Provider has stated or demonstrated practice patterns outside of professional standard of care.

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9.1.9 Provider is unable to provide professional services within his/her area of practice, with or without reasonable accommodation, for a physical or mental impairment, without posing a direct threat to the health and safety of others.

9.1.10 The CRC determines, based upon the provider's application, credentials and information obtained from primary source verification, the provider's inability to execute the duties and obligations as assigned in the provider legal agreement.

10.1 **The LMHP will maintain the confidentiality of all provider credentialing and re-credentialing information and files.**

DEPARTMENT OF MENTAL HEALTH
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APPROVED BY: Robert Burchuk, Medical Director	SUPERSEDES **01/13/2016**	ORIGINAL ISSUE DATE **10/19/99**	DISTRIBUTION LEVEL(S) **1**

PURPOSE

1.1 To ensure that the credentialing/re-credentialing, limitation, and termination decisions of the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) network providers' privileges are followed in a consistent manner and with due process.

POLICY

2.1 LMHP shall, as appropriate, deny credentialing or re-credentialing, restrict, suspend or terminate a provider's privilege to participate in the LMHP Provider Network if it is determined that a provider:

a) Does not meet the standards enumerated in Policies 313.51, 313.52, or this policy;

b) Does not comply with the credentialing or re-credentialing procedures specified in Policies 313.51, 313.52 or this policy;

c) Fails to comply with any of the provisions set forth in the provider contract;

d) Poses an immediate threat to the health and safety of any individual, including current or prospective beneficiaries;

e) Fails to provide care in a manner consistent with professional standards or fails to provide quality patient care;

f) Violates LMHP rules, policies or other requirements;

g) Violates professional ethics;

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h) Is convicted of a crime related to health care, substance abuse or other crime, the commission of which, demonstrates dishonesty or lack of fitness to provide care within the Provider Network;

i) Is subject to licensure restrictions that limit the provider's practice or require professional oversight for care provided. This provision illustrates that the requirements for credentialing in the LMHP exceed those of licensing authorities;

j) Is excluded or restricted by Federal, State or local authorities from participation in any program receiving public health care reimbursement;

k) Is subject to mandatory termination as described in Section 6.1 of this policy.

2.2 A decision to deny credentialing, re-credentialing, limit or terminate a provider's privilege to participate in the LMHP Provider Network, shall be subject to independent review pursuant to Policy CR4.

PROCEDURES

3.1 Denial of Initial Credentialing/Re-credentialing:

3.1.1 Failure to pass the minimum standards established by the LMHP for credentialing as delineated in Policy 313.51 Section 5.1 will result in the denial of initial credentialing/re-credentialing.

3.1.2 The credentialing specialist/designee notifies the provider in writing of the failure to meet the minimum credentialing standards.

3.1.3 The provider shall be given 60 days to correct the application or submit additional information to show compliance with the minimum credentialing criteria.

3.1.4 If the provider does not meet criteria a within 60 days, the credentialing specialist/designee shall close the applicant's file for consideration as an LMHP network provider.

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4.1 **Failure to comply with the re-credentialing process:**

4.1.1 The credentialing specialist/designee shall send a request and application for re-credentialing no less than 120 days before the expiration date of the credentials.

4.1.2 If the provider fails to respond to the initial request for re-credentialing within 30 days, the credentialing specialist/designee shall submit a second request in writing to the provider.

4.1.3 If the provider fails to respond to the second request, his or her participation in the LMHP Provider Network shall terminate upon the expiration of the period for which he or she was last credentialed.

5.1 **Termination or denial of credentialing/re-credentialing:**

5.1.1 A provider's participation in the LMHP shall terminate upon the expiration of the period for which he or she was last credentialed, unless he or she is re-credentialed.

5.1.2 The Credentialing Review Committee (CRC) may recommend to the Director or its designee of the Department, that a provider applicant or network provider not be credentialed, not be re-credentialed or have his or her credentials terminated. Such recommendation shall be based on the CRC's full review and evaluation of all available material at a regularly scheduled or special meeting. The content of the CRC and the discussion of the issues relative to the denial recommendation shall be reflected in the meeting minutes. The recommendation shall be forwarded to the Director or its designee of the Department within five business days of the decision. The Director or its designee of the Department may accept, reject, or request additional action on any recommendation of the CRC.

5.1.3 If the Director or its designee of the Department takes action to deny credentialing or re-credentialing based upon the recommendation of the CRC, he or she or a designee shall serve the provider in writing via certified mail with a Notice of Intended Action to deny or restrict the provider's participation it the LMHP Provider Network. The Notice of Intended Action shall include:

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1) The nature of the action proposed to be taken;

2) A date not earlier than thirty days subsequent to receipt of the Notice of Intended Action on which the intended action will take place;

3) The specific reasons for the proposed action;

4) The provider's right to request an independent review of the proposed action in the manner described in Policy CR4;

5) The thirty-day time limit within which the provider may request an independent review pursuant to Policy CR4;

6) A summary of the provider's rights with respect to an independent review. A copy of Policy CR4 shall be enclosed with the notice prescribed by this section.

5.1.4 If the provider does not request an independent review pursuant to Policy CR4, the action taken by the Director or its designee of the Department shall become final and not subject to further appeal or review within the LMHP. The provider will be notified in writing via certified mail that the action is final.

5.1.5 A provider who has sought an independent review pursuant to Policy CR4, and who is not subject to summary suspension or mandatory termination pursuant to Section 6.1 of this policy may participate in the LMHP pending the decision of the Credentialing Appeals Committee (CAC) for up to 120 day:; after receipt by the provider of the Notice of Hearing as described in Policy CR4 Section 3.3.2

5.1.6 A provider who has received a Notice of Intended Action pursuant to Section 5.1.3 of this policy may, upon written notice given to the Chair of the CRC, and as soon as practicable after receipt of the Notice, inspect and at his or her own expense, copy any non-privileged, non-confidential documentary information relevant to the intended action that the CRC has in its possession or under its control.

6.1 **Provider Terminations, Suspensions, and Restriction's during the period of credentialing:**

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6.1.1 At any time during the period of credentialing, the CRC may make a recommendation to the Director or its designee of the Department to terminate, suspend or restrict the privilege of a provider to participate in the LMHP Provider Network if it determines that a provider no longer meets the requirements of this policy or Policies 313.51 and/or 313.52. Any information that might lead to an action by the CRC pursuant to this paragraph shall first be reviewed by the Director or its designee in order to determine the need for, or course of, further investigation. At the discretion of the Director or its designee such investigation may result in informal resolution, referral to the CRC for further evaluation, summary suspension or restriction of clinical privileges as described in Sections 6.1.2, 6.1.3 and 6.1.4 of this policy.

6.1.2 Summary Suspension: The Director or its designee of the Department or the designee, may at any time, immediately suspend or restrict clinical privileges of a provider where failure to take such action may result in imminent danger to the health of any individual including prospective beneficiaries. The terms of the suspension or restriction shall remain in effect pending full investigation, CRC evaluation, and final decision. In the event of such summary suspension, the case shall be forwarded immediately to the CRC and the procedures described in this policy and Policy CR4 shall be followed. Additionally, notification shall be given to the provider and the ACCESS Center to suspend referrals until a full investigation and review has been completed.

6.1.3 Mandatory Termination: Notwithstanding of the provisions of this policy or Policy CR4, a provider shall be terminated from participating in the LMHP upon the occurrence of any of the following events:

a. Revocation, or suspension of the provider's license by the applicable licensing authority;

b. Commitment to jail or imprisonment;

c. Conviction of a crime related to provision of health care within the LMHP;

d. Loss of professional liability insurance;

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e. Exclusion or restriction of participation in the Medi-Cal or Medicare programs.

6.1.3.1 The Director or its designee will immediately notify the provider of the mandatory revocation in writing via certified mail. This notification shall specify the reason for which the provider was terminated and shall include a copy of any documentary proof that supports the revocation. Mandatory termination of privileges pursuant to this paragraph is not subject to a Notice of intended Action as provided in Section 5.1.3 of this policy. However, the terminated provider shall have the right to an independent review of the termination as provided in Policy CR4 with respect to the grounds for mandatory revocation.

6.1.4 In the event of summary suspension or mandatory termination, the following actions shall take place:

6.1.4.1 The credentialing specialist or designee shall:

a. Request a list from the provider of all clients currently in treatment with the provider which is to include the client's name, CIN #, address and phone number

b. Obtain a claims based report of all clients for whom claims were paid to the provider from the Medi-Cal Professional Services and Authorization Division Provider Relations Unit and reconcile the report with the provider list to establish an accurate client list

c. Forward the client list to the Beneficiary Services Program in the Patients' Rights Office who shall notify the clients in writing of the following:

1. The provider is no longer a participant in the LMHP Provider Network

2. Due to the inactive status of the provider, the LMHP is not responsible for any aspects of the services delivered by the provider as of the date of notification

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3. The client may contact the ACCESS Center or the Beneficiary Services Program to receive referrals to other LMHP network providers, directly operated providers or contract providers

4. The Beneficiary Services Program Specialist will assist the client in transferring to another mental health provider if he/she so chooses

5. Confidentiality surrounding adverse actions imposed on the provider will be maintained during the course of client discussions

6.1.5 The Credentialing Specialist or designee shall notify the Contracts Development and Administration Division of the action. The Contracts Development and Administration Division shall immediately terminate the provider contract.

6.1.6 Network Providers who elect to terminate their provider contract shall be responsible for notifying the provider's current beneficiaries in writing of the termination of the contract as provided in Section 6.1.4.1(c) (1-4) of this policy and in accordance with the requirements in the LMHP Provider Manual or through Provider Bulletins.

7.1 **Network Providers with Accusations against their License: The credentialing specialist may identify a provider with an accusation from the "hot sheets" or other published reports of State licensing board activities. In such occurrences, the credentialing specialist shall review the accusation with the Director or its designee to determine the course of further investigation. The provider may be forwarded to the CRC for full evaluation, review and recommended action. The CRC may:**

a) Request additional information from the provider regarding the accusation

b) Conduct further investigation deemed necessary by the CRC

c) Require that the provider provide reports on the status of the accusation on a quarterly basis

d) Pend the case until judgment has been rendered from specific authority investigating the case (i.e., Medical Board).

DEPARTMENT OF MENTAL HEALTH

Intensive Care Division

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7.1.1 If upon full evaluation the CRC recommends imposing a limit, suspension, or termination to the credentialing status of the provider, the procedures delineated in Section 5.1 of this policy shall be followed.

8.1 Reporting Requirements

8.1.1 The LMHP shall comply with the provisions of California Business and Professions Code Sections 800-809 and the Federal Health Care Quality Improvement Act of 1986.

8.1.2 LMHP shall file a Section 805 report with the Medical Board of California or the other appropriate California licensing board and a report with the National Practitioner Data Bank within 15 days after the effective date of the action, when the LMHP takes the following actions:

a) Takes a professional review action that adversely affects the clinical privileges of a provider for a period longer than 30 days

b) Accepts the surrender of clinical privileges of a provider while the provider is under an investigation relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation

c) Takes a professional review action that adversely affects the membership of the provider into the network

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APPROVED BY: Robert Burchuk Medical Director	SUPERSEDES **01/13/2016**	ORIGINAL ISSUE DATE **12/01/04**	DISTRIBUTION LEVELS **1 & 2**

PURPOSE

1.1 To provide a fair, prompt, final and independent review of decisions made to deny provider credentialing or re-credentialing, or limit or terminate a practitioner's privilege to participate in the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) Provider Network.

POLICY

2.1 Providers who wish to contest notices of proposed actions to deny or restrict network participation in the LMHP Provider Network may have an independent review in the fashion described in this policy. This policy is intended to comport with, and should be interpreted to apply to, the provisions of California Business End Professions Code Sections 809.1 through 809.9 and 42 United States Code Section 11112

2.2 All actions taken pursuant to Policy 313.53 shall be subject to final determination pursuant to this policy.

PROCEDURE

3.1 **Demands for Independent Review**

3.1.1 Not later than 30 days after receipt of a Notice of Intended action as described in policy 313.53, a provider may demand an independent review. Such demand will be served on the Director or its designee.

3.1.2 If the provider chooses to be represented by an attorney or other person at the independent Review Hearing, the demand is to provide the

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representative's name and contact information no later than 30 days after receipt of a Notice of Intended Action as described in Policy 313.53.

3.2 **Notice of Independent Review Hearing**

3.2.1 Not later than 30 days after receipt of the provider's demand for an Independent Review Hearing, the Director or its designee will give the provider, or if the provider so designates as provided in section 3.8 of this policy, his or her representative, a written Notice of Hearing that specifies the date, time and place of the Independent Review Hearing, as well as the names of the Hearing Officer described in Section 3.5 of this policy and members of the Credentialing Appeals Committee (CAC) described in Section 3.6 of this policy. In addition, this notice shall specify the names and qualifications of all individuals who will testify or present justification for the intended action at the Independent Review Hearing, along with a very brief summary of the information they will present.

3.2.2 Copies of all records, writings or other ion-verbal materials to be presented by the Credentialing Review Committee (CRC) at the Independent Review Hearing shall be provided along with the notice. This provision is intended to facilitate the independent review process and support full opportunity for advance preparation for the Independent Review Hearing. Failure to provide information as described in this subsection shall foreclose a presentation of verbal or non-verbal materials at the Independent Review Hearing.

3.3 **Objection to the Notice of Hearing**

3.3.1 Not later than 15 days after physical receipt of the Notice of Hearing, the provider, or his or her representative, may submit written questions (voir dire) concerning the qualifications or impartiality of the members of the CAC or of the Hearing Officer to which written responses shall be given within 15 days of submission.

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3.3.2 Not later than 30 days after physical receipt of the Notice of Hearing, the provider, or
his or her representative, may object in writing to the date, time or place of the Independent Review Hearing to the Hearing Officer. The grounds for such objections shall be stated specifically. The Hearing Officer shall promptly consider and determine such objections. However, in all cases, Independent Review Hearings shall take place not later than 120 days after receipt by the provider of the Notice of Hearing described in Section 3.2 of this policy.

3.4 **Responses to the Notice of Hearing**

3.4.1 Not later than 30 days after physical receipt of the Notice of Hearing, the provider, or his or her representative, shall give a written response to the Notice of Hearing to the Director or its designee. The response shall specify the names and qualifications of all individuals who will testify or present in opposition to the intended action at the Independent Review Hearing, along with a very grief summary of the information they will present. Copies of all records, writings or other non-verbal material to be presented shall be provided along with the response. This provision is intended to facilitate the independent review process and support full opportunity for advance preparation for the Independent Review Hearing.

3.4.2 Except as provided in Section 3.1.4 of this policy, failure to provide information as described in this subsection shall foreclose a presentation of verbal or non-verbal materials at the Independent Review Hearing.

3.5 **Role and Qualifications of the Hearing Officer**

3.5.1 The Hearing Officer shall be an attorney or other person knowledgeable about legal process and the introduction and preservation of evidence.

3.5.2 The Hearing Officer shall have no interest in, or derive direct financial benefit from, the outcome of the Independent Review Hearing and shall be

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fair and impartial in all matters pertaining to the Independent Review Hearing process.

3.5.3 The Hearing Officer shall rule on requests, motions or objections made by either party: shall rule upon and regulate the introduction of evidence; shall control the proceedings of, and maintain order at the Independent Review Hearing; and shall instruct the members of the CAC as to their role and responsibilities as decision makers.

3.5.4 The Hearing Officer shall not act as a prosecuting officer, defending officer or decision maker with respect to the outcome of the Independent Review Hearing. However, he or she may ask such questions, challenge such proffered evidence and make such comment as may assist the parties or the CAC or assure the effective and efficient conduct of the independent review process.

3.6 Roles and Qualifications of the Credentialing Appeals Committee

3.6.1 The CAC will consist of three members who shall hear and consider such evidence as is presented to them and shall determine the outcome of the Independent Review Hearing. The CAC members shall have expertise sufficient to understand and decide upon the issues to be determined in The Independent Review Hearing and, where feasible, will include an individual practicing in the same specialty as the provider.

3.6.2 The members of the CAC will have no interest in the outcome of the Independent Review Hearing: shall not have acted as an accuser, investigator, fact-finder, or initial decision maker; shall be fair and impartial in all matters pertaining to the Independent Review Hearing; and may not be in direct economic competition with the provider.

3.7 Representation of Parties

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3.7.1 In all matters pertaining to this policy, the provider may be represented by an attorney licensed to practice law in California or other person of the provider's choice. If the provider is represented, the CRC may be represented. The attorney or other representative shall comply with the requirements and constraints of this policy and of law. The Hearing Officer is empowered to make such rulings, and take such actions, as will assure such compliance.

3.8 **Pre-hearing Communications and Pre-Hearing Conference**

3.8.1 All written communication to the provider shall be made by United States mail at the address provided by him or her to the LMHP. All written communication to the LMHP shall be made to the Director or its designee Department of Mental Health, 550 S. Vermont Avenue, Room 704, Los Angeles, California 90020.

3.8.2 If the provider or the LMHP is represented by an attorney or other person, each may designate that written communications and service of documents be given to the representative at an address provided.

3.8.3 Copies of all written communications and documents described in this policy will be provided to the Hearing Officer.

3.8.4 At the discretion of the Hearing Officer, pre-hearing conferences or settlement discussions may occur.

3.9 **Time, Place and Attendance at the Independent Review Hearing and Record of Hearing**

3.9.1 The Independent Review Hearing will be held in a single session at the time and place specified in the Notice of Hearing, unless otherwise mutually agreed upon by the Director or its designee, the Provider and approved by the Hearing Officer.

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3.9.2 The Independent Review Hearing will take place during the period of one and one half hours unless, for good cause shown, the Hearing Officer extends the time.

3.9.3 Those in attendance at the hearing may be: the Director of Mental Health, the Director or its designee of the Department of Mental Health, the provider and his or her representative, if any, the Director or its designee, the Chair and members of the CRC and their representative, if any, witnesses to be called, and such others as permitted by the Hearing Officer for good cause shown. The Hearing Officer may hear and determine objections to the attendance of anyone during all or part of the Hearing.

3.9.4 A record will be made of the Independent Review Hearing and a copy of will be given to the provider upon payment of charges associated with its preparation.

3.10 **Procedure at independent Review Hearing**

3.10.1 The CRC and the provider will have equal time to present at the Independent Review Hearing. During such time they may call, examine and cross-examine witnesses, present documentary evidence, rebut evidence presented, object to or move to strike evidence, and make arguments, and submit written statements of any length. In no event shall the CRC or the provider exceed its total allocated time for any such purpose.

3.10.2 The Hearing Officer will permit only relevant evidence at the Independent Review Hearing. For purposes of this policy relevant evidence tends logically to prove or disprove something at issue. Evidence of the qualifications or credibility of witnesses will be permitted. A party offering documentary or demonstrative proof must establish its authenticity. Neither party shall be permitted to present evidence that was not provided pursuant to paragraphs 3.2 or 3.3 of this policy or not

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otherwise previously available to the opposing party and the Hearing Officer.

3.10.3 The Hearing Officer may exclude evidence if its probative value is substantially outweighed by the probability that it will consume undue time, create undue prejudice, confuse the issues at the independent Review Hearing, or mislead the CAC.

3.10.4 Except as provided in this subsection, all evidence is admissible at the Independent Review Hearing and the rules of evidence in judicial proceedings shall not apply.

3.11 **Presentation of Evidence and Burden of Persuasion**

3.11.1 At all Independent Review Hearings, the CRC will have the initial responsibility to present evidence sufficient to support its intended action.

3.11.2 The party bearing the burden of persuasion must persuade the CAC by a preponderance of the evidence that what it asserts is more likely to be true than not true.

3.11.3 The burden of persuasion shall be on the provider in cases where the reason for denial of credentialing is failure to meet any of the additional requirements in 313.51 Section 6.1 which the CRC finds inadequate reason 10 waive.

3.11.4 **Burden of persuasion for Initial Credentialing:** if the provider is challenging a decision related to initial credentialing, he or she shall bear the burden of persuasion with respect to his or her qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning such qualifications. However, an initial applicant shall not be permitted to introduce information not provided with the completed provider application described in Policy 313.51,

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Section 4.2, or to the CRC pursuant to Policy 313.52, Section 8.1.2 or Section 8.1.3, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

3.11.5 **Burden of Persuasion at Other Hearings**: If the Provider is challenging a decision other than one related to initial credentialing, the CRC shall bear the burden of persuasion to establish that its intended action is reasonable and warranted under LMHP policies related to patient care and provider credentialing.

3.12 **Consideration of Evidence**

3.12.1 Notwithstanding the burden of presenting evidence or the burden of persuasion, the CAC may consider all evidence admitted at the Independent Review Hearing.

3.13 **Submission to and Decision of the Credentialing Appeals Committee**

3.13.1 After submission of all evidence and arguments, the Independent Review Hearing shall end and the procedures described below shall take place.

3.13.1.1 **Questions**: After all evidence has been submitted and arguments made, the members of the CAC may ask relevant questions of the parties or their representatives or of the Hearing Officer.

3.13.1.2 **Instructions**: The Hearing Officer shall instruct the CAC concerning the consideration of evidence, burdens of persuasion and their responsibilities to decide the matter before the Committee.

3.13.1.3 **Decision**: A final determination of the provider's credentialing status shall be rendered by the CAC and communicated to the

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provider in writing via certified mail by the Chair of the CAC, or his or her designee, within 14 days of the Independent Review Hearing. If the determination is adverse, the communication shall include a statement of the basis for the decision.

3.14 **LMHP Participation Pending Final Determination**

3.14.1 During the periods provided in this policy for independent review and pending the final decision by the CAC, a provider who has sought an Independent Review Hearing and who is not subject to summary suspension or mandatory termination may participate in the LMHP.

3.14.2 Consistent with the provisions of Section 3.2 of this policy, however, the provider's participation in the LMHP shall in all cases terminate 120 days after receipt by the provider of the Notice of Independent Review Hearing described in section 3.2.1 of this policy.

3.15 **Finality of Decision**

3.15.1 The decision of the CAC is final and the provider has no further right of appeal to the LMHP.

3.16 **Strict Construction of Procedures**

3.16.1 Consistent with the purposes of this policy, the procedures described herein shall be strictly applied.

3.16.2 Deviation from these procedures shall be permitted only if found by the Hearing Officer to constitute a threat of gross injustice to a party or a substantial detriment to the role and responsibilities of the CAC.

ADDITIONAL INFORMATION CONTRACTOR ADDRESS FORM

PROVIDER NUMBERS are primary locations where the services are provided. Please ensure the correct Provider Numbers are reflected in this Contractor Address Form.

THE PAY TO ADDRESS is the address that will be used FOR REIMBURSEMENT. If you receive reimbursement at more than one location, please indicate in writing by placing a checkmark in the proper Pay To Address, which corresponds with the correct Provider Numbers.

USE THIS FORM IF YOU HAVE A CHANGE OF ADDRESS

Complete this form and return to the address printed on the form. If you have several Provider Numbers, ensure that the correct numbers are included with the Contractor Address Form.

Be extra careful to ensure the correct Provider Numbers are on this form.

CONTRACTOR ADDRESS FORM

☐ New
☐ Change of Address

Contractor Name: (Must be the same name in the NPI Registry & contract)	
DBA: (Must be the same name in the NPI Registry & contract)	
Contract Number:	
Provider Type	**Group** ☐ **Individual** ☐

☐ **Add** ☐ **Delete Other Service address (published for referrals)**

A. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm:

Service Area: 1 2 3 4 5 6 7 8 OOC **Supervisorial District: 1 2 3 4 5**

* Use another sheet for additional Service location on Provider Directory

☐ **Add** ☐ **Delete Other Service address (published for referrals)**

B. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm:

Service Area: 1 2 3 4 5 6 7 8 OOC **Supervisorial District: 1 2 3 4 5**

* Use another sheet for additional Service location on Provider Directory

☐ **Add** ☐ **Delete Other Service address (published for referrals)**

C. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm:

Service Area: 1 2 3 4 5 6 7 8 OOC **Supervisorial District: 1 2 3 4 5**

* Use another sheet for additional Service location on Provider Directory

Please fax to (213) 381-7092 and mail the signed form and attachments to Contracts Development and Administration Division, ATTN: Fee-For-Service Section, 550 S. Vermont, 5th Floor, Los Angeles, CA 90020.

Signature: _____ Date: _____

Print Name of Authorized Signer:_____ Title:_____

CONTRACTOR ADDRESS FORM

Contractor Name: (Must be the same name in the NPI Registry & contract)	
DBA: (Must be the same name in the NPI Registry & contract)	
Contract Number:	
Provider Type	**Group** ☐ **Individual** ☐

☐ **Add** ☐ **Delete Other Service address (published for referrals)**

A. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm:

Service Area: 1 2 3 4 5 6 7 8 OOC **Supervisorial District: 1 2 3 4 5**

* Use another sheet for additional Service location on Provider Directory

☐ **Add** ☐ **Delete Other Service address (published for referrals)**

B. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm:

Service Area: 1 2 3 4 5 6 7 8 OOC **Supervisorial District: 1 2 3 4 5**

* Use another sheet for additional Service location on Provider Directory

☐ **Add** ☐ **Delete Other Service address (published for referrals)**

C. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm:

Service Area: 1 2 3 4 5 6 7 8 OOC **Supervisorial District: 1 2 3 4 5**

* Use another sheet for additional Service location on Provider Directory

Please fax to (213) 381-7092 and mail the signed form and attachments to Contracts Development and Administration Division, ATTN: Fee-For-Service Section, 550 S. Vermont, 5th Floor, Los Angeles, CA 90020.

Signature: _____ Date: _____

Print Name of Authorized Signer:_____ Title:_____

SAMPLE BENEFICIARY NOTIFICATION LETTER

Date

Client Name
Address
City, State

Dear Client/Parent/Caregiver:

The purpose of this letter is to inform you that I am no longer a Medi-Cal provider in the County of Los Angeles Department of Mental Health Provider Network.

If you would like assistance locating another mental health provider or other mental health services in the provider network, you may call the Department of Mental Health ACCESS Center at 1-800-854-7771. The ACCESS Center is available for calls 24 hours a day, 7 days a week.

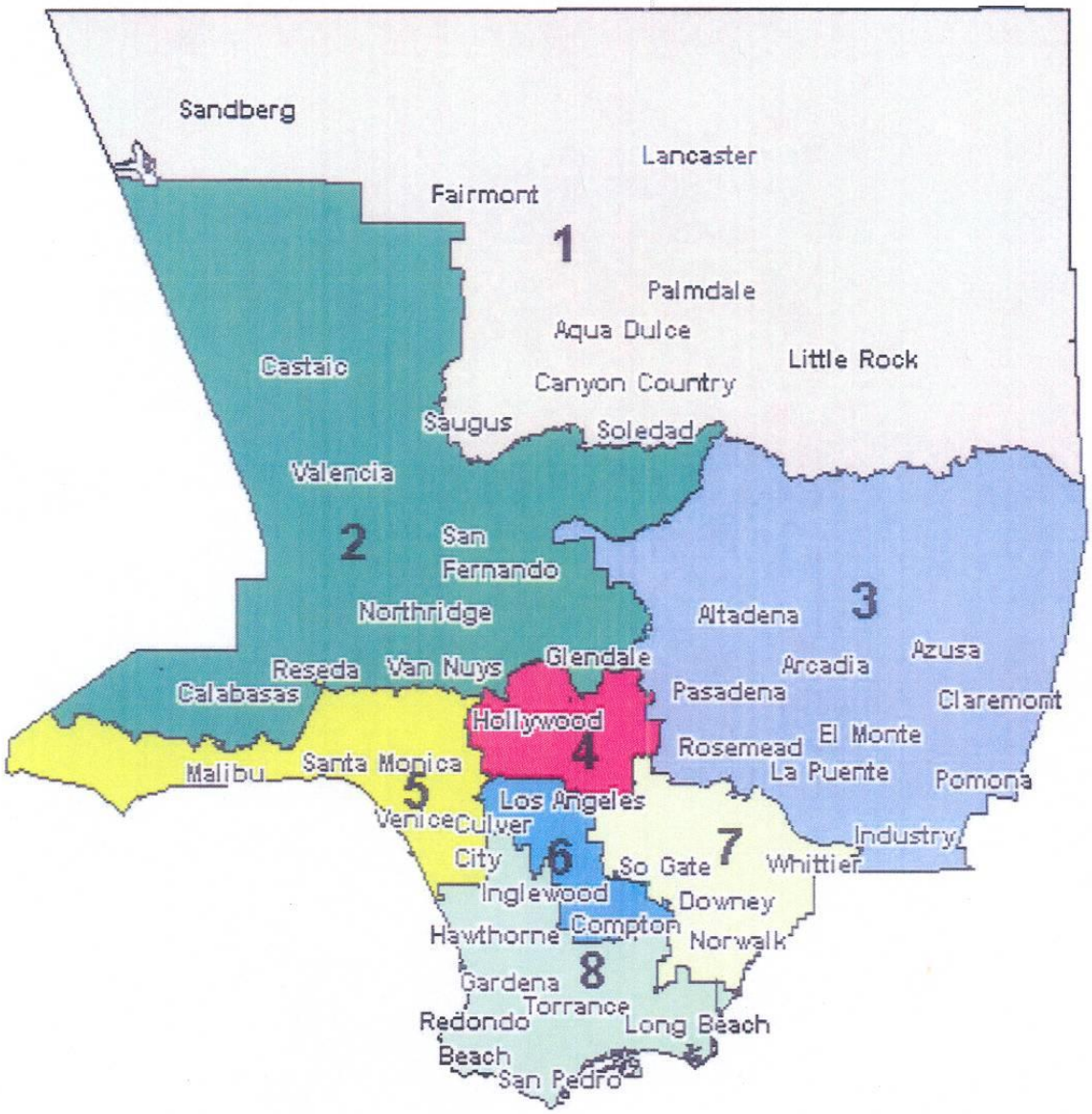
If you need additional assistance you may also contact the Beneficiary Services Program at (213) 738-4949.

Sincerely,

Provider Name

FIGURE A:

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
SERVICE AREA MAP



SECTION III – THE PROVIDER SUPPORT OFFICE

The Provider Support Office provides technical, administrative and clinical assistance to Local Mental Health Plan (LMHP) network providers and their authorized representative (e.g., billing agent, group provider administrator) to aid in the delivery of quality specialty mental health services. The Provider Support Office may be contacted at (213) 738-3311 during the business hours of 8:00 a.m. to 5:00 p.m., or create a Self Service Support ticket at the following link: **https://dmh.sslvpn.lacounty.gov/dmh/contractor** to receive the following technical, administrative, and clinical assistance:

TECHNICAL ASSISTANCE

- Disseminate guidelines regarding changes to County's claims processing information systems technical requirements and the submission of HIPAA-compliant claims to the LMHP;
- Advise and resolve network providers' and billing agents' issues concerning electronic claiming, disputes and reports in the County's claims processing information systems;
- Provide assistance regarding electronic Medi-Cal beneficiary enrollment; and
- Direct network providers and billing agents to appropriate resources, internal and external to the LMHP.

ADMINISTRATIVE ASSISTANCE

- Provide information and assistance to mental health providers on the application, credentialing and contracting process;
- Disseminate LMHP guidelines, policies and State and Federal regulations;
- Compile, prepare and post the Network Provider Manual via the Department's outpatient website;
- Distribute bulletins and other network provider informational materials;
- Provide information regarding network providers' responsibility for obtaining forms for Medi-Cal beneficiary materials;
- Develop and administer the network providers' fiscal appeal process; and
- Provide administrative assistance to network providers and billing agents regarding Notices of Action.

CLINICAL ASSISTANCE

- Serve as liaison between Medi-Cal beneficiaries and network providers to facilitate access to services and care coordination;
- Provide guidelines regarding procedure and diagnosis codes;
- Assist with out-of-county provider services and authorization of over-threshold and psychological testing services;
- Coordinate the clinical appeal process; and
- Provide information to network providers regarding clinical records and consent standards.

If you have any questions or need additional information, please contact the Provider Support Office at the following location:

Department of Mental Health
Provider Support Office
550 S. Vermont Ave., 7th Floor
Los Angeles, CA 90020
Phone: (213) 738-3311
Fax: (213) 487-9658

Email: FFS2@dmh.lacounty.gov

SECTION IV– ACCESS TO SERVICES

Medi-Cal beneficiaries can access specialty mental health services through the Access to Community Care and Effective Services and Support (ACCESS) Center at (800) 854-7771, 24 hours a day, seven days a week. Services are organized on a geographic basis to facilitate greater ease of access. However, Medi-Cal beneficiaries are free to request services in any geographic service area of the mental health system, and may secure referrals to any mental health program, whether directly operated by, or contracted with, the LMHP.

The ACCESS Center (AC) is a major entry point to the LMHP for Medi-Cal beneficiaries and is staffed with multi-disciplinary, multi-cultural and multi-lingual personnel. The AC is also able to provide services to individuals with hearing impairments. The AC provides mental health screening and triage through licensed and unlicensed clinicians who evaluate treatment needs and ensure expedient and appropriate access to LMHP services.

The AC offers the following:

- Information and referrals to Medi-Cal beneficiaries seeking specialty mental health services;
- Determination of appropriateness for specialty mental health services through the LMHP based on medical necessity;
- Screening and triage of client calls to identify service needs;
- Crisis intervention;
- Connection to emergency services such as the Psychiatric Mobile Response Team and other urgent delivery service systems;
- Determination of programs currently providing services to a specific client;
- Referrals to Medi-Cal network providers;
- Direction for network providers to appropriate LMHP Divisions for authorization of psychological testing and other outpatient professional services;
- Direction for out-of-county providers to client enrollment and authorization services;
- Direction for out-of-county and out-of-state provider authorization requests to the appropriate resource;
- Information regarding linkage to community resources;
- Information and referrals for other non-related mental health services;
- Linkage and referral to services provided by the LMHP;
- Information regarding client problem resolution processes; and
- Referral to the Patients' Rights Office and the Provider Support Office

SECTION V – CONFIRMATION OF MEDI-CAL ELIGIBILITY AND ELECTRONIC MEDI-CAL BENEFICIARY ENROLLMENT

ELIGIBILITY VERIFICATION

Confirmation of Medi-Cal eligibility is a MUST by network providers, billing agents/services and clearinghouses. Network providers are required to verify client Medi-Cal eligibility prior to providing services.

Clients are required by the State of California to present their Benefits Identification Cards (BIC) in order to access their Medi-Cal benefits. Carrying the BIC helps providers affirm that the client is entitled to Medi-Cal benefits and facilitates checking clients Medi-Cal eligibility. The issue date can be found on the front of the card along with other information such as the recipient's name, gender, date of birth, and the Client Index Number (CIN). The CIN is a unique identifier assigned to an individual.

Each CIN begins with a 9 followed by seven (7) digits, an alpha character other than B, I, J, K, L, O, P, Q, R, or S, and ends with a "check digit." This sequence is then followed by a four (4) digit sequence (e.g., 91234567A2 **9180**). The issue date for the BIC **is** the sequence after the CIN in the Julian calendar date format. The first number of this sequence represents the year and the last 3 numbers represent the day of the year. For example, in the four (4) digit sequence **9180** the 9 represents the year 2009, and 180 represents the one hundred eightieth day of that year, June 29th. The BIC issue date in this example would be June 29, 2009.

Medi-Cal eligibility and share of cost information may be verified by entering the Medi-Cal beneficiary's Client Index Number (CIN) printed on the beneficiary's Medi-Cal card in one of the State eligibility systems as follows:

- Providers with a California Department of Health Care Services (DHCS) issued provider number may verify Medi-Cal beneficiary eligibility by swiping the beneficiary's Medi-Cal card through the Point of Service (POS) Network Device. Contact the Medi-Cal POS and Internet Help Desk at (800) 427-1295 for information about acquiring a POS device, or at the following website address: https://www.medi-cal.ca.gov/Eligibility/Login.asp.

- Providers with a DHCS issued provider number may verify Medi-Cal beneficiary eligibility by entering the CIN in the Automated Eligibility Verification System (AEVS). The AEVS is an interactive voice response system that allows the provider to verify eligibility through a touch-tone telephone. The AEVS may be accessed by calling (800) 456-2387. Please refer to the AEVS User Guide at: http://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp for more information.

- Groups, licensed clinical social workers, marriage and family therapists and registered nurses are not issued DHCS provider numbers. These disciplines may contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 to obtain specially designated provider numbers (user ID) and personal identification numbers (pin/password) to verify Medi-Cal eligibility via the website at https//www.medi-cal.ca.gov/Eligibility/Login.asp, or AEVS at (800) 456-2387.

It is recommended that network providers maintain a copy of the Benefits Identification Card and a copy of Medi-Cal eligibility obtained from one of the State eligibility systems listed above.

BENEFICIARY ENROLLMENT

Electronic Medi-Cal beneficiary enrollment is a process that requires network providers, billing agents/services and clearinghouses to enroll Medi-Cal eligible clients in the County's claims processing information system (i.e. Provider Connect). The purpose of electronic Medi-Cal beneficiary enrollment is to assign unique Department of Mental Health client identification numbers and maintain a tracking system for Medi-Cal beneficiaries receiving services from network providers. Reimbursement will only be provided if Medi-Cal beneficiaries are enrolled in the County's claims processing information system.

For questions regarding Medi-Cal beneficiary enrollment and Medi-Cal eligibility transactions, please contact the Provider Support Office at (213) 738-3311 or FFS2@dmh.lacounty.gov.

For assistance with the Integrated Behavioral Health Information System (IBHIS) Provider Connect Portal, please report the incident at the following link: https://dmh.sslvpn.lacounty.gov/dmhcontractor or contact the Help desk at (213) 351-1335.

SECTION VI – THE BENEFICIARY SERVICES PROGRAM AND REQUIREMENTS FOR PROVIDING MEDI-CAL BENEFICIARY MATERIALS TO CLIENTS

MEDI-CAL BENEFICIARY MATERIALS

Under California Code of Regulations (CCR), Title 9, Chapter 11, the Local Mental Health Plan (LMHP) and its network providers are required to provide beneficiaries with a booklet and Provider Directory upon request and when a beneficiary first receives a specialty mental health service.

The LMHP has developed user-friendly Medi-Cal beneficiary materials that provide a general understanding of services offered. All Medi-Cal beneficiary materials listed below must be posted in prominent locations where Medi-Cal beneficiaries obtain outpatient specialty mental health services, which includes the waiting areas of a network provider's place of service.

The LMHP has made an effort to ensure that the cultural and linguistic needs of the diverse populations served throughout the LMHP are met by developing Medi-Cal beneficiary materials in the LMHP's threshold languages which are: Arab, Armenian, Cambodian, Chinese Simplified, Chinese Traditional, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese. The Medi-Cal beneficiary materials available in the LMHP's threshold languages are:

- **Guide to Medi-Cal Mental Health Services:** Booklet informs Medi-Cal beneficiaries on how to access and obtain routine and emergency specialty mental health services;
- **Grievance/Appeal Procedures*:*** Pamphlet describes the beneficiary problem resolution process for filing a grievance;
- **Beneficiary Grievance/Appeal Form*:*** Form provides Medi-Cal beneficiaries the opportunity to register written dissatisfaction about any aspect of services offered by the LMHP; and
- **Local Mental Health Plan Poster**: A poster designed to provide Medi-Cal beneficiaries simple and user-friendly information while upholding Title 9, California Code of Regulations. The FFS Network Provider should post the Beneficiary Poster in prominent locations and/or waiting areas where Medi-Cal beneficiaries obtain outpatient specialty mental health services.

To obtain copies of the Medi-Cal beneficiary materials identified above, including the Local Mental Health Poster, you may contact The Patients' Rights Office at:

Department of Mental Health
Patients' Rights Office
550 S. Vermont Ave, 6th Fl., Rm. 608
Los Angeles, CA 90020
(213) 738-2524

Orders to the Patients Rights' Office must be on the organization's letterhead. Materials will only be delivered to a street address, not a P.O. Box. Requests may also be faxed to (213) 252-9740.

Medi-Cal beneficiary materials in all LMHP's threshold languages are available to download from the Department of Mental Health's Internet website, http://dmh.lacounty.gov. Please go to the Patients' Rights Office link on the website to access and print these materials.

For further assistance, the Patient's Rights Office can be reached at (213) 738-4888 or (800) 700-9996. Information is also available on the Patient's Rights Office website at http://dmh.lacounty.gov/patient_rights.asp.

THE BENEFICIARY SERVICES PROGRAM

The Beneficiary Services Program in the Patients' Rights Office assists beneficiaries in filing and resolving an informal complaint, a formal grievance and State Fair Hearings on any aspect of their specialty mental health services under the Local Mental Health Plan. Advocates record, investigate and coordinate resolution of complaints and grievances filed by beneficiaries. Further, the Beneficiary Services Program provides beneficiaries representation at State Fair Hearings conducted by the Department of Social Services. Beneficiary Services may be reached at (213) 738-4949.

BENEFICIARY INFORMATION

The following services are available:

- Provide information to Medi-Cal beneficiaries and/or their representatives regarding the LMHP and services offered.
- Inform Medi-Cal beneficiaries of their rights under California Code of Regulations, Title 9, Chapter 11, including the right to:
    - Use the Beneficiary Problem Resolution Process at any time;
    - Authorize another person to act on his/her behalf;
    - Protection of confidentiality at all times;
    - Request a State Fair Hearing after the appeal process of the LMHP has been exhausted; and
    - A beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.
- Assist Medi-Cal beneficiaries with comprehension of issues related to Notices of Action.
- Develop, prepare and distribute Medi-Cal beneficiary materials.
- Provide information on the Health Insurance Portability and Accountability Act (HIPAA) investigate and resolve DMH HIPAA complaints.

BENEFICIARY ASSISTANCE

- Assist in the problem resolution process for grievances/appeals filed with the LMHP about access to service and service delivery issues.
- Record, investigate, and coordinate resolution of grievances filed by Medi-Cal beneficiaries with the LMHP.

- Provide referrals to emergency shelter and transitional housing.
- Represent Medi-Cal beneficiaries at State Fair Hearings upon request.
- Ensure that Medi-Cal Beneficiaries can access all services in their primary language and in a culturally appropriate manner.

CLINICAL ASSISTANCE

- Assist Medi-Cal beneficiaries in accessing specialty mental health services available through the LMHP, which can include accessing care, changing providers, requesting a second opinion when indicated, and understanding and exercising their rights.
- Serve as liaison between Medi-Cal beneficiaries and network providers during the grievance process and when requested.
- Provide outpatient clinic referrals to Medi-Cal beneficiaries and assist with coordination of transfers.
    - Provide assistance to Medi-Cal beneficiaries who receive notification of their network provider contract termination with the LMHP.

STATISTICAL REPORTING/SYSTEM CHANGE

- Collect and provide statistical information regarding Medi-Cal beneficiary grievances/appeals and the beneficiary problem resolution process.
- Make system change recommendations to the Director of Mental Health and Executive Management Team.
- Make corrective action recommendations to directly operated and network providers.
- Develop policies and procedures to enhance the quality of services to Medi-Cal beneficiaries.

TRAINING AND EDUCATION

- Provide community outreach and education to Medi-Cal beneficiaries and community stakeholders about Medi-Cal beneficiary protection-related issues and State regulations affecting specialty mental health service delivery.
- Provide on-site educational presentations to network providers regarding the Medi-Cal beneficiary resolution process.
- Provide consultation and recommendations to bureaus and other community stakeholders regarding Medi-Cal beneficiary protection-related issues as stipulated under CCR, Title 9, Chapter 11.
- Educate network providers on landlord/tenant law.

PATIENTS' RIGHTS

Local Mental Health Plan (LMHP) network providers shall comply with applicable laws and regulations relating to patients' rights, including but not limited to Welfare and Institutions Code 5325, California Code of Regulations, Tittle 9, *§* 860 through 868 and Code of Federal Regulations (CFR), Title 42, *§* 438.100. The following patients' rights provisions shall be taken into account when providing services, including the right to:

- Receive information about the services, treatment options, and alternatives offered by the LMHP in a form that is easily accessible, easy to read. Such information shall be accessible in all identified threshold languages and shall appropriately accommodate persons with special needs, such as a visual impairment or reading difficulty. Beneficiaries have the right to free language assistance services. This includes information about:
  - The individual's rights and responsibilities
  - Available services
  - Available practitioners and providers
  - Other obligations of the LMHP
  - Requirements of the LMHP's contract with the state in the areas of:
    - Available services;
    - Assurance of adequate capacity and services;
    - Coordination and continuity of care;
    - Coverage;
    - Authorization of service;
    - Title 42 Code of Federal Regulation (CFR) Section 438.10, which describes information requirements; and
    - Health care services in accordance with Title 42 CFR and Sections 438.206 through 438.210.
- Receive a copy of the LMHP Guide to Medi-Cal Mental Health Services and participating provider lists;
- Be treated with personal respect, recognition of their dignity, and right to privacy;
- Receive services in a safe environment;
- Receive, free of charge, language assistance (including beneficiaries who have Limited English Proficiency and/or are Deaf or Hearing Impaired) and upon request, cultural-specific providers and services;
- Participate with practitioners and providers in making decisions about their mental health care, including the right to refuse treatment;
- Participate in candid discussions of appropriate medical necessary treatment options for their condition;
- Voice complaints about the LMHP or the care it provides, as well as file grievances and appeals with the LACDMH Patients' Rights Office (PRO) in accordance with LACDMH Policy No. 200.04, Beneficiary Problem Resolution Process;
  - If the individual is enrolled in a Health Maintenance Organization (HMO) that is separate from Medi-Cal, the grievance and appeal process must go through that HMO.

- Make recommendations regarding the LMHP's beneficiary rights and responsibility policy;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, punishment, or retaliation as specified in federal rules about the use of restraints and seclusion in facilities such as hospitals, nursing facilities, and psychiatric residential treatment facilities where one stays overnight for treatment;
- Request and receive a copy of their medical records and request for amendment(s) or correction(s); consistent with LACDMH Policy No. 501.01, Clients' Right to Access Protected Health Information (PHI), LACDMH Policy No. 501.04, Client Rights to Request Confidential Communication of Protected Health Information; and LACDMH Policy No. 501.06, Client Rights to Amend Mental Health Information.
- Receive a second opinion by a licensed mental health professional, other than a psychiatric technician or a licensed vocational nurse, employed by, contracting with, or otherwise made available by the LMHP when the LMHP or its providers determine that the medical necessity criteria in CCR Title 9 Chapter 11 § 1830.205(b)(1), (b)(2), or (b)(3)(C) and §1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the LMHP;
  - The LMHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.
  - The second opinion shall be provided at no cost to the beneficiary.
  - Receive timely access to mental health services regardless if the mental health need is routine, urgent, or an emergency psychiatric condition; and
- Participate in efforts to promote the delivery of services in a culturally competent and linguistically appropriate manner. These include services for those persons with Limited English Proficiency and/or are Deaf or Hearing Impaired, and have diverse cultural and ethnic backgrounds.

SECTION VII – CONSENTS AND AUTHORIZATION STANDARDS FOR CLIENT ACCESS TO HEALTH INFORMATION AND USE/DISCLOSURE OF HEALTH INFORMATION

CONSENTS

It is the responsibility of network providers to ensure compliance with minimum requirements in obtaining client consent for specialty mental health services. Copies of the Local Mental Health Plan (LMHP) consent forms are at the end of this section for your reference in developing your own unique forms. It is important to ensure that all the required information is included on your consent forms and that they do not include a reference to the LMHP.

Form deficiencies identified during reviews are frequently the result of the absence of required information. The minimum content for consents is included in this section to assist you with ensuring compliance when developing a unique form.

The following types of consents must be included in a Medi-Cal beneficiary's clinical record:

- Consent for Services (Attachment I);
- Consent of Minor (Attachment II);
- Consent of Minor in Spanish (Attachment III) when appropriate; and
- Informed Consent for Psychotropic Medication when appropriate.

CONSENT FOR SERVICES

DEFINED

This process documents the Medi-Cal beneficiary's agreement to receive specialty mental health services, the mental health services provided, instructions and client rights. A *Consent for Services* form must be signed during the first contact with a client and remains in effect for the course of treatment

MINIMUM CONTENT REQUIRED

- Client Name
- Name of individual, group, or organizational network provider
- Type of Services Provided:
  - ♦ List in specific language the type of service(s) that may be delivered, such as an assessment, psychological testing, psychotherapy, medication, laboratory tests, and/or diagnostic procedures.
- General Information:
  - ♦ The client has a right to be informed and participate in the selection of treatment services;
  - ♦ Treatment services are voluntary;
  - ♦ The client may request a change of service provider (agency or treating clinician); and
  - ♦ The information contained in the clinical record may be released to any LMHP operated or contracted agency or provider, pursuant to Welfare and Institutions Code Section 5328, without obtaining the consent of the client.

- Signatures Required:
  - For adults: Client signature and date, or indication on the form if the client is unable/unwilling to sign the *Consent for Services* form.
  - For minors: Signature of responsible adult, relationship to client, and date.
  - For clients unwilling to sign or a minor signing without parental consent: A witness statement (which may be by the clinician) explaining the absence of the client signature with the witness' signature and date.
  - For translators: Translator signature and date.

- Additional Requirements:
  - Affirmation that the *Consent of Minor* form has been completed for under-aged child or adolescent;
  - Printed client name and the DMH Client ID number;
  - Confidentiality and disclosure statement; and
  - Date when the client or responsible adult was given or declined a copy of the *Consent for Services* form.

CONSENT OF MINOR

DEFINED

This process documents the right of a minor, under the age of 18, to consent to services without parental consent. This can occur only when one of the following special circumstances exists:

- Emancipated: only a court can decide this status;
- Self-sufficient: client must be at least 15 years of age, living apart from the parent or guardian (with or without their consent), and managing his/her own affairs;
- Military: client currently on active duty;
- Married: client currently or formerly married; or
- In need of mental health services:
  - client must be at least 12 years of age and mature enough to participate in the services provided;
  - there must be a danger of serious physical or mental harm if services are not provided or there is alleged incest or child abuse;
  - there is documentation that the parent(s)/guardian(s) were contacted or the reason why they were not contacted;
  - there is documentation regarding the parent(s)/guardian(s) participation or unwillingness to participate in treatment; and it is documented that the client will not be prescribed psychotropic medications without parental/guardian consent.

MINIMUM CONTENT REQUIRED

- Emancipated: a copy of the minor's Department of Motor Vehicles emancipated minor ID card;
- Self-sufficient: no official designated document; the network provider must consider and document evidence presented by the minor;
- Military: a copy of the minor's military ID;
- Married: a copy of the marriage certificate; or
- In need of mental health services: the network provider must note and attest to the five requirements on the *Consent of Minor* form (Attachment II or III).

Documentation validating at least one of the five special circumstances above must be obtained at the same time the *Consent for Services* form (Attachment I) is signed.

Documentation is required only once for minors who are emancipated or are, or have been, married.

Documentation for minors who are in the military, declare themselves to be self-sufficient, or are between the ages of 12–18 must be obtained each time a Medi-Cal beneficiary re-enters service following a discharge either by the clinician or in the IS. A new *Consent for Services* form must also be signed for the new course of treatment.

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

DEFINED

This process documents the voluntary consent of the Medi-Cal beneficiary to take psychotropic medication after the physician has reviewed all the information with the client listed below under Minimum Requirements. An *Informed Consent for Psychotropic Medication* form is required for the following:

- When a new or different type of medication, such as anti-depressant or anti-psychotic, is prescribed;
- At least annually, even if there is no medication change; and
- When the client resumes taking medication following a documented withdrawal of consent.

MINIMUM CONTENT REQUIRED

- Explanation of the nature of mental disorder, what the medication(s) will address and why psychotropic medication is being recommended;
- The general type of medication being prescribed (anti-psychotic, anti-depressant, etc.) and the medication's specific name;
- The dose, frequency, and administration route of the medication(s) being prescribed;
- Situations, if any, which may warrant taking additional medications;
- How long it is expected that the client will be taking the medications;
- Potential side effects; and
- Whether there are reasonable treatment alternatives.
- Signed by the beneficiary
- A statement that informs the beneficiary that the consent may be withdrawn at any time by the beneficiary

AUTHORIZATION STANDARDS

This section, which is in compliance with the LMHP interpretation of Health Insurance Portability and Accountability Act (HIPAA) regulations, is not to be viewed as legal advice or take the place of advice provided by your legal counsel.

The LMHP authorization forms at the end of this section may be adopted by network providers or used as a reference in developing your own unique forms. If a unique form is developed, it is important to ensure that all the required information is included.

Form deficiencies identified during reviews are frequently the result of the absence of required information. To provide assistance with developing unique forms, the minimum content for the Access and Authorization forms are included in this section.

The following types of authorizations are required:

- Medi-Cal beneficiary's access to his/her health information
- Medi-Cal beneficiary's authorization to release or request information

CLIENT ACCESS TO PROTECTED HEALTH INFORMATION

A client has the right to inspect and obtain a copy of their protected health information (PHI) in a designated record. Upon submitting a request to the network provider, any current or former adult client, any minor client authorized by law to consent to treatment and any client's legally authorized personal representative, has the right to inspect and receive copies of the PHI contained in the mental health record. A *Client's Request for Access to Health Information* form (Attachment IV) may be used to assist the client in making the request in writing, to access his/her records

There are a limited number of circumstances in which a client may not have access to all or some of his/her PHI, such as information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding.

DEFINITIONS

- Access: to inspect, copy or arrange for copying, PHI maintained by the LMHP or its business associates.
- PHI: under HIPAA, any information about health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted to include any part of a client's clinical record or payment history.

MINIMUM CONTENT REQUIRED

- Client name;
- Indicate if the request is to access and inspect health information or to request a copy of health information;
- Description of the information to be accessed, copied or inspected;
- Inspection period;
- Fee information;
- Statement of rights:

- To receive a copy of the signed request;
- To request a review of denial of access;
- Signature of the client or the client's personal representative; and
- Verification of identity.

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

It is the network provider's responsibility to obtain a client's written authorization before using, requesting, or disclosing PHI for purposes other than treatment, payment or mental health care, except as permitted by the HIPAA Privacy Rule. Use and disclosure of a client's PHI must be consistent with the valid authorization obtained from the client.

A network provider may release PHI under HIPAA rules only with a valid *Authorization for Request or Use/Disclosure of Protected Health Information* form (Attachment V), unless the rules specifically allow release without an authorization. The authorization is to be documented in a standard form. The authorization form is to include required elements, which will be more extensive if the network provider, rather than the client, is requesting release of the information.

DEFINITIONS

- Disclosure: to release, obtain, transfer, provide access to, or divulge in any other manner, PHI outside the entity holding the information.
- Use: the sharing, application, utilization, examination, or analysis of such PHI within an entity that maintains such information.

MINIMUM CONTENT REQUIRED

- Client name;
- Name of disclosing party;
- Name of recipient of PHI;
- Information to be released;
- Purpose of disclosure;
- Expiration date;
- Statement of right to receive a copy of, and right to revoke the authorization;
- Statement that refusal to sign the authorization form will not affect the client's ability to obtain treatment; and
- Client signature and date.

In addition, an *Authorization for Request or Use/Disclosure of Protected Health Information* form must contain further elements if the network provider is requesting the information for his/her own purposes, e.g., if a network provider is seeking authorization to use/disclose PHI that is already in his/her custody or if the network provider will be receiving any remuneration as a result of use or disclosure.

MH 500N
11/15/05

CONSENT FOR SERVICES

The undersigned client or responsible adult* consents to and authorizes mental health services by

_____
Name of Individual/Group/Organizational Network Provider

These services may include assessment, psychological testing, psychotherapy/counseling, rehabilitation service, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at different locations, services provided within the Los Angeles County mental health system are often coordinated by the staff of a single agency.

The undersigned understands:

1. He/she has the right to
   a. be informed of and participate in the selection of any of the above services to be provided;
   b. receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
2. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or treating clinician) or service coordinator or withdraw this consent at any time.
3. Information from a client's service record relative to service delivery needs may be shared with any agency within the Los Angeles County Mental Health Plans system of care (County-operated and contract) without obtaining the consent of the client.
4. To ensure treatment staff have available to them the most complete information about you when deciding on treatment appropriate to your needs and for quality of care, any information you disclose to staff which is determined by them to be important to your care, will be recorded in your clinical record.
5. Providers of mental health services are prohibited from sharing client information except as allowed under Federal, State, and Los Angeles County Mental Health Plans confidentiality laws, policies, and procedures.
6. All client names are entered into a computer-based Management Information System operated by the Local Mental Health Plan that identifies the program(s) that is (are) providing services to the client. This information is available without client consent to any representative of the Department's directly operated or contract service agency system.

_____ _____
Signature of Client Date

_____ _____ _____
Signature of Responsible Adult* Relationship to Client Date

Witness attests: ☐ Client is willing to accept services, but unwilling to sign the Consent.
Witness affirms: ☐ I have completed or have caused to be completed the Consent of Minor form for any client under the age of 18 signing without parental/guardian consent.

This consent was translated into _____ for the client and/or responsible adult.

_____ _____
Signature of Witness/Translator Date

Signature ☐ was given or ☐ declined a copy of this Consent on _____ by _____
Date Initials

*Responsible Adult = Guardian, Conservator, or Parent of Minor

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.	**Name:**_____ **DMH Client ID#:** _____ **Individual/Group/Organizational Provider Name:** _____

CONSENT FOR SERVICES

MH 521N
11/15/05

CONSENT OF MINOR

☐ **EMANCIPATED: (To be completed by staff)** This minor has been declared emancipated from his/her parent/guardian by the courts and has been issued an identification card by the Department of Motor Vehicles (Cal Fam Code 7120). A copy of the identification card must be filed with this form.

☐ **SELF SUFFICIENT: (To be completed by the client)** This minor is self- sufficient as exhibited by being able to declare all of the following (Cal Fam Code 6922).

I am 15 years of age or older, having been born on the _____ day of _____ in the year _____ .

I am living at the address given on admission for services which is apart from the home/residence of my parents or legal guardian.

I am managing my own financial affairs indicated by the financial information provided by me on admission for services.

I understand that I am financially responsible for the charges for my mental health services and I may not disaffirm this consent because I am a minor.

_____ _____
Signature of Client Date

☐ **ACTIVE DUTY WITH ARMED FORCES: (To be completed by staff)** This minor must be currently serving in the US Armed Forces. A copy of his/her military ID must be filed with this form (Cal Fam Code 7002).

☐ **MARRIED: (To be completed by staff)** This minor is or has been married (Cal Fam Code 7002). A copy of the marriage certificate must be filed with this form.

☐ **NEED OF MENTAL HEALTH SERVICES: (To be completed by licensed clinical staff).** This minor is in need of mental health services. I certify that each of the following five requirements are met (Cal Fam Code 6924).

1. the client is 12 or older and mature enough to participate intelligently in the services provided
2. the client meets on of the following:

☐ there is danger of serious physical or mental harm if participation is not permitted or

☐ there is alleged incest or child abuse

3. the client's parent(s)/guardian(s):

☐ were contacted on _____ by _____ or

☐ were not contacted because _____

4. the client's parent(s)/guardians(s)

☐ are currently involved in the services provided

☐ do not want or are unwilling to participate in the treatment or

☐ are not appropriate to participation in the services provided

5. the client WILL NOT be prescribed psychiatric medications without his/her parent/guardian signing the *Consent for Services* form.

_____ _____
Clinician Signature and Discipline Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.	**Name:** _____ **DMH Client ID #:** _____ _ **Individual/Group/Organizational Provider Name:** _____

MH 521S-N
11/16/05

CONSENT OF MINOR

CONSENTIMIENTO
DE MENOR / CONSENT OF MINOR

☐ **EMANCIPATED: (To be completed by staff)** This minor has been declared emancipated from his/her parent/guardian by the courts and has been issued an identification card by the Department of Motor Vehicles (Cal Fam Code 7120). A copy of the identification card must be filed with this form.

☐ **CAPACITADO: (para ser completada por el paciente)** Este menor a demostrado estar suficiente capacitado para declarar todo lo siguiente (Código Familiar de California 6922):

Tengo 15 años de edad o mayor, habiendo nacido el dia _____ del mes de _____ del ano ____.

Vivo en la dirección principiada de admision para recibir servicios; aparte de la casa/residencia de mi padres/tutores.

Manejo mis propios ingresos como lo indique en la información financiera estipulada por mi al servicio de

Entiendo que soy responsable de los cargos por los servicios de salud mental y no podria anular este consentimiento porque soy un menor de edad.

_____ _____
Firma del Paciente Fecha

☐ **ACTIVE DUTY WITH ARMED FORCES**: **(To be completed by staff)** This minor must be currently serving in the US Armed Forces. A copy of his/her military ID must be filed with this form (Cal Fam Code 7002).

☐ **MARRIED: (To be completed by staff)** This minor is or has been married (Cal Fam Code 7002). A copy of the marriage certificate must be filed with this form.

NEED OF MENTAL HEALTH SERVICES: (To be completed by licensed clinical staff). This minor is in need of mental health services. I certify that each of the following five requirements are met (Cal Fam Code 6924) **.**

1. the client is 12 or older and mature enough to participate intelligently in the services provided
2. ☐ there is danger of serious physical or mental harm if participation is not permitted or
   ☐ there is alleged incest or child abuse
3. the client's parent(s)/guardian(s):
   ☐ were contacted on _____ by _____ or
   ☐ were not contacted because _____
4. the client's parent(s)/guardian(s)
   ☐ are currently involved in the services provided
   ☐ do not want or are unwilling to participate in the treatment or
   ☐ are not appropriate to participation in the services provided
5. the client **WILL NOT** be prescribed psychiatric medications without his/her parent/guardian signing the *Consent for Services* form.

_____ _____
Clinician Signature and Discipline Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.	**Name:**_____ **DMH Client ID #:** _____ **Individual/Group/Organizational Provider Name:** _____

CONSENTIMIENTO DE MENOR / CONSENT OF MINOR

CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

CLIENT:

Name of Client	Birth Date of Client	DMH Client ID#

Street Address	City, State, Zip

❑ **REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION ONSITE**

❑ **REQUEST** Agency Name **SEND A COPY OF MY REQUESTED HEALTH INFORMATION TO:**

Name	FAX Number (include area code)

Street Address	City, State, Zip Code

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

_____

_____

_____

INSPECTION PERIOD: I request information regarding the following time period:

FROM _____/_____/_____ **TO** _____/_____/_____
Month Day Year Month Day Year

❑ **REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION**

COPY FEES: AGENCY NAME MAY CHARGE YOU FOR MAKING COPIES OF YOUR HEALTH INFORMATION. THE ASSOCIATED FEES MAY BE 25 CENTS PER PAGE FOR PAPER OR FAX COPY; 50 CENTS PER PAGE FOR MICROFILM.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I must be provided with a signed copy of the form.

Right to Request Review of Denial of Access- I understand that **Agency Name** may deny my request to access my health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a ***Request for Review of Denial of Access***. In most circumstances, **Agency Name** will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

SIGNATURE OF CLIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE:

_____

If signed by other than client, state relationship and authority to do so:

_____

DATE: _____/_____/_____
Month Day Year

FORM(S) OF IDENTIFICATION PROVIDED:

___ State Driver's License _____

___ State Identification Card _____

___ Birth Certificate _____

___ Military ID _____

___ Other (Provide details) _____

FACILITY: _____

PRACTITIONER:_____ **DATE:** _____/_____/_____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at www. **Agency Name** .com or by sending a written request to:

Patient's Rights Office
Agency Name
Agency Address

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

CLIENT:

_____ _____ _____
Name of Client/Previous Names Birth Date DMH Client ID#

_____ _____
Street Address City, State, Zip

AUTHORIZES:

_____
Name of Agency

_____
Street Address

_____
City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Assessment/Evaluation ___ Results of Psychological Tests ___ Diagnosis
___ Laboratory Results ___ Medication History/ ___ Treatment
___ Entire Record (Justify) ___ Current Medications
___ Other (Specify):_____

PURPOSE OF DISCLOSURE: (Check applicable categories)

___ Client's Request
___ Other (Specify):

_____
__
_____
__

Will the agency receive any benefits for the disclosure of this information? ___ Yes ___ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date:____/_____/___
Month Day Year

MH 602N
11/17/2005

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling Agency Name in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____	_____
Contact person	Agency Name
_____	_____
Street Address	City, State, Zip

I also understand that a revocation will not affect the ability of Agency Name or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, Agency Name may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Client / Personal Representative Date
If signed by other than the client, state relationship and authority to do so:

_____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year

SECTION VIII – DOCUMENTATION STANDARDS, TREATMENT STANDARDS AND MEDICAL NECESSITY CRITERIA

DOCUMENTATION STANDARDS

Each network provider must open and maintain his/her own clinical mental health record in order to document complete, accurate and current documentation of all services provided, including assessment activities. The record must be secured and kept confidential in a locked file.

With the exception of the services that require Local Mental Health Plan (LMHP) authorization, psychological testing and over-threshold services, network providers are not required to use the LMHP forms for documenting clinical services as long as the documentation complies with Medi-Cal requirements and meets medical necessity criteria. Minimal documentation requirements are reflected on the forms contained in this section. Network providers must adhere to the clinical records content and documentation standards of the LMHP. The minimum content includes both administrative and clinical documentation.

If a network provider uses any forms other than the forms in this Provider Manual, each page must include the Medi-Cal beneficiary's name, the Department of Mental Health (DMH) Client ID Number, the name of the individual or group network provider and a confidentiality/disclosure statement similar to the statement on the LMHP forms.

OUTPATIENT MEDICAL NECESSITY CRITERIA

Every service claimed, other than those for assessment purposes, must meet the test of medical necessity; i.e., the service must be directed towards reducing or ameliorating the effect of symptoms/behaviors of an included diagnosis causing functional impairments or, minimally, preventing an increase of those symptoms/behaviors or functional impairments. Each time a service is claimed, the provider who delivered the service and submitted the claim is attesting that he/she believes that there is sufficient documentation in the medical record to support the intervention provided.

The following medical necessity criteria, as defined in the California Code of Regulations, (CCR), Title 9, Chapter 11, Section 1830.205, must be met for reimbursement by the LMHP for all outpatient services rendered by Network Providers.

1. The Medi-Cal beneficiary must have one of the included diagnoses in the most current Diagnostic and Statistical Manual of Mental Disorder (DSM 5).

   The complete list of allowable ICD-10-CM diagnosis codes in excel format can be found at:
   http://www.dhcs.ca.gov/providersandpartners/publications/lettersandnotices.

   The State of California Department of Health Care Services (DHCS) Information Notice No. is 18-053 was published on October 26, 2018. The 2019 International Classification of Diseases, Tenth Revision (ICD-10) included code sets are effective from October 1, 2018 through September 30, 2019. Annual updates will be published through the Quality Assurance Bulletin. Network Provider should keep abreast of Quality Assurance Bulletins on updated changes to allowable diagnoses.

All providers must utilize the criteria found in DSM-5 to formulate the diagnosis and make determinations of medical necessity for specialty mental health services (SMHS). Once the diagnosis is formulated using the criteria found in DSM-5, a corresponding ICD-10-CM code should be selected. DSM-5 provides a suggested ICD-10 for each diagnosis. So long as the criteria from DSM-5 were used to formulate the diagnosis, a different ICD-10-CM code (from the one found in DSM-5) may be used. At times, there may be an ICD-10-CM code that provides greater specificity than the ICD-10-CM code found in DSM-5.

DSM-IV criteria should continue to be used for Pervasive Developmental Disorders (Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Rett's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified) because DSM-5 only has a single diagnosis of Autism Spectrum Disorder and the list of included diagnoses does not account for this. ICD-10-CM codes can be found for each of the DSM-IV Pervasive Developmental Disorders.

2. The diagnosis in the clinical record must be consistent with the most recent and up-to-date clinical information documented in the assessment.

3. The beneficiary, as a result of the mental disorder, must have at least one of the following impairments:

a) A significant impairment in an important area of life functioning;
b) A reasonable probability of significant deterioration in an important area of life functioning;
c) A reasonable probability a beneficiary, under the age of 21 years, will not progress developmentally as individually appropriate.
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of mental disorder that Specialty Mental Health Services (SMHS) can correct or ameliorate.

4. The intervention must meet each of the following intervention criteria:

a) The focus of the proposed intervention is to address the condition or impairments identified in "2" above.
b) The expectation is that the proposed intervention will:

- Significantly diminish the impairment, or
- Prevent significant deterioration in an important area of life functioning, or
- Allow a beneficiary under the age of 21 years, to progress developmentally as individually appropriate;

Medical Necessity Criteria for Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age

CCR, Title 9, Chapter 11, Section 1810.215 defines Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services as mental health related diagnostic services and treatment, other than physical care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by the State Department of Health Care Services (DHCS) to meet the

criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered as specialty mental health services.

For child, defined as a person under 21 years of age, who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity criteria specified on the Outpatient Medical Necessity Criteria described in this section, shall be met when all of the following exist:

1. The beneficiary meets the allowable diagnosis codes found in DSM-5 and the allowable code sets in ICD-10-CM. The yearly updated allowable code sets may also be found on the DHCS website at: dhcs.ca.gov/providers and partners/publications/lettersnoticesandbulletins

2. The beneficiary has a condition that would not be responsive to physical health care based treatment; and

3. Persons who do not meet the medical necessity criteria listed above will meet the medical necessity criteria per EPSDT (Title 22, Section 51340(e)(3)) eligibility when specialty mental health services are needed to correct or ameliorate a defect, mental illness or condition.

THE CLINICAL LOOP

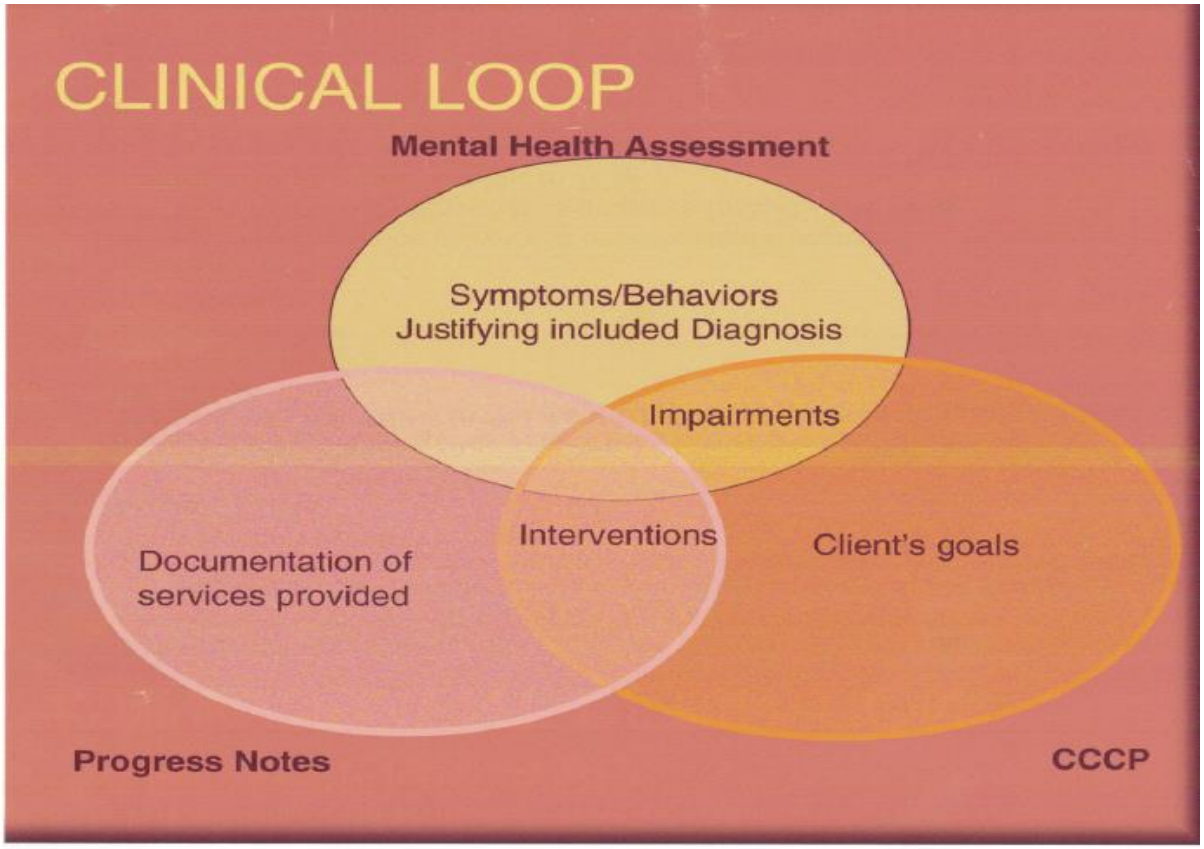
The "Clinical Loop" is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are reimbursable. All services claimed to Medi-Cal, except for emergency services, MUST fit into the Clinical Loop and support Medical Necessity in order to be reimbursed. The Clinical Loop is not a one-time activity. It occurs throughout the beneficiary's treatment and should be reviewed and updated on a regular basis to ensure that current interventions are consistent with current symptoms/behaviors and impairments documented in the Clinical Record.

The sequence of documentation on which medical necessity requirements converge is:

1. **The Assessment**. The completion of an Assessment establishes the foundation for an included diagnosis and impairments in life functioning. It further documents needs, barriers and strengths which are helpful in the formulation of a treatment plan.

2. **The Beneficiary Treatment Plan**. The demonstration of medical necessity is carried forward into the Beneficiary Treatment Plan where the diagnosis and impairments are used to establish treatment goals/objectives and the proposed interventions to effect the identified objectives. It creates a "road map" for the beneficiary, family and mental health professional.

3. **The Progress Note**. Progress Note documents a service delivered that is related back to an intervention identified in the Treatment Plan and the beneficiary's response toward the intervention.



ASSESSMENT

An initial assessment must be completed within 60 days of intake for a new admission (No open episode in the entire system), or within 30 days when the beneficiary is being opened to a new service, but has other open episodes. An assessment must be completed on all new Medi-Cal beneficiaries. If a comprehensive assessment has been completed by another agency or network provider in the last 6-12 months accompanies the referral, a copy of that assessment can be filed in the clinical record and used as a baseline for the new provider's assessment. For children or certain other beneficiaries who are unable to provide a history, this information may be obtained from the parents/care-givers, etc. The assessment must clearly establish that mental health services are medically necessary. For Contractors with an Electronic Health Record System (EHRS), the relevant form with all required data elements shall be used. The assessment is to include, but is not limited to, the following:

a. Presenting Problem: The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;

b. Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;

c. Mental Health History: Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

d. Medical History: Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;

e. Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;

f. Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

g. Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

h. Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;

i. A mental status examination;

j. Complete 5 Axis psychiatric diagnosis from the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data. To meet medical necessity criteria for Medi-Cal reimbursement, the beneficiary must have one of the diagnoses specified in the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1830.205(b)(1)(A-R). The diagnosis in the clinical record must be consistent with the most recent and up-to-date clinical information documented in the assessment; and

k. Adequate information to assess the beneficiary's needs in order to formulate a treatment plan.

l. Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes. In addition to the staff signature, discipline/title, identification number and date shall be included.

ASSESSMENT ADDENDUM

An Assessment addendum is required when there is additional information gathered, whether a change or an addition, after the completion of an Assessment and prior to providing any services that are not justified by the current Assessment. If using the LACDMH paper forms, the

Assessment Addendum shall be used. For Contractors with EHRS, the relevant form shall be used.

The Department of Health Care Services has set minimum standards for the content of an assessment. In order to facilitate compliance, these standards were converted into forms which when used help to ensure that the clinician covers all the required content of an assessment. The assessment forms in this section have been in use in the LMHP for several years. The formats, which are either equivalent to, or exceed, the content of the LMHP forms, may use their own forms/formats. **Note:** The use of the 3-page MH 667, Network Provider Child/Adolescent Assessment form shall be discontinued because the form does not have all the required elements.

The primary assessment forms are:

- *Child/Adolescent Initial Assessment form MH533 (*Attachment I*)*
- *Adult Full Assessment form MH532 (*Attachment II*)*

The *Network Provider Child/Adolescent Assessment Addendum* and the *Network Provider Adult Assessment Addendum* forms are to be used if additional writing space is needed for the initial assessment, for assessment updates, or to confirm information on the original assessment.

ASSESSMENT UPDATE

The Assessment shall be completed every three years for clients receiving ongoing Specialty Mental Health Services, including Medication Support. The Assessment is required when there is a significant change in the clinical information, or at a minimum, every three years from the date of the last assessment.

TREATMENT PLAN

The Treatment Plan is required for all services, including Medication Support after the completion of a client assessment and prior to the initiation of treatment services for a client. It must clearly address the problems identified in the most current assessment. It shall be completed by the end of the Intake Period (first 60 days) or within 1 month if opened elsewhere. As long as services never exceed the LMHP authorization threshold frequency of eight sessions in a four-month trimester period, the Medi-Cal beneficiary's treatment plan, if clearly identified as such, can be documented in the progress note, provided all the required elements are present. The treatment plan must include the following required elements:

- Specific and observable or quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- The proposed types of interventions/modality including a detailed description of the interventions designed to address the identified functional impairments;
- The proposed duration and frequency of the interventions;
- The signature of the person providing the service (a Physician, Licensed Psychologist, Licensed Social Worker, Licensed Marriage and Family Therapist, Nurse Practitioner and Clinical Nurse Specialist); and
- Documentation of the beneficiary's participation in and agreement with the treatment plan as evidenced by the beneficiary's dated signature. (Per DMH Policy 104.9, Clinical Documentation, Section 4.3.8)

- In cases where the client is unable, or refuses, to sign the plan due to his/her mental state (e.g. agitated or psychotic), the client plan shall include a written explanation of the refusal of unavailability. It is best practice to make subsequent attempts to obtain the signature must be made and documented when the clinical record indicates that the situation that justified the initial absence of signature is no longer a factor or in effect.
- When the client, or other required participant in the treatment planning process, is unwilling to sign the Client Treatment Plan due to disagreement with the plan, every reasonable effort shall be made to adjust the Client Treatment Plan in order to achieve mutually agreed-upon acceptance by the client or other required participant, and the provider.
- Linguistic and interpretive needs: When special cultural and/or linguistic needs are present, there must be documentation in the assessment, beneficiary treatment plan or initial progress note indicating a plan to address the cultural and/or linguistic needs (e.g. linking the beneficiary to culturally and/or linguistically specific services in accord with LAC/DMH Policy No. 202.21, Language Interpreters). In accordance with Title VI (Civil Rights Act) requirements, the expectation that family members provide interpreter services is prohibited. If a beneficiary insists on using a family member or friend as an interpreter, they may do so only after being informed of the availability of free interpreter services. Under no circumstances shall a consumer be denied services because of language barriers.

TREATMENT PLAN UPDATE

The Client Treatment Plan shall be reviewed and updated as clinically appropriate when there is a change in the client's mental status or treatment or every 365 days from the start date of the first Client Treatment Plan. If the client is not available to participate in the review prior to the expiration of the 365-day period, the Treatment Plan shall be reviewed and updated with the client at the next contact with the client and prior to additional treatment services being provided. The Client Plan is not final unless signed by the provider and client or responsible adult.

For services that exceed the LMHP threshold frequency, a copy of the treatment plan must accompany the *Client Plan/Over-Threshold Authorization Request* form (Attachment IV) and submitted to the LMHP for over- threshold authorization (Refer to Section XV: Over-Threshold Services and Inpatient Professional Services).

NETWORK PROVIDER PROGRESS NOTE

Service documentation should at a minimum include a recording for every service rendered on the *Network Provider Progress Note* (Attachment III). Progress notes help ensure quality and continuity of care and are required to support claims. The content of the progress note must always be consistent with the goals established in the beneficiary's treatment plan and reflect client care, clinical decisions, interventions, progress, and referrals (when appropriate). The progress notes must describe how the services provided reduced the identified impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the beneficiary treatment plan.

The progress note must include:

- Date and time of service;

- The date the service was documented in the medical record by the person providing the service;
- The amount of time taken to provide services;
- Procedure code;
- Location of service;
- Timely documentation of relevant aspects of client care, including documentation of medical necessity;
- A description of changes in the medical necessity criteria, when they occur;
- Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Interventions applied, beneficiary's response to the interventions;
- Documentation of referrals to community resources and other agencies, when appropriate;
- Documentation of follow-up care, or if appropriate, a discharge summary;
- For family therapy, clear documentation of family therapeutic interventions shall be clearly documented. The first names of the family members in attendance must be documented; however, only one claim for the family session is to be submitted, regardless of the number of family members present.
- The discharge summary (when applicable), if not recorded on a separate form; and
- The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title and the relevant identification number; and
- Documentation for all unique services such as psychological testing, family and group therapy, medication support, etc. The type of service may be abbreviated, e.g., assessment-A, individual-I, group-G, psychological testing-PsyT, medication-Meds;

Other key features to remember regarding Progress Notes:

- Notes must be legible;
- References to other clients should only be by first name or initials;
- White-out or other forms of error correction materials are not allowed;
- If a mistake is made, place a single line through the mistake, write "mistaken entry", initial, discipline and date;
- Never skip lines when writing the note;
- Cross out all unused lines at the bottom of the entry; and
- Use black ink. The use of felt tip pens is not acceptable.

Timeliness/Frequency of Progress Notes.

There must be documentation on the progress notes for every Specialty Mental Health Services, Medication Support or Crisis Intervention provided.

Requirements for Claiming for Service Function Based on Minutes of Time

For Fee-For-Service Network Providers, Mental Health Services and Medication Support are billed in minutes of time. The following requirements apply for claiming of services:

1. The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 minutes of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.
2. When the person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.
3. For the Network Provider's Family therapy services, the documentation shall include family therapeutic interventions. The first name of the family members in attendance shall be documented in the medical record. Only one claim for the family session is to be submitted, regardless of the number of family members present.

MEDICATION SERVICES

Psychiatrists and nurse practitioners prescribing medications must document that the Medi-Cal beneficiary or the person responsible for the Medi-Cal beneficiary understands and agree to the administration of the psychiatric medications that are being prescribed. This understanding is known as *Informed Consent*. Informed consent must be obtained and documented when a new or different type of medication is prescribed or at least annually and if a client resumes taking medications (Refer to Section VII: Consents and Release of Information Forms).

Elements to be documented on the *Informed Consent* shall include but not limited to:

- the reasons for taking such medications;
- reasonable alternative treatments available, if any;
- the type, range of frequency and amount, method (oral or injection), and duration of taking the medication;
- probable side effects, possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and,
- The written medication consent form must be signed by the beneficiary.
- the consent, once given, may be withdrawn at any time by the beneficiary.

When medications are prescribed, the service may be documented on either the Network Provider Complex Medication Support Service (90862) form (Attachment V) or the Network Provider Brief Follow-Up Medication Support Service (99212) form (Attachment VI) instead of on a progress note. These two forms include the required documentation elements of medication support services referenced below. The Complex Medication Support Service form should be used for initial medication evaluations or when a client is unstable on his/her medications. The Brief Follow-Up Medication Support Service form should be used when a client is stable on his/her medications (Refer to Chapter IX: Procedure Codes, Diagnosis Codes and Rates, for the appropriate use of Medication Support/Evaluation and Management Procedure Codes).

When not using the medication support forms the progress notes must include:

- Name, dosage and quantity of the medication;
- Frequency and route of administration.
- Presence or absence of side effects;
- Response to medication(s), both positive and negative; and
- The beneficiary's compliance with the medication regime.

When medications or dosages are changed, the reason for the change must be documented.

DISCHARGE SUMMARY

A discharge summary must be written within 30 days of discharge and must include the admission date, presenting problem, a summary of the services delivered, medications (if any), referrals, recommendations and follow-up plans if applicable, reason for termination and a discharge diagnosis. As an alternative to the use of the *Discharge Summary* form (Attachment I) a progress note may be used as long as it contains the required elements.

Outpatient Treatment Standards

In addition to the medical necessity criteria listed above, the LMHP requires the presence of a valid and complete treatment plan and the general standards listed below:

A. Network Provider

- Must be credentialed and contracted through the LMHP;
- Must render specialty mental health services to accomplish the treatment goals; and
- Must be accessible and engaged in a good working relationship with the LMHP.
- Network Providers who provide Psychiatric Inpatient Hospital Professional Services shall apply the medical necessity criteria found in CCR, Title 9, Chapter 11, Section 1820.205.
- Network Providers who provide Outpatient Specialty Mental Health Services shall apply the medical necessity criteria found in CCR, Title 9, Chapter 11, Sections 1830.205 and 1830.210.
- Must maintain a complete clinical record in accordance with the structure and content specified by County DMH. All services provided to a beneficiary, for which Medi-Cal reimbursement is sought, must be documented in this record in a manner which complies with all applicable regulations and standards established by State Department of Health Care Services and County DMH.
- The Network Provider shall provide clinical records to County, and any Federal or State Department representatives having monitoring or reviewing authority, at reasonable times during normal business hours. Furthermore, the Network Provider shall provide access to and the right to monitor all work performed under the Network Agreement to evaluate the quality, ensure appropriateness and timeliness of services performed.

B. Treatment Services

- Must be generally acknowledged as the most effective and safe treatment modality available for achieving the treatment goals specific to the diagnosis and severity of symptomatology;
- Must be delivered with a level of intensity consistent with the diagnosis and severity of symptoms;
- Must have a reasonable expectation of effectiveness in a time frame consistent with acceptable standards of treatment specific to the diagnosis; and
- Must be consistent with the wishes of the Medi-Cal beneficiary.

C. Treatment Course

- Progress rate must be appropriate;
- Must have ongoing post-treatment and discharge planning;
- Complications must be appropriately managed;
- Medi-Cal beneficiary must have an appropriate level of satisfaction with the care.

CLINICAL RECORD CONTENT

Clinical Minimum Record Content	Attachment	Comments
Referral Information from LMHP	N/A	Referral Information from LMHP
Medication Informed Consent	Refer to Medication Services for elements of an Informed Consent	Must be signed and can be withdrawn at any time by beneficiary. Obtained annually.
Network Provider Child/Adolescent Assessment Addendum OR Network Provider Adult Assessment Addendum	Attachment I Attachment II	An assessment must be completed for all new Medi-Cal beneficiaries within 60 days of admission. All required elements must be present
Network Provider Child/Adolescent Assessment Addendum OR Network Provider Adult Assessment Addendum	Attachment I Attachment II	An assessment addendum may be used when any changes/updates are made to the assessment in the clinical record
Beneficiary Treatment Plan	Refer to Treatment Plan Elements	Must be formulated within 60 days of admission and with the beneficiary's participation, dated and signed by provider and beneficiary. Refusal to sign or unavailability must be documented.
Network Provider Progress Note	Attachment III	Required for every service rendered.
Client Plan/Over-Threshold Authorization Request	Attachment IV	Required when requesting over-threshold services.
Network Provider Complex Medication Support Service or Network Provider Brief Follow-Up Medication Support Service (M0064)	Attachment V Attachment VI	Used for initial medication evaluations or when a client is unstable on his/her medications. Used when a client is stable on his/her medications.
Laboratory Results	N/A	Required when laboratory tests are requested.
Psychological Testing • Authorization Request	Attachment VII	Authorization request & response are required prior to the administration of tests.
Network Provider Discharge Summary	Attachment VIII	As an alternative to the use of the Discharge Summary form, the summary of the course of treatment with a final diagnosis may be documented in the progress notes.

MH677A
Revised05/05/09

Attachment I

NETWORK PROVIDER
CHILD/ADOLSCENT ASSESSMENT ADDENDUM

Date: _____

Please categorize information into one of the following areas when updating the Initial Assessment:

Identifying Information **Medical and Psychiatric History** **Living Situation**
Reason for Referral/Chief Complaint **Mental Status** **Diagnosis**
Other Information

(If diagnosis is changed, document justification below)

☐ **Continued (Sign & complete information on last page of Network Provider Child/Adolescent Assessment Addendum)**

_____ _____ _____ _____
Signature & Discipline Date Co-Signature & Discipline Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

NETWORK PROVIDER CHILD/ADOLSCENT ASSESSMENT ADDENDUM

MH 538A
Revised 05/5/09

NETWORK PROVIDER
ADULT ASSESSMENT ADDENDUM

Date: _____

Please categorize information into one of the following areas when updating the Initial Assessment:

Demographic Data **Psychiatric History** **Substance Abuse** **Medications**
Presenting Problem/Chief Complaint **Medical/Surgical History** **Psychosocial History** **Diagnosis**
Other Information

(If diagnosis is changed, document justification below)

☐ **Continued (Sign & complete information on last page of Network Provider Adult Assessment Addendum)**

_____ _____ _____ _____
Signature & Discipline Date Co-Signature & Discipline Date

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Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

NETWORK PROVIDER ADULT ASSESSMENT ADDENDUM

MH 668
Revised 05/05/09

NETWORK PROVIDER PROGRESS NOTE

Attachment III

All entries must include date of service, procedure code, time in minutes, and signature with discipline/title. • **Every service contact** must be documented. **Notes** must reflect client care, clinical decisions, interventions, progress, and referrals. • A new or revised **client plan** must be formulated annually and must include specific, measurable, observable, and quantifiable goals; the proposed duration of the goals and the type of intervention; a statement about the client's involvement; and the signature of the service provider. • A **discharge summary** must be written within 30 days of discharge* and must include the admission date, presenting problem, a summary of the services delivered, medications (if any), referrals and recommendations, and a discharge diagnosis.

Date, Procedure Code, Time	Notes

☐ **Continued (Sign & complete claim information on last page of note.)**

*** While a discharge summary may be written at a later date, the last date of service will be the discharge date.**

Signature & Discipline	Date	Co-Signature & Discipline	Date

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Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

NETWORK PROVIDER PROGRESS NOTE

CLIENT PLAN/
OVER-THRESHOLD AUTHORIZATION REQUEST (OTAR)

For initial requests, include the Child/Adolescent or Adult Assessment.
Include the Change of Diagnosis form whenever there has been a change from the assessment of last Client Plan.

Desired outcome(s) as stated by: ☐ **Client and/or** ☐ **Parent/Responsible Adult** **Initial Date of Service** _____

Major Barriers/Impairments (functional or skill) to attaining outcome(s):

Need for additional services and Risk Factors (attach supporting documentation; i.e., summary or relevant progress notes from clinical record):

Diagnosis Code:_____ Nomenclature:_____

☐ Severe life crisis: _____

☐ Decompensation/marked decline in functioning: _____

☐ Use of more costly/restrictive setting: _____

☐ Other: _____

Goal(s) (please number; must be specific, observable or quantifiable): Date: _____

Intervention Plan for requested services (must be consistent with diagnosis and client goals):

Client Role:

Participation of Significant Other:

☐ Not desired by client

Provider's principal modalities/intervention(s): Medication Evaluation: ☐Yes ☐ No Date: _____

Intervention Partner(s) (Note any other professionals currently providing services and their role(s)):

Progress toward goals since date of last service plan **Date:** _____

Service Request Begin Date:_____ End Date:_____ Code: _____No.:_____ Code:_____ No.:_____

Code:_____ No.:_____ Code:_____ No.:_____ Total # of svcs. Remaining in current request _____

Signatures

_____ _____ _____

Client and/or Parent/Guardian/Responsible Adult Date Significant Other or Minor

If client is unwilling/unable to sign, give reason _____ _____ _____

Provider's Signature and Discipline Date

This confidential information is provided to you in accord with applicable Welfare and Institutions Code Section. Duplication of this information for further disclosure is prohibited without the prior written consent of patient/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request if fulfilled.

Client Name: **Birth date:**

Medi-Cal #:

DMH Client ID #

Facility/Provider:

MC Provider #:

Los Angeles County – Department of Mental Health

MH 670
Revised 05/05/09

NETWORK PROVIDER COMPLEX MEDICATION SUPPORT SERVICE (90862)

(For Use by MD/DO and NP)

For use with client not yet stable on medication which requires detailed history, assessment and decision-making for prescribing medication using appropriate Evaluation and Management Codes. If psychotherapy is provided, a separate Progress Note should be used.

Date: _____	Procedure Code:	Time

Target Symptoms/Emergent Issues/Client Goals:

History [Include any changes or additions to the Initial Assessment]:

Treatment Response/Medication Side Effects:

Adherence to Medication:

Current/Changes in Medical Status:

Mental Status:

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Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

NETWORK PROVIDER COMPLEX MEDICATION SUPPORT SERVICE (90862)

MH 670
Revised 05/05/09

(For Use by MD/DO and NP)

Assessment:

Intervention/Plan/Clinical Decisions/Recommended Consultations (Include explanation of changes in Plan and/or Medication)**:**

Laboratory Tests Ordered:
☐ CBC ☐ LFT ☐ Electrolytes ☐ Lipids ☐ Glucose ☐ HgbA1C ☐ Tox Screen ☐ Med Levels ☐ Other/Details:

Medication(s) Prescribed: An Informed Consent for Psychotropic Medication must be completed by the MD/DO/NP annually and any time a new medication is prescribed or resumed following a documented withdrawal of the medication.

Name	Dosage	Frequency	Route of Administration	Amount	# of Refills

☐ **Continued (Sign & complete information on Network Provider Progress Note)**

Signature & Discipline _____ Date _____

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Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

NETWORK PROVIDER BRIEF FOLLOW-UP MEDICATION SUPPORT SERVICE (99212)

MH 671
Revised 05/05/09

(For Use by MD/DO and NP)

Date: _____ Procedure Code: M0064 Time

Target Symptoms/Emergent Issues/Client Goals:

Treatment Response/Medication Side Effects:

Adherence to Medication:

Mental Status:

Assessment/Intervention/Plan/Clinical Decisions (Include explanation of changes in Plan and/or Medication)**:**

Laboratory Tests Ordered:
☐ CBC ☐ LFT ☐ Electrolytes ☐ Lipids ☐ Glucose ☐ HgbA1C ☐ Tox Screen ☐ Med Levels ☐
☐ Other/Details:

Medication(s) Prescribed: An *Informed Consent* for Psychotropic Medication must be completed by the MD/DO/NP annually and any time a new medication is prescribed or resumed following a documented withdrawal of the medication.

Name	Dosage	Frequency	Route of Administration	Amount	# of Refills

☐ **Continued (Sign & complete information on Network Provider Progress Note**)

_____ _____ _____ _____
Signature & Discipline Date Co-Signature & Discipline Date

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Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)

Client Name: _____ DOB: _____ Primary Language: _____

Client Address: _____ City/State/Zip: _____

Phone No(s): _____

Social Worker's Name: _____ Contact No: _____
(Form 5005 is **required** if under DCFS supervision. Please fax directly to the Psychological Testing Authorization Unit)

Psychological Testing Referred by: Phone No.:

Primary Therapist/Physician: _____ Agency: _____

Address: City/State/Zip:

Phone: _____ Fax: _____ Email: _____

Prior Psychological Testing: ☐ No ☐ Yes Date tested: _____ By Whom: _____

Specific referral questions:
Test referral questions must relate to mental health treatment. Attach additional pages if necessary.

_____

_____

_____

_____

_____

_____

_____

How long has your client been in treatment with you: _____

Select One: ☐ Assign to psychologist selected by the Psychological Testing Authorization Unit

☐ Name of psychologist suggested for testing: _____

Contact Phone: _____ Fax: _____

Please note:
- **The Psychological Testing Authorization Unit reserves the right to assign specific psychologists.**
- **Fax this request to 213-738-4412. Please use HIPPA compliant faxing procedures.**
- **This client should be tested only after written authorization from the Psychological Testing Authorization Unit.**

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential under applicable Federal or State Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you have received this message in error, please telephone the originator of this message immediately.

MH 672
Revised 05/05/09

NETWORK PROVIDER DISCHARGE SUMMARY

Admission Date: _____ **Discharge Date*:** _____

Presenting Information:

Services Received and Response:

Medication(s): (Include Dosage & Response) ☐ None

Disposition and Recommendations: [if referred, include name of agency(s) or practitioner(s)]

Referral Out Code: _____

Discharge Diagnosis:

Axis I ☐ Prin ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____

Axis II ☐ Prin ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____

Axis III _____ Code _____
_____ Code _____
_____ Code _____

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis (Check all that apply)

1. ☐ Primary support group 2. ☐ Social environment 3. ☐ Educational 4. ☐ Occupational 5. ☐ Housing 6. ☐ Economics
7. ☐ Access to health care 8. ☐ Interaction with legal system 9. ☐ Other psychosocial/environmental 10. ☐ Inadequate information

Axis V Discharge GAF: _____ Prognosis: _____

*Discharge Date: last service date or last cancelled or missed appointment

_____ _____ _____ _____
Signature & Discipline Date Co-Signature & Discipline Date

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Name: **DMH Client ID#:**

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

SECTION IX – PROCEDURE CODES, DIAGNOSIS CODES AND RATES

PROCEDURE CODES

Network Providers and their designated billing agents must ensure that the correct procedure and diagnosis codes are appropriately submitted on electronic claims. When choosing the appropriate procedure code and diagnosis codes, Network Providers must select the appropriate set of codes that are identified according to the published guides on the Department Web site.

A Guide to Procedure Codes for Claiming Mental Health Services is available at https://dmh.lacounty.gov/for-providers/administrative-tools/provider-manuals-directories/. Select "*A Guide to Procedure Codes for Claiming Mental Health Services*" and look up definitions of procedure codes applicable to Network Medi-Cal Rendering Provider.

One of the objectives of the Health Insurance Portability and Accountability Act (HIPAA) is to enable health care providers throughout the country to be able to conversant with each other about the services they are providing through the use of a single coding system. Health care claiming has also been improved and simplified as a result of HIPAA.

The two nationally recognized coding systems approved for use are the Current Procedural Terminology (CPT) codes and the Health Care Procedure Coding System (HCPCS). The CPT codes are five digit numeric codes, such as 90791. The HCPCS are a letter followed by four digits, such as H0032.

CPT code definitions come from the CPT Codes Manual. HCPCS codes are almost exclusively simply code titles absent definition. Therefore, the definitions for HCPCS codes were established either exclusively or in combination from one of these sources - 1) California Code of Regulations (CCR), Title 9, Chapter 11, Medi-Cal Specialty Mental Health Services; 2) California Department of Health Care Services (DHCS) Letters and Information Notices; or 3) program definitions such as the Clubhouse Model.

Network providers must ensure that procedure codes documented in the client record and submitted to the County's claims processing information system on electronic claims accurately reflect the specialty mental health services provided to the client.

CLARIFICATION OF FAMILY THERAPY, GROUP AND PLAN DEVELOPMENT PRODEDURE CODES

FAMILY THERAPY

Family therapy is defined as a specialty mental health service provided to an individual or multiple individuals **within a family**. The service must include the client's significant others, whether or not related by marriage or blood, such as a partner or spouse, parents, siblings, children, grandparents, etc. The client must be present when family therapy is provided.

A client's significant other(s) may be involved in the client's treatment with or without the client present, if the network provider determines that this would be of therapeutic value to the client. If the client is not present, the service is to be claimed as collateral.

It is not appropriate to open a case for the client's significant other(s) for the sole purpose of providing family therapy to the client. Each clinical case that is opened must meet medical necessity criteria and meet all Medi-Cal requirements for the delivery of specialty mental health services.

In no case will family therapy be reimbursed if the family is present only to observe the intervention of the therapist. Family observation of individual therapy is not considered an acceptable therapeutic intervention.

When family therapy is provided, **only one claim is to be submitted** regardless of the number of clients in the session. The name of any one client is to be selected and claimed once for the entire family session. That is, provider cannot bill for three separate family therapy sessions if there are three family members in the session. There are no exceptions to this rule.

Claiming for multiple units of family therapy is allowed only when the parents/caregivers/significant others are seen with a particular client at a different time from another client. There must be clinical justification clearly documented in the clinical record when multiple family therapy sessions are claimed.

GROUP THERAPY

Group therapy is therapy delivered to more than one family unit, each with at least one enrolled client. Multi-family group therapy is to be claimed as group therapy and not family therapy. This includes insight oriented, behavior modifying, supportive services delivered at the same time to **more than one non-family client**.

Only one claim is to be submitted regardless of the number of clients and family units in the session. Documentation for each group service claim must include how many clients were present/presented, who the facilitators were, and how long the group therapy lasted. That is, provider cannot bill for three separate group therapy sessions if there are three non-family clients in the session. There are no exceptions to this rule.

PLAN DEVELOPMENT

Plan development is a stand-alone Mental Health Service that includes developing Client Care Plans, approval of Client Care Plans and/or monitoring of a client's progress. Plan development may be done as part of an interdisciplinary inter/intra-agency conference and/or consultation with other mental health providers in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contract with the client in order to develop and/or monitor the client's mental health treatment.

Team conference/case consultation claims must be clearly documented in the clinical record and include a summary of the client treatment planning process. The names of all attendees are to be included in the progress note.

PROCEDURE CODE RATE

The network provider rates associated with the procedure codes FY18-19 are included in the procedure code lists on Attachment I.

DIAGNOSIS CODES

Assessments are to include a five axis *Diagnostic and Statistical Manual* (DSM) diagnosis which is consistent with the client's presenting problems, history, mental status and other assessment data. To meet medical necessity criteria for Medi-Cal reimbursement the client must have one of the diagnoses specified in the CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R).

ICD-10 is the HIPAA standard code set for dates of service and dates of discharge on and after October 2014. Update on ICD-10 is available at:
https://dmh.lacounty.gov/for-providers/qa-bulletins/

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES

ASSESSMENT

This is an activity that may include a clinical analysis of the history and current status of a client's mental, emotional, or behavioral disorder; relevant cultural issues and history; and diagnosis. These codes should be used when completing an Initial Assessment form or when performing subsequent assessment activities that are documented on an assessment form. An "Evaluation by Physician" form, when completed as part of an evaluation for medication by an MD/DO, should be claimed as Medication Support.

Service	Code	Duration of Face-to- Face	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
Psychiatric diagnostic interview	99311	1-19 min.	$0.00	$0.00
Psychiatric diagnostic interview	90791	20-39 min. 40+ min.	$20.00 $40.00	$32.00 $53.00

Note:

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
PHD/PSYD AND MD/DO

PSYCHOLOGIST SERVICES - PSYCHOLOGICAL TESTING

All psychological testing performed by network providers must have prior authorization.

Service	Code	Duration of Face-to-Face	Rate for PhD/PsyD	Rate for MD/DO
Psychological Testing Psycho-diagnostic assessment (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS). For children, referrals are made to clarify symptomology, rule out diagnoses and help delineate emotional from learning disabilities.	96101 (Inactivated 12/31/2018)	60-1200 min for MD/DO 60-900 min. for PhD/PsyD	$36.00 per hour or $0.60 per minute	$45.00 per hour or $0.75 per minute
Neuropsychological Testing (e.g. Halstead-Reitan Neuropsychological Batter, Wechsler Memory Scales and Wisconsin Care Sorting Test)	96118 (Inactivated 12/31/2018)	60-1200 min for MD/DO 60-900 min. for PhD/PsyD	$36.00 per hour or $0.60 per minute	$45.00 per hour or $0.75 per minute

Notes:

- Testing is recorded in the clinical record and reported into the County's claims processing information system in minutes.
- Providers must document and submit a claim for the administration of tests on the day of the administration indicating which tests were administered. On the day interpretation and report writing is performed, a separate claim must be submitted.
- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- DMH will notify providers as soon as possible regarding the use of the replacement procedure codes in order for providers to resume claiming on or after January 1, 2019.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)

Service	Duration of Face-to-Face	Code	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	1-19 min.	No Code	$0.00	$0.00
	20-39 min.	90832	$20.00	$32.00
	40 and over	90834 or 90837	$40.00	$53.00

Note:

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

Documentation:

- Clinical interventions must be included in the progress note and must be consistent with the client's goals/desired results identified in the treatment plan.

- The service focuses primarily on symptom reductions as a means of improving functional impairments.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT, NP/CNS AND RN

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

Service	Code	Duration of Face- to-Face	Rate for PhD/PsyD, LCSW, MFT, NP/CNS & RN	Rate for MD/DO
Psychotherapy in Crisis: Implementation of psychotherapeutic interventions to minimize the potential for psychological trauma while a client is in a crisis state.	**90839**	**40+ minutes**	**$40.00**	**$53.00**

Notes:

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- There must be an objective on the Client Care Plan related to the services provided during Psychotherapy in Crisis or documented discussion of whether or not an objective on the Client Care Plan is needed.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES

FAMILY AND GROUP SERVICES (EXCEPT MED SUPPORT GROUP)

Service	Code	Duration of Face- to-Face	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
Family Psychotherapy with One or <u>More</u> Client(s) Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client(s). * **Note:** Family Psychotherapy without the client present is not a reimbursable service through the LMHP. Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the "Collateral" service definition below may be claimed to 90887.	90847	20-39 min. 40-59 min.	$24.00 47.00	$42.00 $70.00
Collateral (one <u>or more</u> clients represented) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist client.	90887	60 + min.	$71.00	$70.00
Multi-family Group Psychotherapy Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.	90849	30 minutes minimum with 2 clients minimum to 9 clients maximum	$14.00 per client per hour. Maximum billable session is $126.00	$15.00 per client per hour. Maximum billable session is $135.00
Group Psychotherapy Insight orientated, behavior modifying, supportive services delivered at the same time to more than one non-family client.	90853			

Notes:

- If 2 or more clients within a family are seen together, only one family therapy claim can be reimbursed regardless of the number of clients in the family therapy session. Use the name of any one client to bill for the entire session. (See Clarification of Family Therapy in this Section for more information.)

- When group therapy is provided, only one claim is to be submitted. (See Clarification of Group Therapy in this Section for more information.)

- These services are recorded in the clinical record and reported into the County's claims processing information system in minu

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO AND NP SERVICES

MEDICATION SUPPORT

Service	Code	Duration of Face- to-Face	Rate
Individual Medication Service (Face-to-Face) This service requires expanded problem-focused or detailed history and medical decision-making of low to moderate complexity for prescribing, adjusting, or monitoring meds. **Note:** If more than minimal, supportive psychotherapy is provided; the service must be claimed as an E&M Individual Psychotherapy service.	99201	15+ min.	$20.00
Brief Medication Visit (Face-to-Face) This service typically requires only a brief or problem-focused history including evaluation of safety & effectiveness with straightforward decision-making regarding renewal or simple dosage adjustments. The client is usually stable.	99212	10+ min.	$20.00

Notes:

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- Medi-Cal Lockout: Medication Support services are reimbursable up to a maximum of 4 hours a day per client.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES

PLAN DEVELOPMENT

Service	Code	Duration of Face-to-Face	Rate for PhD/PsyD, LCSW, MFT, NP/CNS & RN	Rate for MD/DO
Plan Development A stand-alone service that includes developing Client Care Plans, approval of Client Care Plans and/or monitoring of a client's progress. Plan development may be done as part of an interdisciplinary inter/intra-agency conference and/or consultation in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contact with the client in order to develop and/or monitor the client's mental health treatment.	**H0032**	**1+ minutes**	**$36.00**	**$53.00**

Notes:

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- This service is classified as an Individual Mental Health Service and is reported under Service Function 42.
- For Team Conferences: Claimable time should only include the actual time a staff person participated in the conference and any other time a staff person actually spent related to the conference, such as travel or documentation. Participation includes time when information was shared that can be used in planning for client care or services to the client.
- When plan development is done as part of a team conference and/or consultation, it is best practice that only those practitioners who are providing direct services to that client claim. If the practitioner is not providing direct services, there should be detailed documentation to support the practitioner's involvement and time claimed.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

ELECTROCONVULSIVE THERAPY (ECT)

This service may only be delivered in a properly equipped Outpatient setting.

This service is to be performed by Psychiatrists and must have prior authorization.

Service	Type	Code	Duration	Rate
ECT including monitoring	Single seizure	90870	20+ min.	$89.25
	Multiple seizures/day	90871		

Note:

- These services are categorized in the data system as Medication Support Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

EVALUATION AND MANAGEMENT - HOSPITAL INPATIENT SERVICES

These services may only be delivered in Inpatient setting (Place of Service Code 21 or 51)

Service	Components	Severity of Condition	Duration of Face-to-Face or on Unit	Procedure Code	Rate
Initial Care The first hospital encounter the admitting physician has with a client on the inpatient unit for the management and evaluation of a new client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Detailed history • Detailed or comprehensive exam • Straight-forward or low complexity decision-making	Low	1-29 min.	99221	$0.00
	• Comprehensive history • Comprehensive examination • Decision-making of moderate complexity	Moderate	30-69 min.	99222	21+ years of age: $78.00 20 years of age and under: $85.00
	• Comprehensive history • Comprehensive examination • Decision-making of high complexity	High	70+ min.	99223	21+ years of age: $78.00 20 years of age and under: $85.00
Subsequent Care, per day, for the evaluation and management of a client that requires at least two of three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making	Stable, recovering, or improving	1-24 min.	99231	$20.00
	• Expanded problem focused history • Expanded problem focused exam • Decision-making of moderate complexity	Inadequate response to therapy or minor complication	25-34 min.	99232	21+ years of age: $40.00 20 years of age and under: $44.00
	• Detailed history • Detailed examination Decision making of moderate to high complexity	Unstable, Significant complication, or new problem	35+ min.	99233	21+ years of age: $40.00 20 years of age and under: $44.00
Discharge	All services on day of discharge	N/A	1-24 min.	99238	$20.00
			25+ min.	99239	21+ years of age: $40.00 20 years of age and under: $44.00

Note:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

EVALUATION AND MANAGEMENT - NURSING FACILITY

These services may be delivered at any of these locations:

- Skilled Nursing Facility (POS* Code 31)
- Nursing Facility (POS Code 32)
- Intermediate Care Facility/Mentally Retarded (POS Code 54)
- Residential Substance Abuse Treatment Facility (POS Code 55)
- Psychiatric Residential Treatment Center (POS Code 56)

Service	Components	Severity of Condition and/or Plan Requirements	Duration of Face-to-Face or on Unit	Procedure Code	Rate
Assessment Annual assessment for the evaluation and management of a new or established client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Detailed history • Comprehensive examination • Straight-forward or low complexity decision-making	Stable, recovering, or improving; Affirmation of plan of care required	20-39 min.	99301	$32.00
	• Detailed history • Comprehensive examination • Decision-making of moderate to high complexity	Significant complication or new problem; New plan of care required	40-49 min.	99302	$53.00
	• Comprehensive history • Comprehensive examination • Decision-making of moderate to high complexity	Creation plan of care required	50+ min.	99303	53.00
Subsequent Care, per day, for the evaluation and management of a new or established client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs	• Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making	Stable, recovering, or improving	1-19 min.	99311	$0.00
	• Expanded history • Expanded examination • Decision-making of moderate complexity	Inadequate response to therapy or minor complication	20-39 min.	99312	$32.00
	• Detailed history • Detailed examination • decision making of moderate to high complexity	Unstable, Significant complication or new problem	40+ min.	99313	$53.00
Discharge	All services on day of discharge	N/A	20-39 min.	99315	$32.00
			40+ min.	99316	$53.00

* Place of Service

Note:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

EVALUATION AND MANAGEMENT
DOMICILIARY, BOARD, & CARE, OR CUSTODIAL CARE FACILITY

These services may only be delivered at a custodial care facility (Place of Service Code 33).

Service	Components	Severity of Presenting Problem	Procedure Code	Duration of Face-to-Face	Rate
New Client Service for the evaluation and management of a new client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • Straight-forward or low complexity decision making	Low	99321	20-39 min.	$32.00
				40+ min.	$53.00
	• Expanded history • Expanded examination • Decision-making of moderate	Moderate	99322	20-39 min.	$32.00
				40+ min.	$53.00
	• Detailed history • Detailed examination • Decision-making of high complexity	High	99323	20-39 min.	$32.00
				40+ min.	$53.00
Established Client Services for the evaluation and management of an established client that requires at least two of three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making	Stable, recovering, or improving	99331	20-39 min.	$32.00
				40+ min.	$53.00
	• Expanded history • Expanded examination • Decision-making of moderate complexity	Inadequate response to therapy or minor complication	99332	20-39 min.	$32.00
				40+ min.	$53.00
	• Detailed history • Detailed examination • Decision making of high complexity	Significant complication or new problem	99333	20-39 min.	$32.00
				40+ min.	$53.00

Note:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES

These services may only be delivered in an Office (Place of Service Code 11).

Service	Components	Severity of Presenting Problem(s)	NEW CLIENT Duration of Face-to-Face w/Client and/or Family and Code	NEW CLIENT Rate	ESTAB. CLIENT Duration of Face-to-Face w/Client and/or Family and Code	ESTAB. CLIENT Rate
Evaluation and management of a client that includes at least the three components noted in the next column. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • Straightforward medical decision making	Minor	1-19 min. No Code	$0.00	No Code	$0.00
	• Expanded problem focused history • Expanded problem focused exam • Straightforward medical decision making	Low to Moderate	20-29 min. 99202	$32.00	1-19 min. 99212	$0.00
	• Detailed history • Detailed examination • Medical decision making of low complexity	Moderate	30-39 min. 99203	$32.00	20-24 min. 99213	$32.00
	• Comprehensive history • Comprehensive examination • Medical decision making of moderate complexity	Moderate to High	40-59 min. 99204	$53.00	25-39 min. 99214	$32.00
	• Problem focused history • Problem focused examination • Medical decision making of high complexity	Moderate to High	60+ min. 99205	$53.00	40+ min. 99215	$53.00

Note:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO AND ADMITTING PHD/PSYD SERVICES

EVALUATION AND MANAGEMENT – CONSULTATIONS

These services may only be delivered at an outpatient hospital (Place of Service Code 22).

Service	Components	Severity of Presenting Problem	Initial Consult Code	Confirmatory Consult	Rate PhD/ PsyD	Rate MD/DO
Initial Inpatient or Nursing Facility Service for the evaluation and management of a new or established client that requires three components. Confirmatory Service to a new or established client to confirm an existing opinion regarding services. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	Problem focused history • Problem focused examination • Straightforward decision making	Self limited or minor	20-39 min. 99251	20-39 min. 99271	$20.00	$32.00
	Expanded problem focused history • Expanded problem focused exam • Straightforward decision making	Low	40-54 min. 99252	40+ min. 99272	$40.00	$53.00
	Detailed history • Detailed examination • Decision making of low complexity	Moderate	55-79 min. 99253	40+ min. 99273	$40.00	$53.00
	Comprehensive history • Comprehensive examination • Decision making of moderate complexity	Moderate to high	80-109 min. 99254	80+ min. 99274	$40.00	$53.00
	Comprehensive history • Comprehensive examination • Decision making of high complexity	High	110+ min. 99255	80+ min. 99275	$40.00	$53.00
Follow –up Inpatient Service to an established client to complete a consultation, monitor progress, or recommend modifications to management or a new plan of care based on changes in client status. At least 2 of 3 components are required. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	Problem focused history • Problem focused examination • Straightforward or low complexity decision making	Stable, recovering, or improving	1-19 min. 99261	1-19 min. 99261	$0.00	$0.00
	Expanded problem focused history • Expanded problem focused exam • Decision making of moderate complexity	Inadequate response to therapy or minor complication	20-39 min. 99262	20-39 min. 99262	$20.00	$32.00
	Detailed history • Detailed examination • Decision making of high complexity	Significant complication or new problem	20-39 min. 99263	20-39 min. 99263	$20.00	$32.00

Note:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

EVALUATION AND MANAGEMENT – CONSULTATIONS, OFFICE OR OTHER OUTPATIENT

These services may be delivered in any setting other than Inpatient Hospital:

- Office (POS* 11)
- Home (POS 12)
- Urgent Care (POS 20)
- Outpatient Hospital (POS 22)
- Hospital Emergency Room (POS 23)
- Ambulatory Surgical Center (POS 24)
- Skilled Nursing Facility (POS* Code 31)
- Nursing Facility (POS Code 32)
- Custodial Care Facility (POS Code 33)
- Hospital (POS Code 34)

Service	Components	Presenting Problems	Duration of Face-to Face w/Client and/or Family	Code	Rate
New or Established Client Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs	Problem focused history • Problem focused examination • Straightforward decision making	Self Limited or Minor	20-29 min.	99241	$32.00
	Expanded problem focused history • Expanded problem focused exam • Straightforward decision making	Low Severity	30-39 min.	99242	$32.00
	Detailed history • Detailed examination • Decision making of low complexity	Moderate Severity	40-59 min.	99243	$53.00
	Comprehensive history • Comprehensive examination • Decision making of moderate complexity	Moderate to High Severity	60-79 min.	99244	$53.00
	Comprehensive history • Comprehensive examination • Decision making of high complexity	Moderate to High Severity	80+ min.	99245	$53.00

* Place of Service

Note:

- Services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

SECTION X – QUALITY IMPROVEMENT

The Local Mental Health Plan (LMHP) has a responsibility and shared commitment with network providers, to maintain and improve the quality of the service delivery system. It is a function of the LMHP to support this commitment by establishing processes for the resolution of service and system issues and the continuous improvement of the delivery of specialty mental health services.

The LMHP quality improvement activities focus on each of the following areas:

- Service accessibility
- Service delivery capacity
- Medi-Cal beneficiary satisfaction
- Network provider satisfaction
- Appropriateness of care
- Continuity of care
- Coordination with health care
- Utilization management
- Adverse outcomes
- Credentialing and peer review

NETWORK PROVIDER RESPONSIBILITIES

- Compliance with the terms and conditions of the LMHP Medi-Cal Professional Services Legal Agreement, Exhibit A of the Legal Agreement (Service Provisions) and the requirements in the LMHP Provider Manual and Provider Bulletins;
- Compliance with all relevant Federal, State and County statutes, rules and regulations;
- Maintenance of the clinical record for at least seven years following the discharge date of the client. Clinical records of minors are to be maintained at least one year after the minor has turned 18 years of age, but in any case, not less than seven years;
- Ensuring availability of all clinical records during normal business hours to authorized representatives of the Federal, State and County government for the purposes of inspection, program review and audit;
- Coordination of care with other treating mental and physical health care providers which should, at a minimum, include information exchange regarding treatment planning and medications;
- Emergency coverage at all times;
- Reporting of adverse incidents to the LMHP;
- Prompt response to requests from the LMHP Credentialing Review Committee; and
- Immediate notification to the LMHP of any accusations or actions against the network provider's clinical license, including, but not limited to, license suspension or termination.

MANDATORY SELF-ASSESSMENT TOOL AND SITE VISITS

The Medi-Cal Professional Services Legal Agreement mandates a review of individual and group network providers on not less than an annual basis to determine compliance with the LMHP legal agreement; however, this annual review is based on the number of unit staff and special projects being undertaken. The network provider reviews for inpatient and outpatient will be scheduled every three years and more often when egregious issues are identified. This Agreement stipulates under, "*Monitoring, Quality Improvement, Records, and Audits*", that Contractors shall establish

clinical records in accordance with the structure and content specified by DMH in accordance with the structure and content specified by DMH.

There are two assessments tools. The first tool is *The General Administrative Profile* self-assessment for re-credentialing Network Providers. The second tool is the *Outpatient/Inpatient Chart Review Checklist*.

- The *General Administrative Profile* is a mandatory self-assessment tool sent to network providers triennially to coincide with the re-credentialing process (Refer to Section II: Provider Network, Attachment I). Network providers are to utilize this tool to review their administrative procedures and clinical practices to evaluate compliance with the LMHP legal agreement and Medi-Cal requirements. Network providers are required to return the self-assessment tools to the Credentialing Unit upon completion. The information contained in this form shall be validated for accuracy during compliance reviews. A Plan of Correction shall be issued for non-compliance to the following:

    1. Physical Environment;
    2. Confidentiality;
    3. Maintenance of Records;
    4. Notification; and
    5. Medication Compliance, if applicable.

- The *Outpatient/Inpatient Chart Review Checklist* is used during the onsite review for clinical and claiming chart documentation, as discussed in the Medi-Cal Professional Services Agreement (Attachment II).

COMPLIANCE PROGRAM REVIEWS AND PROGRAM INTEGRITY

Pursuant to the Medi-Cal Professional Services Agreement with Individual and Group Providers, the Compliance Unit of the Intensive Care Division, has a right to access, review and to copy any records and supporting documentation pertaining to the performance of the Agreement during normal business hours. The Outpatient/Inpatient Chart Review Checklist is used during this process.

The purposes of the site visits and outpatient clinical chart reviews are:

1. To validate the information provided on the self-assessment tool through site inspection;
2. To review the quality of specialty mIental health services provided to beneficiaries, including access to services;
3. To ensure compliance with the LMHP legal agreement, and Medi-Cal documentation requirements;
4. To help identify fraud, waste and abuse issues; and
5. To help identify quality of care issues that need further improvement to better meet the needs of the beneficiaries.

Another part of the clinical chart review is the beneficiary interview. This process may be conducted either telephonic or through survey questions sent to the beneficiaries addresses. The questions include verification whether services were actually furnished to beneficiaries. This process helps the LMHP in meeting its obligation under Code of Federal Regulations (CFR), Title

42, Section 455.1(a) (2) and the Program Integrity requirement found in the LMHP Contract with DHCS and California Code of Regulations, Title 9, Chapter 11, Section 1810.436.

The Compliance Unit will send a letter informing the providers of the date of the site visit at least three (3) weeks prior to the review. The letter includes copies of Reasons for Recoupment and Outpatient Chart and Review Worksheet. A list of the clinical charts for review will be sent to the provider at least four (4) business days prior to the review. Within two months of the site visit, the provider will receive a report summarizing the site visit and clinical chart review findings. Documentation on the medical record that does not conform to the published county, state and federal rules and regulations will be denied and payment already made will be recouped using the "Reasons for Recoupment". The reason(s) for recoupment and the dollar amount(s) of the denied service date(s) will be identified in the "Line List of Disallowances", which is a part of the review report. When actions are required to correct deficiencies, a request for a Plan of Correction (POC) will be included in the report. The POC is due from the providers within sixty (60) days of the receipt of the written review findings, whether the provider is accessing the appeal process or not. The POC will state how the provider will correct the deficiencies and a timeframe for application to service provisions. A follow-up site visit may be scheduled to confirm implementation of the POC. Further, when egregious clinical, financial and administrative issues are identified during a compliance review, a follow-up review maybe scheduled within six months from the time of the last site visit to ensure that the provider is in compliance with county, state and federal rules and regulations.

Review findings regarding credentialing issues will be referred to the Credentialing Unit in addition to the issuance of a POC.

The LMHP Compliance Program Office (CPO) also conducts reviews and audits of LMHP programs, providers and contractors. The Intensive Care Division, Compliance Unit may refer cases to the CPO when egregious over utilization of services, suspected fraud or abuse has occurred, or if the findings are beyond the scope or capacity of the Compliance Unit to pursue. The provider should be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code, Section 10115.10.

A memo from the Director of Mental Health to network providers dated February 14, 2008 (Attachment I) provided notification that the CPO would be conducting audits of network providers to ensure quality of care is being upheld and to determine compliance with billing requirements.

The LMHP has established a payment limit or threshold of the expected annual payment range for our FFS providers. All providers that were paid equal to, or in excess of, the threshold amount as of June 2007, will be audited. The payment threshold established for psychiatrists is total payments, equal to or in excess of, $100,000 in a fiscal year. The payment threshold established for psychologists, social workers, marriage and family therapists, clinical nurse specialists and nurse practitioners is total payments, equal to or in excess of, $25,000 in a fiscal year.

BENEFICIARY PROBLEM RESOLUTION PROCESSES

The LMHP's Patients' Rights posters explaining the grievance and appeal processes, together with informing materials, are required to be posted in provider's offices or locations of service. In addition to the posters, informing materials and self-addressed envelopes from the LMHP shall be available to the beneficiaries without the beneficiary having to make a verbal or written request to anyone.

Problem resolution processes like grievance, appeals and expedited appeals regarding the clinical quality of care rendered by network providers received from beneficiaries will be thoroughly evaluated by the LMHP. The LMHP's Patients' Rights Office (PRO) shall acknowledge receipt of each grievance and appeal to the beneficiary in writing. The PRO shall notify the beneficiary and the provider identified by the beneficiary, in writing, of the final disposition of the problem resolution process, including the reason for the disposition. For questions regarding Notice of Action (NOA), refer to Section XVII: Notice of Adverse Benefit Determination (NOABD), Section VI: Beneficiary Services and Section XIII: Process of Resolving Fiscal and Authorization Request Appeals.

PROVIDER APPEAL RELATED TO QUALITY OF CARE

When a dispute arises from a decision of the Intensive Care Division (ICD), Compliance Unit staff during clinical chart reviews, the provider shall seek resolution following the procedure outlined below:

LMHP First Level appeal process

1. If the provider does not agree in whole or in part with the report of review findings, then notification in writing shall be addressed and received by the office of the Mental Health Program Manager III, Intensive Care Division within 15 calendar days of the provider's receipt of the report. The date that the notification is received by the ICD will be the verification of receipt for the appeal.

   The appeal letter shall include the following:
   a) The appeal shall state the reason(s) for the dispute;
   b) The LMHP's reason for the denial of reimbursement; and
   c) The remedy sought.

   The provider shall include copies of supporting evidence or documentation to refute the LMHP's findings and support the appeal.

2. The Mental Health Program Manager III shall assign the appeal to a clinical person not involved with the clinical chart review.

3. ICD staff shall review and make a decision based on the documentation submitted and the original documents obtained during the chart review. This written decision shall be in writing and sent to the provider within sixty days of the receipt of the appeal. If the appeal is not granted in full, the provider shall be notified of any right to submit a second level appeal.

   Second Level appeal process

2. When resolution is not to the provider's satisfaction, the provider may file a request for a second level appeal. The appeal correspondence shall be directed to the ICD Mental Health Program Manager III. It shall be received within 30 calendar days after the receipt of the first level appeal decision. The letter will be stamped date as verification of LMHP receipt.

The appeal packet shall include the reason for disagreement along with supporting evidence or documentation to support the appeal and a copy of the first level appeal decision.

3. The appeal will be reviewed by a clinical staff not involved with the chart review or the first level appeal. If the appeal is granted in part, a decision letter signed by the Mental Health Program Manager III will be sent to the provider within thirty (30) calendar days of the receipt. The decision is final.

   If the LMHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by the LMHP.

   First and second level appeals may be forwarded to:

   Name of Mental Health Program Manager III
   Mental Health Program Manager III
   Intensive Care Division
   550 South Vermont Avenue, 7th Floor
   Los Angeles, CA 90020

REPORTING CLINICAL EVENTS

The LMHP has established reporting of clinical events through the Policy/Procedure No. DMH Policy 303.05 Reporting Clinical Events Involving Active Clients.

A clinical event is defined as an event involves an active client, whether or not the event occurred while receiving services as described by the following categories:

1. Death - Unknown Cause;
2. Death - Suspected or Known Cause Other Than Suicide;
3. Death - Suspected or Known Suicide;
4. Suspected or Known Suicide Attempt Requiring Emergency Medical Treatment (EMT);
5. Client Self-Injury Requiring EMT (Not Suicide Attempt);
6. Client Injured Another Person Who Required EMT;
7. Suspected or Alleged Homicide by Client;
8. Medication Error;
9. Suspected or Alleged Inappropriate Interpersonal Relationship with Client by Staff;
10. Threat of Legal Action;
11. Client Assault by Another Client Requiring EMT;
12. Adverse Drug Reaction Requiring EMT;
13. Alleged Assault by Staff Member to Client; or
14. Inaccurate or Absent Laboratory Data Resulting in a Client Requiring EMT.

Clinical Events may either be:

a) non-critical or
b) critical

NON-CRITICAL CLINICAL EVENT

Non-critical clinical event is one that does not generate governmental and/or immediate community-wide attention and, does not require a report by the Mental Health Director to the Board of Supervisors.

If the event is considered a non-critical clinical event, the network provider is to complete and send Page 1 of the Clinical Event Report within two (2) business days of the event to:

Department of Mental Health
Office of the Medical Director
550 S. Vermont Ave, 12th Floor
Los Angeles, CA 90020
Fax: (213) 386-1297

CRITICAL CLINICAL EVENT

A critical clinical event is one that may generate governmental and or immediate community-wide attention and, thus, may require a report by the Mental Health Director to the Board of Supervisors. All network providers must report critical clinical events to the LMHP.

If the event is a critical clinical event, the network provider is to call the Office of the Medical Director immediately at (213) 738-4603 during normal business hours or the Access Center immediately at (800) 854-7771 after hours. For critical clinical , as well as event reports which contain time-sensitive information, the Clinical Event Report form (Attachment III), is to be faxed, as well as mailed, to the Office of the Medical Director within 24 hours of the incident to:

Department of Mental Health
Office of the Medical Director
550 S. Vermont Ave, 12th Floor
Los Angeles, CA 90020
Fax: (213) 386-1297

Before the Critical Clinical Event Report is faxed, a telephone call is to be made to the Office of the Medical Director to provide notification that the material will be transmitted.

CLINICAL EVENT REPORT ELEMENTS

Network providers are to adhere to the clinical event reporting elements on the Clinical Event Report form (Attachment III). If the form is not used, the report is to contain the following information:

- Medi-Cal beneficiary name, date of birth, address, phone number(s), sex, patient file number, diagnosis; medications prescribed, and whether or not the prescribed medications were within the LMHP parameters for the use of psychotropic medications; network provider's name, address, telephone number; incident date and time; report date.
- The type of reportable event (See reportable event types listed on page 5.)
- A complete description of the event, including outcome/status of the Medi-Cal beneficiary;
- Efforts to contact the Medi-Cal beneficiary's significant others and their reactions;

- Name, address, relationship and phone number of the Medi-Cal beneficiary's family contact or witness; and
- Equipment involved.

Note: In order to protect the information on the report from discovery in the event of legal actions, a Clinical Event Report should not be emailed, filed or referenced in the Medi-Cal beneficiary's record. One copy of the Clinical Event Report may be kept by the network provider in a separate file.

Network providers may contact the Clinical Risk Management office at (213) 637-4588 or by email to dmhsafetyintelligence@dmh.lacounty.gov for additional information and questions regarding Clinical Event Reporting.

COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-2466
Fax: (213) 351-2024

February 14, 2008

CERTIFIED MAIL

TO: Individual Fee-For-Service Network Providers

FROM: Marvin J. Southard, D.S.W.
Director of Mental Health

SUBJECT: **COMPLIANCE AUDITS**

The Medi-Cal Professional Services Legal Agreement mandates the Department of Mental Health (DMH) conduct a review of individual network providers' performance not less than once every two years. Such an evaluation includes assessing compliance with all contract terms and performance standards; evaluating the quality, appropriateness and timeliness of services performed; and the examination and audit of all records and documents necessary to determine compliance with relevant Federal, State and local statutes, rules and regulations.

The purpose of this memo is to provide notification that the DMH Compliance Program Office will be conducting audits to determine compliance with billing requirements. As you may be aware, over the past several years, the Department of Justice (DOJ) and the Department of Health and Human Services Office of Inspector General (HHS OIG) have launched a number of detection and enforcement initiatives that are national in scope. These efforts typically involve investigations stemming from an analysis of national claims data that indicates a pattern of improper billing to government health care programs by similarly situated health care providers across the country.

DMH has analyzed payment data to determine what the expected annual payment range should be for our Fee-For-Service (FFS) providers. Further, using this payment data DMH has also established a payment limit or threshold. All providers that were paid equal to, or in excess of, the threshold amount as of June 2007, will be audited. The payment threshold established for psychiatrists is total payments, equal to, or in excess of $100,000. The payment threshold for psychologists, social workers, marriage and family therapists, nurse practitioners and clinical nurse specialists is total payments equal to or in excess of $25,000.

Outpatient/Inpatient Chart Review Checklist - LAC-DMH, Intensive Care Division, Compliance Unit

Beneficiary's First Name:	**MR#**	**Line #**
Provider:	**Reviewer:**	
Provider Number:	**Service Area:**	
Date of Admission:	**Date of Discharge:**	

Section I Administration - Required Forms	**YES**	**NO**	**N/A**
Client Face Sheet or Client Demographic Information			
One of these Consents is present (indicate which with a yes):			
Consent for Services signed by client/parent/guardian or refusal to sign is documented			
If Consent for services is signed by minor, Consent of Minor has been completed			
Medication Informed Consent has been completed			
Acknowledgement of Receipt of Privacy Practices			
Evidence that informing materials were provided to client or caregiver upon first accessing services & upon request?			
Are Patients' Rights posters beneficiary grievance and appeal forms, and LMHP self-addressed envelopes prominently displayed in the Provider's workplace where Medi-Cal beneficiaries are being seen?			
Is the address of the beneficiary correctly identified in the clinical record?			
Is the current telephone number of the beneficiary correctly identified in the clinical record?			
Is there a complete medical record for every Medi-Cal beneficiary?			
If the Provider determined that there is no medical necessity for admission, is a Notice of Action (NOA-A) form given to the beneficiary or legal guardian?			

Section II Assessment	**YES**	**NO**	**N/A**
For a patient being evaluated for the first time, is the timeframe between the assessment and referral within the acceptable parameter of the County?			
Is the Assessment completed within the required timeframe? (within 60 days of intake for a new admission; within 30 days if being opened to new service but has other open episodes)			
Is there a new re-Assessment every 3 years or when significant changes in the beneficiary's situation occurred?			
Are all the components of an Assessment completed? The Assessment is to include, but not limited to the following:			
a) Presenting Problem: The Beneficiary's chief complaint, HPI, current level of functioning, relevant family history and current family information;			
b) Relevant conditions and psychological factors affecting the Beneficiary's physical and mental health, , including as applicable: living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;			
c) Mental Health History, including names of Providers, therapeutic modality and response, inpatient admissions, and relevant psychological testings;			
d) Medical History: Relevant physical health conditions. For children and adolescents, the history must include prenatal and perinatal events and relevant developmental history;			
e) Medications: Information about medications the Beneficiary has received or is receiving, presence or absence of allergies or adverse reactions to medications;			
f) Substance Exposure/Substance Use: Past or present use of tobacco, alcohol, caffeine, ellicit and over the counter drug			
g) Beneficiary's strengths in achieving plan goals related to the Beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;			
h) Risks: Situations that present a risk to the Beneficiary and/or others, including present trauma;			
i) A mental status examination;			
j) The beneficiary must have one of the diagnosis specified in the ICD 10;			
k) Adequate information to assess the Beneficiary's needs in order to formulate a treatment plan;			
l) Signature of a staff allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes. In addition to the staff signature, discipline/title, license number and date shall be included.			
For Inpatient services, is the Initial Psychiatric Evaluation completed at the time of admission?			
Does the Psychiatric Evaluation contain all the required components?			

Section III Medical Necessity	**YES**	**NO**	**N/A**
Does the client meet all three of the following reimbursment criteria (1a, 1b, 1c below)?			
1a. The client has an ICD 10 or DSM 5 included diagnosis? * Refer to DHCS MHSUDS Information Notice No.:16-051			
1b. The client, as a result of a mental disorder listed in 1a. Must have at least, one of the following criteria (1-4 below) *			
1) A significant impairment in an important area of functioning.			
2) A probability of significant deterioration in an important area of functioning.			
3) A probability that the child will not progress developmentally as individually appropriate.			
4) For full-scope MC clients under the age of 21, a condition as a result of the mental health disorder that SMHS can correct or ameliorate.			
1c. Must meet each of the intervention criteria listed below: *			
1) The focused of the proposed intervention is to address the condition identified in No. 1b. (1-3) above, or for full-scope MC clients under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate per No. 1b. (4) *			

2) The expectation is that the proposed intervention will do, at least, one of the following (A, B, C, D): *			
A. Significantly diminish the impairment.			
B. Prevent significant deterioration in an important area of life functioning.			
C. Allow the child to progress developmentally as individually appropriate.			
D. For full-scope MC clients under the age of 21 years, correct or ameliorate the condition.			
For Inpatient services, does the documentation for admission meet medical necessity per Title 9, Section 1820.205?			
Section IV Treatment Plan * (If no Treatment Plan) Required for all services	**YES**	**NO**	**N/A**
Are the goals specific, measurable, achievable, realistic, time framed and related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis?			
Does the plan directly address the behaviors and risks that were identified on admission?			
Is there a detailed description of the MHS interventions designed to address the identified functional impairment(s)?			
Is there documentation of the proposed duration and frequency of the interventions?			
Is there a signature of the person providing the service?			
Is there documentation of the Beneficiary's participation in and agreement with the treatment plan as evidenced by the Beneficiary's dated signature? *			
In cases where the Beneficiary is unable to sign the plan, did the Provider document the reason for the unavailability of the Beneficiary's signature? *			
Does the plan reflect the beneficiary and/or family preferences, if applicable?			
is there documentation that the Beneficiary needs linguistic or interpretative services?			
For Outpatient Services, is the plan updated annually?			
Is there documented evidence that a copy of the treatment plan was offered to the Beneficiary?			
For Inpatient Services, is the Initial Treatment Plan formulated within 72 hours of admission?			
Does the Plan contain all the components identified above?			
Section V Progress Notes	**YES**	**NO**	**N/A**
Is there a progress note for every service rendered and billed to Medi-Cal? *			
On Beneficiary encounters, do the progress notes include decisions, interventions and Beneficiary responses? * (What was attempted and/or accomplished during the contact towards the attainment of the treatment goals)			
Are the progress notes signed (or electronic equivalent) by the Provider including discipline and license number? *			
Are progress note entries legible? *			
When family therapy is provided, is there a clear documentation of family therapeutic interventions? *			
Did the Provider bill only one claim regardless of the number of family members present? *			
For Medication Support Services, did the Provider document the following? *			
a) side effects			
b) response to medication(s)			
c) Beneficiary's compliance with the medication regimen			
Are correct Procedure Codes used? *			
Is the "Place of Service" that appears on the reimbursement sheet coded correctly?			
For inpatient services, is there evidence that the progress note is written by a person credentialed by DMH?			
Section VI Tracking, Adapting, and Plan Implementation	**YES**	**NO**	**N/A**
Are identified needs and problems being acted on in a timely manner?			
Is progress or lack thereof being identified and noted?			
Are new strategies developed if no progress is noted?			
Are detected problems being reported and addressed promptly?			
Is the plan being modified as a result of progress made, not made or changes in the Beneficiary's condition?			
Are crisis situations being addressed promptly?			
Section VI Treatment Authorization (TAR)	**YES**	**NO**	**N/A**
Is there a TAR submitted for every inpatient admission?			
Did the Provider bill authorized dates only?			
Section VII Timely Access *Referenc: 42 CFR Sub-Section438.206©(1)(i).*	**YES**	**NO**	**N/A**
Did the Provider provide SMHS to the M/C beneficiary within 15 business days from request of appointment?			
For non-urgent appointments with a non-physician mental health care provider, did the beneficiary receive SMHS within 10 business days from request of appointment?			
For Reviewers: (Include a walkthrough of the facility to ensure compliance to self assessment tool)			
FINDINGS: (Use additional paper for findings and comments)			

Revised 11-27-07

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
CLINICAL INCIDENT REPORT (DMH Policy #202.18 Attachment I, Pg. 1)

You may complete this report on a computer or print, but do not e-mail this report.

1. Client's Name:	2. Date of Birth	3. Sex:	4. MIS #:	5. Incident Date	6. Time:

7. Provider #	8. Clinic/Program Name: (Include address if contractor)	9. Incident Location:	10. Treating Psychiatrist/Psychiatric Mental Health Nurse Practitioner (PMHNP.)

11. List the frequency and dosages of all current medications:	12. Diagnosis

13. Is the medication regimen within DMH Parameters? Y [O] N [O] (Please note: The treating MD/PMHNP and reviewing psychiatrist should determine this response and also reply to No. 24 on pg. 2 should the incident fall in categories *3-*10 I in No. 14 below. DMH parameters for medication use are posted on http://dmh.lacounty.gov/Clinical_Issues.asp.

14. Clinical Incident Type: (Check number) Note :*Asterisked numbers require the completion of pg. 2 by the manager

[O] 1. Death-Other Than Suspected or Known Medical Cause or Suicide
[O] 2. Death Suspected or Known Medical Cause
[O] *3. Death-Suspected or Known Suicide
[O] *4. Suicide Attempt Requiring Emergency Medical Treatment (EMT)
[O] *5. Client Sustained Intentional Injury by Self or Another Client (not suicide attempt) Requiring EMT
[O] *6. Client Injured Another Person Who Required EMT
[O] *7. Homicide by Client
[O] *8. Medication Error or Adverse Medication Event Requiring EMT
[O] *9. Suspected Client Abuse by Staff
[O]*10. Possibility or Threat of Legal Action

15. Description of the Incident: Include important facts. If needed, use an additional sheet(s) that includes a statement of confidentiality, i.e., the last sentence4 at the bottom of this page.

DRAFT

16. Is the family aware of this event? Y[O] N[O]	17. Client/Family Attitude:	18. Name/Title or Reporting Staff:	19. Signature:

20. Tel. # of reporting staff:	21. Date of Report:	22. Agency Manager's Name:	23. Manager' Telephone #:

Send Pg. 1 (sealed securely) to Department of Mental Health, Office of the Medical Director, 550 S. Vermont Ave., 12th Floor, Los Angeles, CA 90020 within 1 business day. Make only 1 other copy to be kept in a separate file at the clinic. Do not file this report or make reference it or to communication with the Clinical Risk Mgr. in the client's chart. ***To allow sufficient time for a clinical review of significant events, the Manager's Report of Clinical Review (Pg. 2) should be completed and sent within 30 days to the Clinical Risk Manager for asterisked (*) categories 3-10 above.** Please call 213-637-4588 for questions. Thank you for reporting.

This information is privileged and confidential under Evidence Code Section 1157.6 and Government Code 6254 [c.]

Please Type or Print LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH MIS: #: _____
Revised 11-27-07 MANAGER'S REPORT OF CLINICAL REVIEW (DMH Policy #202.18 Attachment 1 – Pg. 2

Submit this page within 30 days of the clinical incident after completing a clinical review for incidents in asterisked categories 3-10 on Pg. 1. If item 13. on page 1 is "N," please complete item 24. and submit with Pg. 1 Send Pg. 2 (Sealed securely) to: Department of Mental Health, Office of the Medical Director., 550 S. Vermont Ave., 12th Fl. Los Angeles CA 90020.

Manager's Name:_____ Date:_____ Date of Clinical Incident Report:_____ Date and Type of Last Contact:_____ _____ Check Y or N if indicated. Please use additional page(s) if needed, referring to the number and include the disclaimer on the last line of this page. Please attach the Clinical Case Review if conducted

24. If item 13. on pg. 1 is N, i.e. the medication regimen was outside of DMH parameters, is supportive documentation present in the medical record? Y[O] N[O]. If N, please explain. (Please note: The treating or reviewing psychiatrist/PMHNP should determine this response.)

25. Was this a suspected suicide or a suicide attempt requiring emergency medical treatment (EMT)? Y [O] N [O]
If Y, please describe relevant factors, e.g. prior attempt requiring EMT, recent discharge from inpatient for a suicide attempt, date of the first out-patient visit post hospital admission for suicide attempt.

26. If substance abuse (SA) was a factor in this event, was the client receiving SA/Dual DX RX? Y O N O If N, please explain.

27. List any pre-disposing factor(s) or root cause(s) that may be relevant in this type of event, e.g. include, if relevant, factors in the transfer of care between providers, e.g., medications supplied for transition to the receiving provider.

28. List any recommendations for operational changes or managerial actions that may be considered to lessen the impact or likelihood of this type of event occurring in the future:

29. List any current or new systems, parameters, policies & procedures or training in your agency or through DMH, that may help your staff deal more effectively with the clinical or other issues inherent in this type of event:

Do not e-mail this report or the client's name. Make only 1 other copy to be kept in a separate file at the clinic.
Do not file this report or make reference it or to communication with the DMH, Office of the Medical Director, in the clients chart.

This information is privileged and confidential under Evidence Code Section 1197 and Government Code 6254 [c.]

DRAFT

SECTION XI – FINANCIAL SCREENING

FINANCIAL FOLDERS

Network providers are required to maintain a financial folder for each client receiving services at their facility. The financial folder should contain all financial information regarding the client and a detailed history of contacts and conversations with the client. The following are examples of the types of information that should be filed in the financial folder:

1. Payor Financial Information (PFI) form
2. Verification of employment, income, allowable expenses and assets
3. Photocopy of identification, Social Security Card, paycheck stubs and health insurance cards
4. Financial Obligation Agreement
5. Photocopy of the Medi-Cal beneficiary's Benefit Identification Card (BIC)
6. Department of Public Social Services/Social Security Administration (SSA) Referral Card
7. Insurance Authorization and Assignment of Benefits
8. Lifetime Extended Signature Authorization
9. Authorization for Request or Use/Disclosure of PHI
10. Any correspondence to or from the client
11. Re-evaluation Follow-Up Letter

Financial screening is the process of evaluating a client or a responsible party's ability to pay for services. This includes the individual's ability to personally contribute, the individual's ability to access third-party benefits and the individual's ability to qualify for benefits from social welfare programs.

Clients have the right to refuse to provide financial information. However, if the client refuses to provide financial information they then become liable for the actual cost of care; unless the client has full scope Medi-Cal. There can be only one annual liability period for each Medi-Cal beneficiary/payor and their resident dependent family members regardless of the number of service providers within the state or county.

The objective of the financial screening interview is to obtain complete and accurate billing information on each client. It is imperative that all third-party billing sources are identified and clients are appropriately referred to social welfare programs for which they are potentially eligible.

It is the goal of the LMHP to interview all clients at the time of their first visit. If this goal is not attained, measures must be taken to ensure an interview takes place during a subsequent visit. Basic billing information, e.g., name, address, telephone number and Social Security Number is to be obtained on all clients during their first visit, including those clients receiving emergency services.

In the absence of adequate information to determine the UMDAP liability amount, the client should be billed the actual cost of care; unless the client has full scope Medi-Cal. . The actual cost of care amount can be rescinded once the information is provided.

UNIFORM METHOD OF DETERMINING ABILITY TO PAY

The Uniform Method of Determining Ability to Pay (UMDAP) liability applies to services extended to the client and dependent family members. It is valid for a period of one year. The UMDAP liability amounts can be adjusted should the client's financial condition change during the liability period. Under no circumstances should a client, including Share of Cost (SOC) clients, be billed the UMDAP liability amount if the client has not incurred that amount in actual services. The client is responsible for the actual cost of care or the annual liability amount (whichever is less).

DHCS requires that all Short/Doyle providers employ the UMDAP when assessing a client's ability to personally pay for services rendered.

Third-party benefits are separate and aside. They apply first to the actual cost of care, then to the annual UMDAP liability. Third-party payments do not lessen the established UMDAP liability except in instances when the combined third-party payment and the UMDAP liability exceed the actual cost of care. Assisting Medi-Cal beneficiaries in understanding this process is often one of the most difficult tasks a financial screener encounters. See the following examples:

The actual cost of care is $1,000 and the UMDAP liability amount is $100. If the client has insurance that paid $500, nothing is applied to the UMDAP liability because the amount paid by the insurance did not reach or go below the UMDAP liability of $100.

Insurance Payment	$500
Client's obligation is the entire UMDAP liability amount	$100
County Cost:	$400
Actual Cost of Care:	$1,000

The actual cost of care is $1,000 and the UMDAP liability amount is $100. If the client has insurance that paid $950, then $50 would be applied to the UMDAP liability. The client would be liable for the remaining $50 liability.

Insurance Payment	$950
Client's obligation is the remaining portion of the actual cost of care	$50
Actual Cost of Care:	$1,000

The UMDAP process that occurs during a client's financial screening may be waived for those full-scope clients with no share-of-cost. However, network providers are still required to complete the PFI form for all clients during the financial screening. The waiver only applies to the UMDAP Liability Determination Sections 19, 20 and 21. All other sections of the PFI form must be completed.

If a client is identified as being Medi-Cal eligible only after meeting their Medi-Cal share-of-cost, technically they are not Medi-Cal eligible and must interface with the UMDAP process.

PAYOR FINANCIAL INFORMATION FORM

The financial screener is to base the financial interview on obtaining the information required to complete the Payor Financial Information (PFI) form (Attachment I). The PFI form is used to capture client financial information in order to determine a client's ability to pay. It is also used to identify and document third-party payor sources for billing purposes. All information recorded on the PFI form is confidential per Welfare and Institutions Code Section 5328.

The PFI form is mandated by the DHCS for content, but not for format. A PFI form must be completed for each client treated in the county mental health care system. Each provider/clinic should provide a written request for a copy of the PFI form completed at another facility. Each clinic should provide a copy of the PFI form when a written request for information is received. The following provides detailed instructions for the completion of the PFI form:

CLIENT INFORMATION

Line 1:

- **CLIENT NAME:** First, middle and last name
- **CLIENT INDEX NUMBER:** Enter the client's CIN number
- **DMH CLIENT ID NUMBER**: Enter the DMH Client ID number

Line 2:

- **MAIDEN NAME:** If applicable
- **DOB**: Date of Birth**:** Month, Day, and Year
- **MARITAL STATUS:** Circle one
  - M - Married
  - S - Single
  - D - Divorced
  - W - Widowed
  - SP- Separated
- **SPOUSE NAME:** If applicable

THIRD-PARTY INFORMATION

Line 3:

- **NO THIRD-PARTY PAYOR:** ☐ Check the applicable box to indicate whether or not the client has a Third-party Payor.

Line 4:

- **MEDI-CAL:** ☐ Yes ☐ No Check the appropriate box to indicate whether the client has Medi-Cal benefits
- **MEDI-CAL COUNTY CODE/AID CODE/CLAIM NUMBER**
- **MEDI-CAL PENDING:** ☐ Yes ☐ No Check the appropriate box to indicate whether a Medi-Cal application is pending through the DPSS and/or a Supplemental Security Income (SSI) application is pending through Social Security Administration (SSA).

- **REFERRED FOR ELIGIBILITY:** ☐ Yes ☐ No Check the applicable box to indicate whether the client was referred to DPSS to apply for Medi-Cal benefits and/or referred to SSA to apply for SSI. (See the Medi-Cal Eligibility Requirements and SSI Requirements following the PFI form instructions).
  - **DATE REFERRED:** Enter the date the client was referred

Line 5:

- **SHARE OF COST:** ☐ Yes ☐ No Check the appropriate box to indicate whether the client has a Share of Cost amount.
- **SHARE OF COST AMOUNT:** Enter the amount of the client's Share of Cost.
- **SSI PENDING:** ☐ Yes ☐ No Check the appropriate box to indicate whether an SSI application is pending through SSA.
- **SSI APPLICATION DATE:** Enter the SSI application date.
- **IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON:** If the client appeared eligible for Medi-Cal benefits and not referred to DPSS, indicate why the client was not referred. In addition, if the client appears eligible for SSI and not referred to SSA, indicate why the client was not referred.

Line 6: Check the appropriate box for the following:

- **MEDI-CAL HMO** ☐ Yes ☐ No
- **CalWORKs** ☐ Yes ☐ No
- **AB3632** ☐ Yes ☐ No
- **GROW** ☐ Yes ☐ No
- **HEALTHY FAMILIES** ☐ Yes ☐ No
- **HEALTHY FAMILIES CIN** Enter the Client Index Number.
- **OTHER FUNDING** If applicable, enter other funding sources.

Line 7:

- **MEDICARE:** A Federal Health Insurance Program for people who have attained the age of 65 or over, or have received SSD for two or more years.
  ☐ Yes ☐ No Check the applicable box to indicate if the client is eligible for Medicare.
- **MEDI-GAP INSURANCE:** A private insurance policy that pays for some of the items that Medicare does not cover such as deductible, co-payment, prescription drugs and dental.
  ☐ Yes ☐ No Check the applicable box to indicate whether or not the client is covered by Medi-Gap insurance
- **CHAMPUS:** Insurance for retired military service personnel, their dependents, and the dependents of active duty service personnel.
  ☐ Yes ☐ No Check the applicable box to indicate whether or not the client is covered by CHAMPUS.
- **VET/ADM (Veterans Administration):** Veterans should obtain all medical care at VA facilities. Refer to the DMH Policy identified below regarding exceptional instances such as emergency care when clinics may treat veterans and bill the VA the cost of care.

401.4.1 Procedures for Screening Veterans and Referring Veterans to the U.S. Department of Veteran Affairs.

☐ Yes ☐ No Check the applicable box to indicate if the client is a veteran.

- **PRIVATE INS** ☐ Yes ☐ No Check the appropriate box to indicate whether the client is covered by an indemnity, private, or group health/medical insurance policy.
- **HMO (Health Maintenance Organization):** To clarify who is eligible for treatment refer to the appropriate DMH policy identified below:

401.6 Medi-Cal Prepaid Health Care Treatments and Billing

401.7 Medicare Prepaid Health Care Treatment and Billing

401.8 Private Prepaid Health Care Treatment and Billing

☐ Yes ☐ No Check the applicable box to indicate whether or not the client is covered by an HMO.

- Enter the applicable **CLAIM NUMBER**.

Line 8:

- **NAME OF CARRIER:** Enter the name of the insurance policy carrier.
- Enter the applicable **GROUP/POLICY/ID NUMBER**.
- **NAME OF INSURED:** Enter the name of the primary client of the policy.

Line 9:

- Enter the insurance **CARRIER'S ADDRESS**.
- Check the applicable box to indicate whether an **ASSIGNMENT/RELEASE OF INFORMATION** was OBTAINED.
  ☐ Yes ☐ No

PAYOR PREFERENCES

LINE 10:

- **NAME OF PAYOR**: (responsible person) if different from client.
- **RELATION TO CLIENT**
- **DOB:** Date of Birth: Month, Day and Year
- **MARITAL STATUS:** Circle one
  M - Married
  S - Single
  D - Divorced
  W - Widowed

SP - Separated

- **PAYOR CDL/CAL ID:** California Drivers License or California Identification Number. (This information is not required in the event of a conservator or foster parent.)

LINE 11:

- Client or payor residence **ADDRESS, CITY, STATE** and **ZIP CODE.** (A post office box is not acceptable as a residence address.)
- **TELEPHONE NUMBER** where client or payor may be reached. When necessary this can be the telephone number of a neighbor or relative where the client regularly receives messages.

LINE 12:

- **SOURCE OF INCOME**
  - ☐ Salary
  - ☐ Self-Employed
  - ☐ Unemployment Insurance
  - ☐ Disability Insurance
  - ☐ SSI
  - ☐ GR
  - ☐ VA
  - ☐ Other Public Assistance
  - ☐ In-Kind
  - ☐ Unknown
  - ☐ Other: _____

Check the box(es) for the appropriate source(s) of income. Clarification must be provided if "Other" is selected for how the client/payor is supported. "In-Kind" should be checked for a client receiving room and board from another person. Check "Other" and enter "unemployed" when the client/payor or spouse is no longer employed.

- Client/Payor **CIN NUMBER**

Line 13:

- Client/Payor **EMPLOYER** name
- Client/Payor **POSITION**, payroll title, or occupation
- **IF NOT EMPLOYED, INDICATE DATE LAST WORKED**

Line 14:

- **EMPLOYER'S ADDRESS:** (Include City, State & Zip Code.)
- Enter the employer's **TELEPHONE NUMBER.**

Line 15:

- **SPOUSE:** If applicable, enter spouse's name.
- Enter spouse's **ADDRESS:** (Include City, State & Zip Code.)
- Enter Client/Payors **SPOUSE'S SOCIAL SECURITY NUMBER**

Line 16:

- Enter Client/Payor **SPOUSE'S EMPLOYER** name
- Enter Client/Payor **POSITION**, payroll title, or occupation
- **IF NOT EMPLOYED, INDICATE DATE LAST WORKED**

Line 17:

- **SPOUSE'S EMPLOYER'S ADDRESS:** (Include City, State & Zip Code)
- Enter spouse's employers **TELEPHONE NUMBER.**

Line 18:

- **NEAREST RELATIVE AND THE RELATIONSHIP**
- Enter **ADDRESS** of nearest relative and the relationship. (Include City, State & Zip Code)
- Enter **TELEPHONE NUMBER** of nearest relative/relationship

COMPLETION OF PAYOR FINANCIAL INFORMATION FORM FOR CALWORKS CLIENTS

The Medi-Cal program **Cal**ifornia **W**ork **O**pportunities and **R**esponsibilities to **K**ids (CalWORKs) replaced Medi-Cal Aid for Dependent Children on January 1, 1998. Therefore, all clients identified as CalWORKs are eligible for Medi-Cal benefits.

DHCS has directed that clients receiving full-scope Medi-Cal with no share-of-cost do not have an annual liability. CalWORKs clients receive full-scope Medi-Cal with no share-of-cost. During the financial screening process, a PFI form is completed for all CalWORKs clients. However, the annual liability amount will be zero. The UMDAP Liability Determination sections 19, 20, and 21 on the PFI form may be disregarded (crossed out and not completed).

SECTION 19

LIQUID ASSETS	
Savings	$ _____
Checking Accounts	$ _____
IRA, CD, Market Value of stocks, bonds and mutual funds.	$ _____
TOTAL LIQUID ASSETS	$ _____
Less Asset Allowance	$ _____
Net Asset Valuation	$ _____
Monthly Asset Valuation (Divide Net Asset By 12)	$ _____
(5) VERIFICATION OBTAINED	**[ ] YES [ ] NO**

1. Enter the combined total of liquid assets (those easily converted into cash) of the client and their spouse if applicable. Network providers are not limited to those indicated on the PFI Form. Liquid assets also include Individual Retirement Accounts (IRAs), deferred compensation plans, trust funds, etc.
2. Subtract the asset allowance amount. The asset allowance is the dollar amount of liquid assets (savings, stocks, bonds, etc.) a family is allowed to retain without it being added into their income for purposes of determining their annual liability. (The chart identified in this training guide indicates the asset allowances for 1988 and 1989. The 1989 data should be used to determine the asset allowance. This is the most current chart issued by the DHCS and is still in use. When an update becomes available, it will be issued to all network providers.)
3. Enter the **NET ASSET VALUATION** (the total liquid assets less the asset allowance).
4. The **MONTHLY ASSET VALUATION** is determined by dividing the Net Asset Valuation by twelve (12). The amount entered here is to be carried forward to Section 21 - **ADJUSTED MONTHLY INCOME**, and entered on the line identified as **ADD MONTHLY ASSET VALUATION**.
5. **VERIFICATION ATTACHED**. (**[ ] YES [ ] NO**) The client must be charged the actual cost of care if verification is not attached or available in the client's financial folder.

SECTION 20

ALLOWABLE EXPENSES	
Court ordered obligations paid monthly	$ _____
Monthly child care payments (necessary for employment)	$ _____
Monthly dependent support payments	$ _____
Monthly medical expense payments	$ _____
Monthly mandated deductions from income for retirement plans. (Do not include Social Security)	$ _____
TOTAL ALLOWABLE EXPENSES	**$** _____
VERIFICATION OBTAINED [ ] YES [ ] NO	

1. Monthly obligations include court ordered child support and alimony obligations that are to be verified with a copy of the certified court order and receipts or canceled checks verifying payment.
2. Monthly childcare payments (necessary for employment) are to be verified with receipts or canceled checks.

3. Monthly medical expense payments include all health, medical and dental premiums as well as expenses and regular monthly payments, i.e., installments on a hospital or dental bill. Payments are to be verified with invoices, receipts, or canceled checks.
4. Monthly mandated deductions from income for retirement plans are those that are required by the employer. **DO NOT INCLUDE SOCIAL SECURITY** (identified as Federal Insurance Contribution Act on paycheck stubs). Verification of deductions is available from the client's or their spouse's paycheck stubs.
5. The total expense amount entered here is to be carried forward to section 21 - **ADJUSTED MONTHLY INCOME**, and entered on the line identified as **SUBTRACT TOTAL EXPENSES**.
6. **VERIFICATION ATTACHED**. (**[ ] YES [ ] NO**) All allowable expenses must be substantiated. Do not include the expense in the determination of the client's annual UMDAP liability if verification is not attached or available in the client's financial folder.

SECTION 21

ADJUSTED MONTHLY INCOME

Gross Monthly Family Income	$ _____
Self/Payor	$ _____
Spouse	**$** _____
Other	$ _____
TOTAL	$ _____
Add monthly asset valuation	$ _____
	_____
Subtract total expenses	$ _____
Adjusted monthly income	$ _____

VERIFICATION OBTAINED [ ] YES [ ] NO

1. Enter the client's gross monthly income.
2. Enter the client's spouse's gross monthly income.
3. Enter any additional monthly income.
4. Enter the total monthly income identified above.
5. The amount identified on this line is to be added to the total monthly income amount. (See section 19 - **LIQUID ASSETS** for information regarding the determination of the **MONTHLY ASSET VALUATION**.)

6. Enter the **TOTAL** monthly income plus the **MONTHLY ASSET VALUATION**.
7. The amount identified on this line is to be subtracted from the combined totals of the monthly income plus the monthly asset valuation. (See section 20 - **ALLOWABLE EXPENSES** for information regarding the determination of monthly allowable expenses.)
8. Enter the balance of the following equation: Total gross monthly income plus monthly asset valuation minus total expenses = adjusted monthly income.
9. **VERIFICATION ATTACHED**: ([ ] YES [ ] NO) The client must be charged the actual cost of care if verification is not attached or available in the client's financial folder.

Line 22:

- **NUMBER DEPENDENT ON ADJUSTED MONTHLY INCOME**: Enter the number of dependents applicable to the adjusted monthly income. Dependents are those persons claimable as dependents on the client's Federal Income Tax Return. Child support, which is paid, but does not qualify client to claim the child as a dependent may be claimed in section 20 - **Allowable Expenses**. Child support must be court ordered and verification of payment must be provided.
- **ANNUAL LIABILITY**: Enter the amount of the annual liability. The annual liability is determined by using the adjusted monthly income amount and the number of dependent on the adjusted monthly income. The Uniform Patient Fee Schedule provides the annual UMDAP liability based on income and number of dependents. The shaded Medi-Cal eligible area on the Uniform Patient Fee Schedule identifies income levels presumed eligible if the client meets Medi-Cal eligibility requirements. Client income levels falling into the shaded Medi-Cal eligible area are to be assessed an annual UMDAP liability of zero. If the client meets the Medi-Cal eligibility requirements, the client is to be referred to the DPSS to apply for Medi-Cal benefits. (See Medi-Cal Eligibility Requirements following the PFI Form instructions.)
- **ANNUAL CHARGE PERIOD**: FROM ___/____/____ TO ____/____/____. The annual liability period runs from the date of the client's first visit (regardless of when the PFI Form is completed or of an adjustment) until the last day of the eleventh subsequent month. For example, the client was admitted to a county mental health facility on October 22, 1996. The UMDAP annual charge period would be 10/22/96 through 9/30/97.

- There is only one circumstance that would warrant a change in the annual charge period. If a provider fails to financially screen a client and later discovers that a PFI Form was completed at another facility, the Network Provider may contact that facility requesting that the annual charge period be changed to include their dates of service. The facility that originated the PFI Form is the only Network Provider authorized to change the annual charge period.
- **PAYMENT PLAN**: $ _____ per month for _____ months

Line 23:

- **PROVIDER OF FINANCIAL INFORMATION**: (If Other Than Patient or Responsible Person)

OTHER

Line 24:

- **PRIOR MH TREATMENT**: (Only applicable to current Annual Charge Period)
  ☐ YES ☐ NO If Yes, where?
- **FROM**: Enter the date prior mental health treatment began.
- **TO**: Enter the date prior mental health treatment ended.
- **PRESENT ANNUAL LIABILITY BALANCE**: Enter the amount of the client's current annual liability balance.

Line 25:

- **ANNUAL LIABILITY ADJUSTED BY**: Enter the signature of the person changing the deductible or payment plan for financial need during a liability and service period. (See Liability Adjustment and Therapeutic Fee Adjustment [TFA] following the PFI Form instructions.)
  Date: Enter the date an adjustment was made.
- **ANNUAL LIABILITY ADJUSTED APPROVED BY**: Enter the signature of the person approving the adjustment of the deductible or payment plan for financial need during a liability and service period.
  Date: Enter the date an adjustment was made.
- **REASON ADJUSTED**: Enter the reason an adjustment was made. Any verification must be kept in the client's financial folder.

Line 26:

- **SIGNATURE OF INTERVIEWER**: Enter the signature of the person preparing the PFI Form. The interviewer acknowledges by signature and date that an explanation of liability and payment responsibility was given to the client or payor.
- **PROVIDER NAME AND NUMBER**: Enter the name and provider number of the mental health facility where the PFI Form was completed.

Line 27:

I AFFIRM THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

- **SIGNATURE OF CLIENT OR RESPONSIBLE PERSON**: The client shall be asked to sign affirming that the statements made are true and correct.
- **DATE**: Enter the date signed.

DISTRIBUTION

Once the PFI Form is completed, copies are to be distributed as follows:

- **FINANCIAL FOLDER**
- **CLINIC** (Medical chart)
- **CLIENT** (Client/responsible person)

VERIFICATION

Verification of Social Security Number, employment, current address, liquid assets, allowable expenses and income are **mandatory**. Copies of verification should be attached to the PFI Form or placed in the client's financial folder. Until verification is received, the client or payor is responsible for the actual cost of care.

Some sources available for verification of income are: pay check stub, tax return form, or bank statements showing direct deposits.

Care must be exercised to maintain confidentiality in making inquiries to sources other than the client or payor. Letterhead stationary that identifies the network provider as a mental health clinician must not be used.

FINANCIAL OBLIGATION AGREEMENT

A Financial Obligation Agreement is a written agreement between the client and the provider, and is required whenever a client has been determined to have an annual liability. This agreement must detail the maximum liability amount and the monthly payment amounts. The agreement must be signed by the client and acknowledged by a clinic representative.

Payment plans should allow the client to pay off their debt in the shortest time possible. The payment plan should rarely exceed the anticipated length of treatment, and under no circumstances should the plan exceed one year.

MEDI-CAL ELIGIBILITY REQUIREMENTS

Individuals age 65 or older, blind, disabled, or meeting the family circumstances required for Temporary Assistance for Needy Families (TANF), are probably eligible for Medi-Cal benefits. Anyone falling into these categories must be referred to their local DPSS office to apply. The client is to be provided with a completed DPSS SSA Referral Card when referred to DPSS.

TANF replaces Aid to Families with Dependent Children (AFDC), which provides support to eligible families when children are deprived of support due to death, incapacity, unemployment, or the absence of one or both parents.

SUPPLEMENTAL SECURITY INCOME REQUIREMENTS

SSI is a program funded with Federal and State funds and administered by the SSA. Disabled persons meeting eligibility requirements would be entitled to monthly cash grant to assist them with living expenses. Individuals who are entitled to Social Security disability benefits lower than the SSI amount will be supplemented with an SSI payment up to the SSI amount.

SSI beneficiaries receive Medi-Cal benefits automatically. Social Security work credits are not required to qualify for SSI. The client should be provided with a completed DPSS SSA Referral Card when referred to SSA.

Eligibility requirements for SSI are:

1. Age 65 or older, disabled adult or child, or blind;

2. A resident of the United States, a citizen, permanent resident alien, or resident under color of law; and
3. Income and resources within SSI limits

LIABILITY ADJUSTMENT

An annual UMDAP liability amount may be adjusted when properly supported by additional financial data justifying such change. An adjustment may be made for the time remaining in the period at any time during the liability period. Reasons for such action may be for any significant change in a person's financial circumstances. Since a client is responsible for prompt notification of a change in financial circumstances, an adjustment cannot be retroactive, but is effective on the date of notification. An adjustment to lower the annual liability cannot be made once a client has incurred services that equal or exceed the amount of the annual liability. Verification documentation supporting the adjustment must be kept in the client's financial folder.

THERAPEUTIC FEE ADJUSTMENT

It is the policy of the DMH to allow UMDAP liability fee adjustments for therapeutic value only. No other basis or rationale for fee adjustments will be accepted.

In the event the provider finds a client's treatment would benefit by an increase or decrease in the annual liability, a therapeutic fee adjustment is indicated. The financial screener may not initiate a therapeutic fee adjustment.

Refer to the DMH Policy 404.3 Therapeutic Fee Adjustments regarding the requirements and procedures for initiating a therapeutic fee adjustment.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

The Insurance Authorization and Assignment of Benefits is to be signed and dated by all clients. The authorization allows network providers to submit insurance claims for reimbursement without obtaining original client signatures on each claim form. A photocopy is attached to the insurance claim, but the original should be kept in the client's financial folder.

LIFETIME EXTENDED SIGNATURE AUTHORIZATION

The Lifetime Extended Signature Authorization is a statement to permit payment of Medicare benefits to a supplier or physician. The authorization is to be completed, signed and dated by the client. The original is to be maintained in the client's financial folder.

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PHI

The Authorization for Request or Use/Disclosure of PHI is a form that grants permission to the provider/clinic to use client PHI, or disclose specific client PHI to another provider/clinic. The authorization is to be completed, signed, and dated by the client. The original is to be maintained in the client's financial folder.

ANNUAL RE-EVALUATION

The client is to be re-evaluated on an annual basis. The Re-evaluation Follow-Up Letter may be used to facilitate the re-evaluation process. Telephone re-evaluations are acceptable, however, missing information and verification of income and expenses are still required. The client signature is to be obtained during the next visit. Clients that have not been re-evaluated are responsible for the actual cost of care until the re-evaluation is completed.

The UMDAP liability period for a client who is still in treatment is continuous regardless of when the PFI Form is completed. The re-evaluation date to be recorded on the PFI Form shall be from the date of the initial UMDAP date and runs for 365 days (366 days for leap years).

DEPARTMENT OF MENTAL HEALTH POLICY MANUAL

The DMH Policy Manual should be accessed regarding specific policies addressed in this manual. The DMH Policy Manual may be downloaded from the following website address: http://dmh.lacounty.gov/wps/portal/dmh/admin_tools. Click the "Policies, Parameters & Guidelines" link, and then click the "DMH Policy and Procedures for Contractors" link to view the DMH Policy Manual.

FINANCIAL SCREENING
GLOSSARY OF TERMS

AB 3632	Synonymous with Special Education Pupils (SEP).
Actual Cost of Care	The actual cost of delivering services to the client. The cost is determined by a provisional billing rate, a negotiated rate, or a cost reimbursement rate.
AFDC	Aid to Families with Dependent Children. AFDC is a public welfare program for needy families and pregnant women. County of Los Angeles administers the program based on requirements set by Federal and State laws and regulations. Temporary Assistance has replaced this program for Needy Families. (See TANF.)
Annual Charge Period	Synonymous with Annual Liability Period.
Annual Liability Amount	The annual liability amount applies to services extended to the client and dependent family members and is determined by using the adjusted monthly income amount and the number dependent on the adjusted monthly income.
Annual Liability Period	The annual liability period runs from the date of the client's first visit until the last day of the eleventh subsequent month.
BIC	Benefit Identification Card. Clients are issued a permanent white plastic identification card by DPSS. The card is not a guarantor of eligibility.
Medi-Cal beneficiary	The person receiving services is synonymous with consumer.
CHAMPUS	Civilian Health and Medical Program of the Uniformed Armed Services. Insurance for retired service personnel, their dependents and the dependents of active duty service personnel.
CIN	Client Index Number. Clients are assigned the Client Index Number by DPSS.
Consumer	Synonymous with client.
Dependents	Those persons within a family unit dependent upon the payor's income for support as well as members outside the family group that payor claims as dependents when filing income tax.
DPSS	Department of Public Social Services.
Family Unit	Payor and his/her dependents.
FCC	Full Cost of Care is synonymous with actual cost or care.

Homeless	A client who does not have an address. The SDHS required entries on the PFI Form are name, SSN if known and the word "Homeless" or "Transient" to indicate the financial condition of the client. In addition to the SDHS requirements, the LMHP is requiring that the annual liability dates and annual liability amount be completed. The annual liability amount for homeless clients will be zero.
Liquid Assets	Any possessions easily converted into cash, i.e., IRAs, 401Ks, or savings bonds.
Managed Care	A term coined originally to refer to the prepaid health care sector (e.g., HMOs and PHPs). In general, the term refers to a means of providing health care services within a defined network of health care providers who are given the responsibility to manage and provide quality cost-effective health care.
Medi-Cal	California's medical assistance program for eligible low-income persons to pay for needed medical care.
Medicare	A Federal Health Insurance Program for people who have attained the age of 65 or over, or have received SSD for two years or more.
Medi-Gap	Insurance companies that contract with a Medicare carrier that allows the carrier to directly cross-over your claims to an insurance company. A Medi-Gap policy would pay for some of the items that Medicare does not cover such as deductible, co-payment, prescription drugs and dental.
Payor	Person legally responsible for payment of client's bills.
PFI	Patient Financial Information. The PFI Form is used to capture client financial information in order to determine a client's ability to pay. It is also used to identify and document third-party payor sources for billing purposes.
PHP	Prepaid Health Plan. A managed care plan.
SEP	Special Education Pupils. Parents of Special Education Pupils receiving mental health services pursuant to an Individualized Education Program (IEP) are not liable for the costs of those services. The client information data, Medi-Cal information (if applicable) and insurance information (if applicable) should be completed on the PFI Form. Services to clients may be billed through the Short-Doyle/Medi-Cal program. Insurance or other third-party payors may only be billed in the usual manner with parental consent. The PFI Form should have written or

	stamped on it the following notation which describes the parent's exempt status:
	Pursuant to Public Law 94-142, services are provided at no charge to the parent or adult pupil, and in accordance with Section 7582 of the Government Code, they are exempt from financial eligibility requirements.
SSA	Social Security Administration
SSD	Social Security Disability. Workers who qualify for disability income when they cannot work or are diagnosed with a condition that is expected to last for a year or result in death. A spouse of a disabled worker is entitled to benefits at age 62 (including some divorced spouses) or at any age if they have children under 16 years of age. A widow(er) at any age with children under age 18 is eligible. A child including adopted or stepchild may receive monthly benefits. Normally, children's benefits may continue indefinitely or start at any age if the child has a severe physical or mental disorder, which began before age 22 and keeps the child (or adult child) from gainful employment.
SSI	Supplemental Security Income. A national program for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled.
SSP	State Supplementary Payments. SSP are any payments made by a State to a recipient with SSI benefits. The payments are made as a supplement to the Federal benefit amount, thereby increasing the amount of income available to the recipient.
TANF	Temporary Assistance for Needy Families. TANF replaced AFDC and provides support to eligible families when children are deprived of support due to death, incapacity, unemployment, or absence of one or both parents.
TFA	Therapeutic Fee Adjustment.
UMDAP	Uniform Method of Determining Ability to Pay. UMDAP is a sliding payment scale that reflects variations in the cost of living by family size and income by geo-economic areas of the State. They are based on the U.S. Bureau of Labor Statistics Consumer Price Index.
VET/ADM	Veterans Administration

Attachment I

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

PAYOR FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W &I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME		SS#	CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS M S D W SP	SPOUSE NAME

THIRD PARTY INFORMATON

3 **NO THIRD PARTY PAYOR** ☐

4	MEDI-CAL ☐ YES ☐ NO	MEDI-CAL OUNTY CODE/AID CODE/ CLAIM #			MEDI-CAL PENDING ☐ YES ☐ NO REFERRED FOR ELIGIBILITY ☐ YES ☐ NO		DATE REFERRED
5	SHARE OF COST ☐ YES ☐ NO	SOC AMT $	SSI PENDING ☐ YES ☐ NO	SSI APPLICATION DATE	IF MEDI-CAL/SSI ELIGIBILE BUT NOT REFERRED, STATE REASON		
6	MEDI-CAL HMO ☐ YES ☐ NO	CAL WORKS ☐ YES ☐ NO	AB3632 ☐ YES ☐ NO	GROW ☐ YES ☐ NO	HEALTHY FAMILIES ☐ YES ☐ NO	HEALTHY FAMILIES CIN #	OTHER FUNDING
7	MEDICARE ☐ YES ☐ NO	MEDI-GAP ☐ YES ☐ NO	CHAMPUS ☐ YES ☐ NO	VET/ADM ☐ YES ☐ NO	PRIVATE INS ☐ YES ☐ NO	HMO ☐ YES ☐ NO	CLAIM #
8	NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED		
9	CARRIER ADDRESS				ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO		

PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10	NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS M S D W SP	PAYOR CLD/CAL ID
11	ADDRESS	CITY	STATE	ZIP CODE	TEL #
12	SOURCE OF INCOME ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER: _____				PAYOR SS #
13	EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED
14	IPLOYER ADDRESS (Include City, State & Zip Code)				TEL #
15	SPOUSE	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #
16	SPOUSE'S EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED
17	SPOUSE'S EMPLOYER ADDRESS (Include City, State & Zip Code)				TEL #
18	NEAREST RELATIVE/RELATIONSHIP	ADDRESS (Include City, State & Zip Code)			TEL #

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS		20 ALLOWABLE EXPENSES		21 ADJUSTED MONTHLY INCOME	
Savings	$ _____	Court ordered obligations paid monthly	$ _____	Gross Monthly Family Income	$ _____
Checking Accounts	$ _____	Monthly child care payments (necessary for employment)	$ _____	Self/Payor	$ _____
IRA, CD Market value of stocks, bonds and mutual funds	$ _____	Monthly dependent support payments	$ _____	Spouse	$ _____
TOTAL LIQUID ASSETS	$ _____	Monthly medical expense payments	$ _____	Other	$ _____
Less Asset Allowance	$ _____	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$ _____	TOTAL	$ _____
Net Asset Valuation	$ _____	**Total Allowable Expenses**	$ _____	Add monthly asset valuation	$ _____
Monthly Asset Valuation (Divide Net Asset by 12)	$ _____			TOTAL	$ _____
				Subtract total expenses	$ _____
				Adjusted Monthly Income	
VERIFICATION OBTAINED ☐ YES ☐ NO		VERIFICATION OBTAINED ☐ YES ☐ NO		VERIFICATION OBTAINED ☐ YES ☐ NO	

22	Number Dependent on Adjusted Monthly Income	**ANNUAL LIABILITY**	**ANNUAL CHARGE PERIOD** **FROM** **TO**	PAYMENT PLAN $ _____ per month for _____ months.
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

OTHER

24	PRIOR MH TREATMENT (Only applicable to current Annual Charge Period) ☐ YES ☐ NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE		REASON ADJUSTED
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER			PROVIDER NAME AND NUMBER
27	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIILE PERSON		DATE	

SECTION XII – CLAIMING INFORMATION

BACKGROUND

Network providers are reimbursed by the Local Mental Health Plan (LMHP) under the rules and guidelines established for Phase II Medi-Cal Consolidation which was effective June 1, 1998.

The LMHP amended its claiming system and the way in which Los Angeles County Medi-Cal beneficiary data is received and processed to comply with Federal mandates. The federal government enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve efficiency in healthcare delivery by standardizing electronic patient health, administrative and financial data and by developing security standards to protect the confidentiality and integrity of patient health information. Entities covered by HIPAA include mental health plans, clearinghouses, and billing agents/services, which are required to transmit mental health care data in a way that is compliant with, and regulated by, HIPAA.

In January 2014, the LMHP implemented the Integrated Behavioral Health Information System (IBHIS), an electronic health record system for the Los Angeles County Department of Mental Health (DMH). IBHIS integrates a broad range of functionality including referral management, client registration, appointment scheduling, clinical documentation, workflow support, authorization, billing, claiming and reporting, along with providing the base for the electronic exchange of clinical information with other healthcare providers. This is an integrated, web-based electronic system that is accessible and available around-the-clock that receives and processes protected health information (PHI) and claims data in a format that complies with HIPAA. The LMHP does not accept manual hardcopy claims from network providers.

When the LMHP receives HIPAA-compliant electronic claims from network providers, billing agents/services and clearinghouses, they are forwarded to the California Department of Health Care Services (DHCS) for adjudication as Short-Doyle/Medi-Cal (SD/MC) service claims. Payments made to network providers are based on IS approvals. The LMHP will recover from network providers denied claim amounts resulting from the DHCS adjudication of SD/MC services. The LMHP shall be held harmless from and against any loss to network providers resulting from any such State denials, unresolved explanation of benefit claims, and/or Federal and/or State audit disallowances.

New network providers are required to enroll or register in the IBHIS. A Dun & Bradstreet (DUNS) number is required to confirm the provider identity in the enrollment process. The providers will be able to create, save, update and submit a Trading Partner Agreement (TPA) request online. The IBHIS TPA Application link is: https://extra.dmh.lacounty.gov/TPR/Security/SignIn.aspx

CLAIMING AND ACCURACY OF CLAIMS DATA

Network providers submit HIPAA-compliant claims for reimbursement of their services in the IBHIS via Electronic Data Interchange (EDI)/Secure File Transfer (SFT) or they can hire a billing agent/service or clearinghouse to submit the claims on behalf of them.

Network providers are requested to thoroughly review the accuracy of claims data before providing information to billing agents/services or clearinghouses to process. Invalid claims data

may prevent and prolong timely reimbursements or the ability to successfully pass EDI/SFT testing requirements. Due to the nature of most billing agents'/services' and clearinghouses' businesses, they simply format data files received from their network providers and are not responsible for data content. Therefore, network providers are required to ensure that all claims submitted to the LMHP on their behalf are as follows:

1) HIPAA-compliant;
2) Reimbursable by the LMHP, i.e.:
   - Procedure codes are HIPAA-compliant and appropriately submitted in the IBHIS as reflected in *A Guide to Procedure Codes for Claiming Mental Health Services* (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates). Procedure codes are valid for the network provider's taxonomy and contain the appropriate units of measurement (minutes) and service time; and,
   - Diagnosis codes are HIPAA-compliant and appropriately submitted (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates);
3) Submitted with valid DMH Client IDs. Network providers and their billing agents/services or clearinghouses use ProviderConnect application to search for clients and obtain the DMH Client ID. ProviderConnect application is a web-based interface used to communicate with IBHIS;
4) Submitted subsequent to being registered in the IBHIS;
5) Entered using the correct IBHIS FFS Provider ID: The number will be issued to the provider, billing agent/service or clearinghouse when their EDI/SFT applications are approved for testing;
6) Submitted with a valid National Provider Identifier (NPI) number and according to the requirements listed in the EDI/SFT IBHIS 837 5010 Companion Guide.
7) Submitted with a valid authorization number. There are 2 types of authorizations. They are Member Authorization and Funding Source Authorization. Network providers will put only 1 authorization on a claim line. Member Authorization is specific to a client and used for specific services (e.g. inpatient professional services, over threshold services, electroconvulsive treatment services or psychological testing services,) and duration of time. Member Authorization numbers are all numeric. Funding Source Authorization is for under threshold and medication support services given by DMH annually according to the disciplines of the providers. Funding Source Authorizations begin with an 'F', followed by a number (Refer to Section XV: Over-Threshold and Inpatient Professional Services & XVI: Psychological Testing Authorization, for additional information on the specific services and how to obtain authorization);
8) Contain valid HIPAA Delay Reason Codes if necessary;
9) Compliant with the EDI/SFT IBHIS 837 5010 Companion Guide, which is available at: http://lacdmh.lacounty.gov/hipaa/documents/LACDMH8375010CcompanionGuidev114.pdf.

Claims submitted in the IBHIS without the information listed above during testing and in production will be denied.

VALID CHARACTERS

The following valid characters may assist DDE and EDI users in avoiding claim denials, negative eligibility and enrollment responses due to invalid character transmissions:

Approved Alphabet Format
"A" through "Z"
"a" through "z"

Approved Numbers
"0" through "9"

Approved Symbols
Dash " - "
Number sign: "#"
Period: "."
Ampersand: "&"

Beneficiary eligibility, enrollment and claims data received by DMH containing characters other than those identified and approved above will cause a denial and may delay successful EDI testing results.

SUPPLEMENTAL NETWORK PROVIDER CLAIMING INFORMATION

The information listed below provides additional claiming requirements essential for network provider compliance:

- Network providers are required to supply the LMHP with their valid National Provider Identifier (NPI) numbers as follows:
    1. Individual providers are required to furnish their type I NPI number;
    2. Individual providers incorporated are required to furnish their incorporation's type II NPI and their rendering providers' type I NPI numbers; and
    3. Group providers are required to furnish their group's type II NPI number and their rendering providers' type I NPI numbers
- Contact the National Plan and Providers Enumeration System at the following website address to apply for an NPI number: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions
- Network providers submit claims using the American Medical Association's Physicians' Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes. Network providers are reimbursed after IBHIS adjudication at the LMHP rates (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates).
- Network providers must list the starting time and ending time of the session in the client's chart and the number of minutes on the electronic claim to ensure full validation of time spent in the delivery of services to Medi-Cal beneficiaries. This rule is necessary to substantiate claims when the definition of the service involves time. In previous years, LMHP's data analysis using minimum times for service confirmed that some network providers were billing for over 20 hours daily. These claims are unacceptable and subject to recoupment. The LMHP will only reimburse for any appropriate and documented sessions.
- Proof of Medi-Cal beneficiary eligibility – Network providers must obtain and keep proof of Medi-Cal beneficiaries' eligibility for each month they receive services.
- The completed Uniform Method of Determining Ability to Pay (UMDAP) is required for all Medi-Cal beneficiaries. The UMDAP instructions are included in Section XI:

Financial Screening. Each network provider must keep UMDAP and other financial information either in a separate financial folder or in the medical chart.

- All accounting records and supporting documents must be retained by network providers for ten years after the closing of the fiscal year or until such time as the audit has been settled for the fiscal year. A licensed psychologist shall retain a patient's health service records for a minimum of seven years from the patient's discharge date. If the patient is a minor, the patient's health service records shall be retained for a minimum of seven years from the date the patient reaches 18 years of age.
- All network providers must be credentialed and entered on the LMHP's Network Provider Master File by the Provider Credentialing Unit.
- Network providers are only paid for services rendered while under a contract with the LMHP, approved by the Board of Supervisors and contingent upon active license and credentials.

Note: The LMHP does not have authority to retroactively pay for services provided outside of the credential/license/contract effective and expiration dates.

- Network providers must contact the LMHP for prior authorization of all psychological testing electroconvulsive therapy and over-threshold services. When submitting a prior authorization request, the Medi-Cal beneficiary's CIN number, DMH Client ID number, network provider's Medi-Cal provider number, procedure code and diagnosis code must be identical on both the authorization request form and the electronic claim or the claim will be denied.
- Claims must be electronically submitted to the LMHP to be processed, approved, converted to a SD/MC claim format and then transmitted to the DHCS.
- Network providers is responsible to ensure claims are submitted in a timely manner and denied claims are promptly corrected and resubmitted in order to comply with all applicable statutes of limitations, or risk loss of reimbursement for their services. Claims that do not reach the LMHP in time to be processed, approved and transmitted to the DHCS within six months from the date of service will be considered late. Under special circumstances, a valid HIPAA Delay Reason Code provided by the State must be entered on claims over the six-month billing limitation but under the one year billing limit to be accepted for claim adjudication.
- The LMHP is not obligated to reimburse network providers for the services covered by any claim if provider submits the claim to County more than one hundred eighty (180) calendar days after the date provider renders the services, or more than ninety (90) calendar days after the contract terminates, whichever is earlier. Additionally, the LMHP is not obligated to reimburse Contractor where the claim does not meet applicable Short Doyle SD/MC requirements.
- Roughly 20% of all claims are denied. In most cases these denials are correctable if reviewed and resubmitted promptly. Network providers, billing agents/services and clearinghouses are to actively monitor the claims response files to reconcile and determine the status of claims that have been received and adjudicated in the IBHIS.

DENIAL REASON EDIT CODES

The "IBHIS Denial and Adjustment Codes" is a list of denial reasons by type and code found on 835 file used to assist network providers, billing agents/services and clearinghouses with the reconciliation of denied claims. The list can be downloaded at the following website address: http://lacdmh.lacounty.gov/hipaa/documents/MSODenialCodesfoPublishing20170613_000.pdf and the State Medi-Cal Claim Payment Advice (835) Denial Codes/Reasons/Remark list is at: http://lacdmh.lacounty.gov/hipaa/documents/MHSUDS17_005Enc2_CARC_RARC_Codes_Eff_20160823_000.pdf

Users are encouraged to monitor the claim response files daily and correct claims eligible for rectification in a timely manner.

REIMBURSEMENT TIMELINE

Network providers are reimbursed based on IBHIS approvals to comply with the DHCS certified public expenditure requirements. The LMHP will recover from network provider's amounts denied by the State. Network providers shall hold County harmless from and against any loss resulting from any such State denials, unresolved explanation of benefit claims, and/or Federal and/or State audit disallowances. The reimbursement timeline is four to six weeks from the date of claim submission.

CERTIFICATION OF MEDI-CAL CLAIMS

The California Code of Regulations, Title 9, Section 1840.112 requires that LMHPs provide certification of compliance with specific statutory, regulatory and contractual obligations that are required for Medi-Cal reimbursement of Short-Doyle/Medi-Cal claims. The Director of Mental Health certifies each monthly claim prior to submission to the State for reimbursement.

The LMHP is unable to certify claims submitted by network providers and Short-Doyle/Medi-Cal Providers and, therefore, requires that each network provider certify that Medi-Cal claims meet Federal and State regulations and statutes annually by completing the Certification on Medi-Cal Claim form in the FFS Medi-Cal Professional Services Agreement packet.

ON-LINE VENDOR REGISTRATION REQUIREMENT

In order to receive payments, network providers are required to register as a vendor with the County of Los Angeles, Internal Services Department (ISD) at the following website address: http://camisvr.co.la.ca.us/webven/. It is recommended that network providers confirm in the system, via the "Vendor Search" link, whether a registration has already been completed before starting the registration process. Registrants should also be prepared to enter the network provider's tax ID.

Click on the "New Registration" link at the website listed above and select the scenario that best fits the network provider's current status.

Note: The network provider's name and address must be exactly the same as the billing address used on their credentialing application and contract to avoid reimbursement delays. In the event that a change of billing address becomes necessary, network providers must also update their ISD vendor registration by selecting "Change Registration" at the website listed above in a timely manner to avoid reimbursement delays.

Please contact ISD Vendor Relations at (323) 267-2725 for questions regarding vendor registration.

ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS

The LMHP network provider legal agreement requires that each provider certify that he/she is not currently excluded from participation in any federally funded health care program or that a recent or current investigation would likely result in exclusion from any federally funded health care program.

Network providers must certify on the *Attestation Regarding Federally Funded Programs* form in the FFS Medi-Cal Professional Services Agreement packet that they will notify the LMHP within thirty (30) days in writing of:

- Any event that would require exclusion or suspension under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or state government against the provider barring the provider from providing goods or services for which federally funded healthcare program payment may be made.

RESOURCE INFORMATION DOCUMENTS AND ONLINE SERVICES

SPECIAL BULLETINS

Network providers, billing agents/services and clearinghouses should regularly review the Special Bulletins for the latest updates regarding issues that may affect billing requirements. The Special Bulletins may be accessed at the following website address: http://lacdmh.lacounty.gov/hipaa/ffs_UIS_Special.htm in the "Outpatient Fee-For-Service" module. Click on the "Special Bulletins" link to access the bulletins.

INTERNET REPORTS

Windows Operating System and Internet Explorer 11 are required to start Windows Secure Application Manager (WSAM) to run Internet Reports. To access the SSLVPN DMH Contactor Login page, navigate to DMH Contractor page: https://dmh.sslvpn.lacounty.gov/dmh/contractor. After WSAM starts, click on Internet Reports – FFS link to access the IBM Cognos Analytics – DMH Contractor Login page. Users may access various reports on the DMH Internet Reports Application to review claim adjudication status and payment records.

The following reports are available on the Clinical Operations link:

1. FFS2 Claims Status Detail Report (CIOB 704)
    - A list of claims submitted with claims' statuses and adjudication detail.
2. FFS2 Processed Claims Summary Report (CIOB 705A)
    - A list of checks with sequence numbers received by the Provider.
3. Claims Reconciliation Report (CIOB 706A)
    - A list of provisional approved/paid claims and State denied claims. Sequence number is required, which can be found in CIOB 705A Report.

If you have any questions or need additional assistance, you may submit a HEAT ticket to DMH using the HEAT Self Service application available on the LACDMH secure website: DMH SSLVPN, or contact the DMH Help Desk at (213) 351-1335. You may contact the ISD Service Desk for password reset at (562) 940-3305.

SECTION XIII – PROCESS FOR RESOLVING FISCAL AND AUTHORIZATION REQUEST APPEALS

FISCAL APPEALS

The Board of Supervisors of the County of Los Angeles authorized the Local Mental Health Plan (LMHP) to establish a process for the resolution of fiscal appeals. The Alternate Dispute Resolution (ADR) process includes procedures for a First Level Appeal and/or a Second Level Appeal to resolve small claims presented to the LMHP by network providers. This appeal process offers network providers and billing agents who are dissatisfied with the processing or payment of an initial or resubmitted claim, a method for resolving disputed claims.

PRINCIPLES OF THE ALTERNATE DISPUTE RESOLUTION PROCESS

1. Time is of the essence and network providers should take all the necessary steps to initially submit a claim to the Department as soon as possible after providing service. Delay in the submission of a claim may attribute to a State denial that would have otherwise been a valid claim.

2. While there will be no commitment to pay all claims, this process offers an expeditious administrative review of denied claims and where it is determined the LMHP or its agent(s) are fully or partially at fault, there is a commitment to a reasonable settlement resolution.

3. The burden of proof will be on the network provider to establish the LMHP or its agent(s) were fully or partially at fault for the denial.

GENERAL STEPS IN THE ALTERNATE DISPUTE RESOLUTION PROCESS

1. Network providers and billing agents must ensure the timely submission of a claim. Refer to general claiming instructions for timelines:

   - Prepare and submit a claim for payment as soon as possible after providing the service.
   - Check the system reports for claim disposition; network providers are strongly encouraged to submit and reconcile claims weekly and no later than one month after the date of service.
   - If the claim is denied, the claim denial reason code should immediately be accessed to determine whether a claim is eligible for correction.
   - Prepare and submit a new and corrected claim as soon as possible.
   - If steps above in timely submitting a claim do not result in a provider reimbursement, a network provider may submit a First Level Appeal and/or Second Level Appeal.

2. The First Level Appeal must be submitted to the LMHP within 90 day calendar days of the denial. The LMHP has 60 calendar days from the receipt of the appeal to provide a written statement of the decision and any action to be taken by the network provider.

3. A Second Level Appeal may be submitted if the First Level Appeal decision is not to the provider's satisfaction. The Second Level Appeal must be submitted within 30 calendar

days of the date on the written decision of the First Level Appeal. The LMHP has 60 calendar days from receipt of the Second Level Appeal to notify provider of the decision.

4. If an appeal leads to a settlement proposal, payment will be made upon the network provider's agreement with the proposal and execution of an appropriate release.

DOCUMENTATION REQUIREMENTS FOR THE FIRST LEVEL AND SECOND LEVEL APPEAL

Network providers who wish to submit a First Level or Second Level Appeal must provide the following documentation:

- A detailed cover letter explaining the reason for the dispute, the circumstances concerning the denial and why the network provider or billing agent determined the fault was that of the LMHP;
- Any correspondence related to the processing of the disputed claim(s) from the LMHP;
- A completed Appeal Form indicating whether the appeal is a First Level or Second Level Appeal;
- A printout of a system report(s) that lists the history of the disputed claim(s) and error reason(s) or discussion of the original electronic claim(s);
- Proof of Medi-Cal beneficiary eligibility for the date of service;
- A copy of the claim(s); and
- Copy of an approved outpatient treatment authorization request (OTAR) or hospital treatment authorization request (TAR), if applicable.

Mail and fax all appeal documents to:

Department of Mental Health
Provider Support Office
550 S. Vermont Ave., 7th Floor
Los Angeles, CA 90020

INSTRUCTIONS FOR COMPLETION OF THE FIRST LEVEL AND SECOND LEVEL APPEAL FORM

Each item below refers to an area on the *Appeal Form* (Attachment I).

ItemDescription

A. Appeal Number. For LMHP use only.

B. Appeal Reference Number. For LMHP use only.

C. Network Provider Name/Address. Enter contracted individual or group network provider's name and mailing address, city, state, and zip code.

D. **Network Provider Telephone/Fax numbers**. Enter network provider's telephone and fax numbers.

E. **Rendering Provider Number**. Enter the nine-digit network provider number (ex. MF0000000, 00A000000, PSY000000, etc.) Without the correct network provider number, appeal acknowledgment and processing may be delayed.

F. **Claim Type.** Enter an "X" in the appropriate box to indicate whether the claim type is in an inpatient or outpatient setting. Only one box may be checked.

G. **Appeal Level.** Check the box to indicate First Level or Second Level Appeal.

H. **Statement of Appeal.** Network provider's attestation statement.

I. **Client's Name.** Last name, First name.

J. **Client's Medi-Cal ID.** Enter the Medi-Cal beneficiary's CIN (client index number) obtained from the beneficiary identification card (BIC).

K. **Number of Minutes**. Enter the number of minutes used by the provider for services.

L. **Claim ID #.** Enter the claim ID number, which can be obtained from one of the adjudication detail reports that displays the disputed claim(s).

M. **POS (Place of Service).** Enter the appropriate service location/facility type code of the place where the service was rendered.

N. **Date of Service.** Enter the date on which services were rendered to the Medi-Cal beneficiary.

O. **Prior Authorization #.** If applicable, enter the hospital treatment authorization request number (TAR) or over-threshold authorization request number (OTAR).

P. **Procedure Code.** Enter the procedure code.

Q. **Diagnosis Code.** Enter the diagnosis code.

R. **Reason for the Appeal.** Indicate the reason for filing the appeal. Be as specific as possible. All supporting documentation must be included and attached to the appeal form in order for the examiners to consider all relevant issues concerning the dispute.

S. **Denial Code.** Enter the denial code (0201, 0708, Validate diagnosis code ,etc.).

T. **Common Appeal Reasons.** Check one of these boxes, if applicable. Include a copy of the claim and supporting documentation.

U. **Signature and Date.** The network provider or an authorized representative (i.e., billing agent, group or organizational provider administrator) must sign and date the Appeal Form.

OVERVIEW OF THE ALTERNATE DISPUTE RESOLUTION REVIEW PROCESS

1. All appeal packages are reviewed applying the same set of rules. The appeal review process is as follows:

   - Packages are logged in to ensure they are received timely;
   - A log is maintained to track each appeal;
   - A cover sheet is attached to each appeal package for status control;
   - Each appeal is sent to the review team, who manually reviews the package based on the review rules. Deductions are made per the rules;
   - The average deduction and approval percentages are calculated;
   - If the entire appeal is denied, there is no further action; and
   - If any portion of the appeal is approved, the claim line detail is forwarded for payment the LMHP Accounting Division - Provider Reimbursement Unit.

2. An electronic review is conducted to:

   - Calculate the correct rate for each minute of service on the date of service;
   - Ensure the claim(s) is not a duplication of an approved claim(s);
   - Ensure there are not duplicate claims in the appeal package;
   - Verify the network provider had a valid contract and credentials on the date of service;
   - Verify that the service occurred during the appeal period;
   - The procedure code billed is valid for the provider type and date of service; and
   - The network provider number is valid.

3. Deductions are made due to the following reasons:

   Late submission of claims (denied claims that were not resolved and paid before the six-month billing limitation from the date of service. These claims are considered late and are measured as the amount of time that passed from the six-month billing limitation up to the one-year billing limitation).

   - 20% - 3+ months after the six (6) month billing limit;
   - 30% - 4+ months after the six (6) month billing limit; or
   - 40% - 5+ months after the six (6) month billing limit.

   Insufficient or missing documentation (determined by the nature of the claim – documentation that directly supports the appeal is required by the review team).

   - 100% - Is deducted if no documentation is submitted to support the appeal issue;
   - 10% - Is deducted per piece of information the appeals committee felt the network provider should have submitted (partial deductions); or
   - 20% - Is deducted if a reasonable explanation was not provided as to why the network provider was unable to provide documentation (partial deductions).

   Follow-up (this is measured by the level of follow-up claim activity performed by the network provider as demonstrated in the appeal and the documentation).

- 10% - Incorrect claim resubmitted;
- 20% - No corrected claim submitted;
- 40% - No follow-up demonstrated; or
- 100% - If the network provider failed to explain why the denials were the fault of the LMHP.

  Once the electronic review is complete, deductions found for each claim will be taken per claim and the appeal total is calculated. This amount represents what the LMHP agrees to pay the network provider and the LMHP's amount of responsibility for the denial of appealed claims.

4. The burden of proof will be on the network provider to establish that the LMHP or its agent(s) were fully or partially at fault for the denial.

PAYMENT

Upon completion of the ADR process, the LMHP will disburse the approved funds to the network provider. The payment is mailed to the network provider.

AUTHORIZATION REQUEST APPEALS

OVER-THRESHOLD

When an over-threshold authorization request is denied, delayed, or modified, the network provider is sent a Notice of Adverse Benefit Determination (NOABD) letter (Refer to XVII: Notice of Adverse Benefit Determination). After receipt of the NOABD letter, the provider may submit a request for reconsideration through the MHP Appeal process (Refer to Appeal Process in Section XV: Over-Threshold and Inpatient Professional Services).

PSYCHOLOGICAL TESTING

When psychological testing service is denied or modified, the provider and beneficiary is sent a Notice of Adverse Benefit Determination (NOABD) letter (Refer to XVII: Notice of Adverse Benefit Determination). After receipt of the NOABD letter, the beneficiary or the provider may submit a request for reconsideration through the MHP Appeal process (Refer to Appeal Process in Section XVI: Psychological Testing Authorization).

A. Appeal Number	B. Appeal Reference Information: Reserved for DMH Use:

APPEAL FORM – CoLA DMH LMHP – Specialty Mental Health Services

READ INSTRUCTIONS PRIOR TO COMPLETING AND SIGNING THIS FORM.

C. Provider Name:

Provider Address:

D. Provider Telephone:

Provider Fax Number:

E. Rendering Provider No:

F. Claim Type
Check Only One
Inpatient Setting ☐
Outpatient ☐

G. First Level Appeal ☐
Second Level Appeal ☐

H. As provided by the California Administrative Code Title 22, Section 51015, and by Section 1850.305 of Title 9, Chapter 11 of the Cal. Code of Regulations, I am submitting an appeal of my claim as defined below. I have enclosed all documentation required for this appeal.

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

I. Patient's Name

J. Patient's Medi-Cal I.D.

R. Reason for Appeal (Enclose all supporting documentation, including copy of claim)	S. Denial Code	K. # of Min.		L. Claim ID #	M. POS	N. Date of Service	O. Prior Auth # (if applicable)	P. Proc. Code	Q. Diag. Code
			01						
			02						
			03						
			04						
			05						
			06						
			07						
			08						
			09						
			10						
			11						
			12						
			13						

T. Common Appeal Reasons
CHECK ONLY ONE (IF APPLICABLE)

[ ] Eligibility [ ] (POS Attached)
[ ] TAR/PA/HPA Denial [ ] (TAR/PA/HPA Attached)
[ ] Crossover [ ] (3rd Party Denial Attached)
[ ] Adjustments Request [ ] (Paid Warrant Attached)
[ ] Past 6 Months SD/MC [ ] (Billing History Attached)

This is to certify that the information contained above is true, accurate and complete and that the Provider has read, understands, and agrees to be bound by and comply with the conditions required by the County of Los Angeles DMH Local Mental Health Plan.

U. Signature of Provider

Date

SECTION XIV – CARE COORDINATION BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH PROVIDERS

Communication between primary health care physicians (PCP's) and the Local Mental Health Plan (LMHP) specialty mental health providers is essential to ensure care coordination and access to services. Periodically, a care coordination packet is disseminated to the PCPs affiliated with Health Net and L.A. CARE health plans. The packet includes Health Insurance Portability and Accountability Act (HIPAA) regulations regarding federally mandated guidelines for Protected Health Information (PHI). Under HIPAA, health plans, health care clearinghouses, and health care providers that maintain or transmit PHI must maintain reasonable and appropriate administrative, technical, and physical safeguards. This is to ensure the integrity and confidentiality of the information, protect against unauthorized use or disclosure of the information, and ensure compliance by their officers and employees.

The care coordination packet also informs PCP's how to make referrals to the LMHP. The *Provider Communication* form *(MH 707)* is for use by PCPs and the LMHP mental health providers (Refer to Attachment I). The exchange of information form allows information exchange between PCPs and network providers. Information requested on the form includes essential medical information such as current medication, significant medical conditions and mental health conditions. By completing the information requested on the form, PCPs and network providers will have crucial information in order to facilitate care coordination.

Providers must obtain from the Medi-Cal beneficiary, a signed *Consent for Physical and Mental Health Care Coordination for Medi-Cal Managed Care Program Beneficiaries* form, to release information (Attachment II). This form must contain all of the required elements and conform to all other requirements according to the current federal and state regulations. Network providers are to retain a copy of the medical information received from the PCP in the client record. When faxing PHI, a HIPAA-compliant cover sheet is required. For convenience, a HIPAA fax sheet is included in this section (Attachment III). For more information on HIPAA refer to the following website address: www.medi-cal.ca.gov and click on the "References" link then scroll down to "HIPAA Update."

Medi-Cal beneficiaries often self-refer to mental health network providers without the knowledge of their PCP. It is important for care coordination and the welfare of the beneficiary for the network provider to obtain a signed consent and forward pertinent information to the PCP. Medi-Cal beneficiaries may not be enrolled in a Medi-Cal managed care physical health plan without having a PCP. In such cases, network providers may obtain a referral for physical health care for these Medi-Cal beneficiaries by contacting the ACCESS Center at (800) 854-7771.

SPECIALTY MENTAL HEALTH SERVICES TO ASSIST PRIMARY CARE PHYSICIANS IN THE TREATMENT OF MEDI-CAL LMHP BENEFICIARIES

CLINICAL EVALUATION AND CONSULTATION PROCEDURES*

1. Outpatient Evaluation and Consultation Services
   Outpatient Evaluation and Consultation
   - PCP's may obtain outpatient evaluations and consultations to assist in the mental health diagnosis and clinical management (psychotherapeutic and psychopharmacological) of

health plan beneficiaries. In contrast to routine services, an urgent evaluation and consultation is required when the beneficiary has non-life threatening symptomatology, that left untreated within 24 hours, may lead to a life threatening emergency or further decompensation. Recommendations may be obtained from a network provider for continued clinical management through the PCP or through initiation of specialty mental health services. Routine and urgent outpatient evaluations and consultations should be sought through:

- The ACCESS Center at: (800) 854-7771; or
- Contact with the Medi-Cal beneficiary's mental health provider, if currently in treatment.

Emergency Outpatient Evaluation and Consultation

- An emergency mental health condition is defined as behavioral symptomatology that may result in imminent harm to self or others. Emergency life-threatening mental health situations should be treated expeditiously. Emergency services may be sought through:
  - Calling 911; or
  - The ACCESS Center at: (800) 854-7771; or (Including Psychiatric Mobile Response Team (PMRT))
  - Contact with the Medi-Cal beneficiary's mental health provider, if currently in treatment; or
  - The Local Police Department.
- Requests for Emergency Outpatient Evaluations should be followed by contact with the current specialty mental health provider to facilitate disposition planning.

2. Inpatient Evaluation and Consultation Services

Non-Emergency Inpatient Evaluations

- Non-Emergency inpatient evaluations are rendered through psychiatrists with clinical staff privileges at the facility in which the Medi-Cal beneficiary is being treated. Information and access to hospital staff psychiatrists are available through the specialty mental health facility.

Emergency Inpatient Evaluations

- Psychiatrists affiliated with the facility treating the Medi-Cal beneficiary render emergency inpatient and emergency room evaluations. Freestanding medical facilities that may not have access to psychiatric evaluations in emergency situations should contact any of the following resources:
  - The ACCESS Center at (800) 854-7771; (Including Psychiatric Mobile Response Team (PMRT)); or
  - The Local Police Department or 911

*Please be aware that all consultations require a face-to-face clinical evaluation.
Listed below are the telephone numbers of the two health care plans, L.A. Care and Health Net, and their Plan Partners. Most Los Angeles County Medi-Cal beneficiaries are enrolled in L.A. Care or Health Net.

Health Plan Behavioral Health Network Contact Information

Medi-Cal Only Beneficiaries

Medi-Cal Managed Care Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Health Net	MHN	Fax: (855) 703-3268 Phone: (800) 675-6110 (Follow member prompts)
Health Net - Molina	Molina	Fax: (562) 499-6105 Phone: (888) 665-4621
L.A. Care	Beacon	Fax: (866) 422-3413 Phone: (877) 344-2858
L.A. Care - Anthem	Anthem	Fax: (855) 473-7902 (Attn: Medi-Cal BH) Email: Medi-CalBHUM@wellpoint.com Phone: (888) 831-2246 (Option 1 for BH, 2 for BH
L.A. Care - Blue Shield	Beacon	Fax: (866) 422-3413 (855) 765-9701 Phone:
L.A. Care -Kaiser	Kaiser	**See below for Regional** Offices:
Bellflower Area Downey/Norwalk	Fax:(562) 657-2497 Phone:(562) 807-6200	San Fernando Valley Woodland Hills Fax:(818) 592-3015 Phone: (855) 701-7955
Lancaster	Fax:(661) 951-2999 Phone: (661) 951-0070	San Gabriel Valley Baldwin Park/West Covina Fax:(626) 856-3010 Phone:(626) 960-4844
Los Angeles Sunset	Fax: (323) 783-4299 Phone: (323)783-2600	South Bay Fax: (310) 517-3499 Phone: (310) 325-6543
Panorama City Santa Clarita/Reseda	Fax:(800) 700-8705 Phone:(818) 758-1200	West L.A. Fax: (323) 298-3119 Phone: (323) 298-3100

Cal MediConnect Beneficiaries

Cal MediConnect Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Blue Shield	Beacon	Fax: (877) 752-3257 Email: cmc Carel st@beaconhs.com Phone: (855) 765-9701
CareMore	Beacon	Fax: (877) 749-3734 Email: cmc_caremore@beaconhs.com Phone: (855) 371-8092
Health Net	MHN	Fax: (855) 703-3268 Email: MHN.CMC@MHN.COM Phone: (855) 464-3571
L.A. Care	Beacon	Fax: (800) 916-4102 Email: cmc_lacare@beaconhs.com Phone: (877) 344-2858
Molina	Molina	Fax: (562) 499-6105 Phone: (855) 665-4627

MH 707
Revised 9/14/15

PROVIDER COMMUNICATION

TYPE OF COMMUNICATION REQUESTED:
☐ INFORMATION EXCHANGE ONLY ☐ CONSULTATION (Use Page 1)
☐ REFERRAL ☐ TRANSFER ☐ NOTIFICATION OF DISCHARGE (Use Pages 1 and 2)
*Indicates required sections for ALL communication types

SENDER*	RECIPIENT*
Agency:	Agency:
Contact Person:	Contact Person:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
E-mail:	E-mail:

RENDERING PROVIDER INFORMATION*

Name: Title:
Contact Information (if different from Sender information above):
Provider Signature: Date:

CLIENT INFORMATION*

Name: Medi-Cal CIN: DOB:
Address: Phone Number:
Gender: Client's Preferred Language: Caregiver's Name (if applicable):
Caregiver's Preferred Language: Caregiver's Phone Number:
Payor Source: ☐ Medi-Cal Only ☐ Medicare Only ☐ Medi-Medi ☐ Uninsured ☐ Other

DOCUMENTS ☐ **PROVIDED – or –** ☐ **REQUESTED*** *Note: The release of Protected Health Information may require a signed client authorization under certain circumstances.*

Check as many boxes as applicable: ☐ Authorization ☐ History & Physical ☐ Laboratory (specify)
☐ Assessment ☐ Assessment Summary ☐ Treatment Plan ☐ Treatment Summary ☐ Problem List ☐ Medication List
☐ Progress Notes ☐ Consultation Outcome ☐ Discharge Plan ☐ Other (specify) ☐ None
Explanation/Additional Comments:

COMPLETE THE SECTION BELOW THAT CORRESPONDS TO THE TYPE OF COMMUNICATION REQUEST

Information Exchange Only – Required Information

Sender must complete form through "Documents Provided or Requested" section above. No additional information necessary.

Request for Care Consultation - Required Information

Description of question or request:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH USE ONLY
Name: DMH ID#:
Agency: Provider #:
Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

PROVIDER COMMUNICATION

Notification of Referral for Services - Required Information

Reason(s) for Referral: ☐ Health Care Services ☐ Substance Use Disorder Services ☐ Housing Assistance ☐ Employment Assistance ☐ Non-specialty Mental Health Services ☐ Specialty Mental Health Services (see below) ☐ Other: _____

Explanation/Additional Comments: _____

Additional Information Required for Specialty Mental Health Services Referral**

Recently released (within past 15 days) from: ☐ Jail ☐ Juvenile Hall ☐ Inpatient facility

☐ Current thoughts of suicide/self-harm? ☐ Current thoughts of homicide/harm to others? ☐ Evidence of grave disability?

Is the individual currently taking psychiatric medication for which a refill may be necessary? ☐ Y ☐ N If yes, # of days remaining? _____

**Medi-Cal Managed Care Plans: For urgent referrals, please use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment. For routine referrals, either form may be used.

Notification of Transfer of Services - Required Information

Discharge Date: _____ Description of client's current services: _____

Reason for Transfer of Care: ☐ Client in need of a higher level of care ☐ Client in need of a lower level of care

☐ Client would like services in a different Service Area ☐ Client in need of services not offered at agency

☐ Client no longer meets specialty mental health criteria ☐ Other: _____

Rendering Provider's Supervisor: _____ Title: _____

Signature: _____ Date: _____

Notification of Discharge from Care - Required Information

Discharge Date: _____

Reason for Discharge: ☐ Treatment goals met ☐ Assessment does not indicate need for services

☐ Client requests termination of services ☐ Client in need of a lower level of care ☐ Needed services are unavailable

☐ Client absent from services (missed appointments/unable to contact) ☐ Further services would not produce additional benefits

☐ Client unwilling to participate in necessary payment, billing, and reimbursement

☐ Other: _____

Discharge Summary: _____

FOR RECIPIENT USE ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

Outcome of Transfer/Referral: ☐ Client Accepted for Services ☐ Client Did Not Show* ☐ Client Declined Services*

☐ Other: _____ *Transferring/referring provider to follow up with individual

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date disposition sent to transfer/referral source: ____/____/____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH USE ONLY

Name: _____ DMH ID#: _____

Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

PROVIDER COMMUNICATION FORM INSTRUCTIONS

Purpose This form is for use by providers to communicate about client services and care. Specifically, the form can be used for the following reasons:

Communication Type	Communication Purpose
Information Exchange for Coordination of Care	To facilitate exchange of information between providers regarding a shared patient/client for coordination of care.
Transfer of Care	To request confirmation of the transfer of responsibility for patient/client care from one treating mental health provider to another when the current mental health provider is discontinuing services.
Referral for Services	To request services for a patient/client not provided by the provider/agency.
Care Consultation	To request the clinical expertise or opinion of another provider regarding treatment of a patient/client currently under the care of the requesting provider.
Discharge from Care	To notify another treating provider when the current treating provider has discontinued patient's/client's services. For information only; does not indicate a transfer of responsibility for patient/client care or require feedback or follow-up unless desired by recipient.

Completion Instructions

The following sections are required for all communication types.

Type of Communication Requested:
- Select the reason for using this form.

Sender:
- The person completing the form should fill in their information as requested on the form.

Recipient:
- The person completing the form (Sender) should complete the information for who the form is intended to be sent (Recipient).

Rendering Provider Information:
- If the agency using this form does not have rendering providers, this section should be used by the person who is making the request on behalf of the individual/client.
- Fill in rendering provider name and title. If person completing the form is not the rendering provider, contact information for the rendering provider should also be completed.
- Provider signature and date should always be completed.

Client Information:
- Fill-in the specific client information requested on the form.
- If appropriate, enter in the caregiver's name, preferred language, and phone number. These fields are not required to be completed.
- Payor Source: only one box should be checked; if "Other" is checked, fill in the specific payor source information.

Documents Provided or Requested:
- The release of Protected Health Information may require a signed authorization from the client or his/her representative. Individuals completing this form are advised to refer to their agency policy when making this determination.

- Check whether the documents listed are provided with the communication or requested from the recipient.
- Check off the information that is being requested or provided. Multiple boxes may be checked and additional comments may be provided. If "Laboratory" is checked, please identify the types of labs. If "Other" is checked, please specify.

Of the sections following, only complete the one that is listed as "Required Information" for the communication type for which the form is being completed. After completing the required section, no further information is needed and the form is complete.

Information Exchange Only – Required Information:
- If the form is being completed only for the purpose of information exchange, no further information is required.

Request for Care Consultation – Required Information:
- Provide a written description of the question or request.

Notification of Referral for Services – Required Information:
- Check the reason for referral. More than one box may be checked if offered by the recipient, and comments can be provided. If "Other" is checked, please specify.
- If the referral is for Specialty Mental Health Services, complete the "Additional Information" section.
- Medi-Cal Managed Care plans and providers referring a patient/client for an urgent appointment must use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment referral.

Notification of Transfer of Services – Required Information:
- Complete the discharge date and include a description of the client's services.
- Check the reason for transfer of care. If "Other" is checked, please specify.
- The name, title, and signature of the rendering provider's supervisor are required.

Notification of Discharge from Care – Required Information:
- Complete the discharge date and reason for discharge. If "Other" is checked, please specify.
- Provide a summary of the discharge in the space provided on the form.

For Recipient Use Only:
- If sending the Provider Communication form, do not complete this section.
- If receiving the Provider Communication form for the purpose of Referral or Transfer:
    - Check the outcome of the transfer or referral. If "Other" is checked, please specify.
    - Complete the assigned case manager/MD/Therapist name and contact information.
    - Complete the date that the disposition was sent to the transfer or referral source, and fax the form to the contact person listed in the "Sender" portion of the form.

NOTE: Sharing information must comply with all HIPAA rules. DMH Directly Operated staff should refer to DMH Policy & Procedures related to HIPAA Privacy. Other providers should refer to their own legal counsel and policies.

Filing Procedures for DMH:
- Paper Chart: File chronologically in Section 2 Correspondence of the Clinical Record
- IBHIS: Scan into the Correspondence folder.

COUNTY OF LOS ANGELES
LOCAL MENTAL HEALTH PLAN

CONSENT FOR PHYSICAL AND MENTAL HEALTH CARE COORDINATION FOR MEDI-CAL MANAGED CARE PROGRAM BENEFICIARIES

Name of Beneficiary _____ Date of Birth _____

I consent to the sharing of information between the physical health and mental health care providers, named on the bottom of this consent, as is necessary for the purpose of coordination of my overall health care. I understand that all mental health records and information have special protection from release under California Welfare & Institutions Code 5328 and, once the stated purpose of the original release is fulfilled, the information may not be released further without my consent. Information specifically released between my physical health and mental health provider may cover:

- The information supplied at the bottom of this form by either party
- Other information regarding my physical health or mental health deemed relevant in the course of my care by either professional and discussed with me prior to the release.

This consent is effective the date of my signature below and remains in effect for one year. A new consent must be obtained each year by my physical and mental health providers who wish to exchange information. I have the option of revoking this consent at any time to the extent that action has not already been taken. I also understand that I have the right to receive a copy of this consent if requested.

The following is a summary record of information shared between my health and mental health care professionals.

Date Discussed With Beneficiary	Information Released	Date Released

☐ Copy of Consent received

Signature of Beneficiary _____ Date _____

Signature of Responsible Adult* _____ Date _____

Signature of Witness _____ Date _____

☐ Consent Revoked

Signature of Beneficiary or Responsible Adult* _____ Date _____

* Responsible Adult = Legal guardian or court appointed custodian, P.P.S. Conservator, or Parent of Minor unless DMH Form 521, CONSENT OF MINOR, has been completed.

FAX COVER FOR TRANSMITTING PHI

FAX DETAILS

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

Intended Recipient: _____

TO

Name: _____

Facility: _____

Address: _____

Telephone #: _____

Fax #: _____

FROM

Name: _____

Facility: _____

Address: _____

Telephone #: _____

Fax #: _____

Documents being faxed:

- ☐ Clinical Records
- ☐ Other: _____

CONFIDENTIALITY STATEMENT

This facsimile transmission may contain information that is privileged and confidential and is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use, or distribution of this information is strictly prohibited. In addition, there are federal, civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received this transmission in error, please notify the contact person listed below immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.

VERIFICATION OF TRANSMISSION OF PHI

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.

I verify the receiver of this Fax has confirmed its transmission:

Name: _____ Date: _____ Time: _____

SECTION XV – OVER-THRESHOLD AND INPATIENT PROFESSIONAL SERVICES

UNDER-THRESHOLD SERVICES

Under-threshold services are defined as eight services rendered by a psychiatrist and eight services rendered by a psychologist to clients in a four-month trimester period. For clients under the age of 21, under-threshold services are eight services rendered by a psychiatrist and eight services rendered by any other network provider in a four-month trimester period. A client meeting medical necessity criteria, as defined in this section, is authorized to receive these services without pre-authorization.

The Local Mental Health Plan (LMHP) defines the four-month trimester period within which the eight services may be rendered as follows: January 1 – April 30, May 1 – August 31, and September 1 – December 31. At the beginning of each trimester period network providers may again provide eight under-threshold sessions without prior authorization.

Client visits to multiple providers will accumulate toward the total of eight threshold services. Network providers should determine if the client is currently receiving specialty mental health services from other network providers. If clients are currently receiving services, providers assume the financial risk that the client may have already received the maximum eight sessions. Network providers may contact the Provider Support Office at (213) 738-3311 for assistance in verifying whether a client has seen other network providers within a trimester period.

OVER-THRESHOLD SERVICES

All services provided which exceed eight sessions per trimester period, as defined above, are considered over-threshold and require prior authorization from the Central Authorization Unit (CAU) (Refer to Figure A).

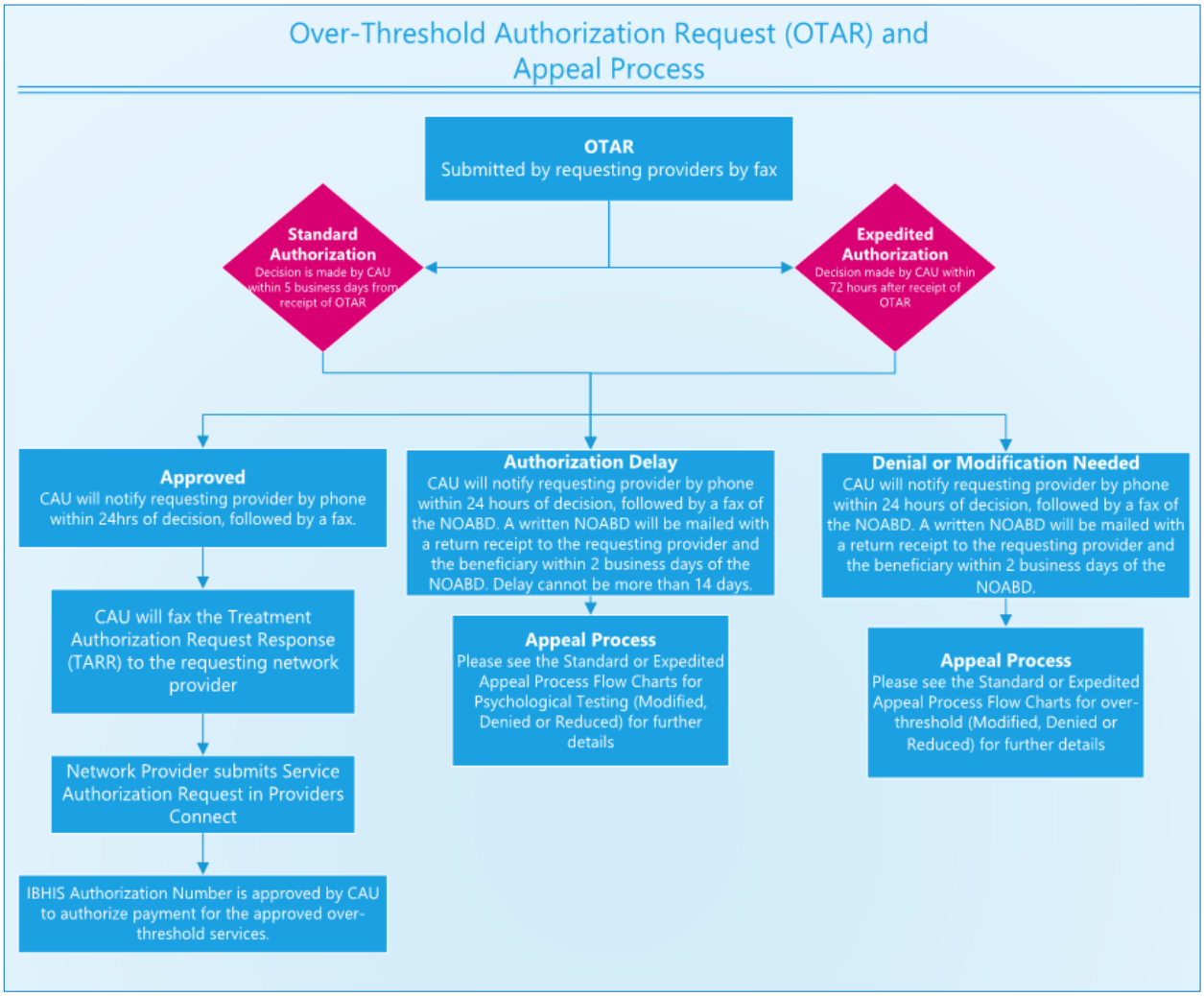
Over-threshold services may be authorized in increments of one to eight additional sessions of service within a trimester period in which the service falls above threshold limits. Services may be authorized for more than eight sessions, up to 12 sessions, if at least one individual session and at least one family therapy session is included in the treatment plan.

> Note: Family therapy must be clearly documented and include family therapeutic interventions. Each member of the family in attendance must be documented in the record. Only one claim for the family session is to be submitted, regardless of the number of clients in attendance.

Services that are excluded from the threshold limit, and therefore do not require prior authorization, are:

- Professional services rendered in an acute psychiatric inpatient unit;
- Emergency services;
- Medication support;
- Psychological testing services; and
- Electroconvulsive Therapy

FIGURE A



OBTAINING PRIOR AUTHORIZATION FOR OVER-THRESHOLD SERVICES

To obtain prior authorization for over-threshold services, the following criteria must be met:

- Over-threshold services will be authorized based upon continued medical necessity. To support medical necessity, the network provider must establish that the proposed treatment approach, additional visits requested, proposed time frame, and expected outcome are appropriate to the client's diagnosis and functional impairment.
- The client's condition, as stated in the documentation, must demonstrate the need for over-threshold specialty mental health services. The following list contains examples of conditions that might contribute to increased impairment without additional intervention:

  - Suicidality
  - Homicidality
  - Significant decompensation in functioning
  - Loss of placement
  - Significant change in living or social situation
  - Recent use of more costly/restrictive setting
  - Any other life change that leads to significant impairment in life functioning

- All supporting documentation should be completed, legible, and include the *Client Plan/Over-Threshold Authorization Request* (OTAR) form (Attachment I), the progress notes from the current trimester period, and the initial assessment. The assessment needs only be submitted with the first OTAR request, unless an updated assessment or addendum is necessary.
- If an OTAR form is returned to a provider for correction and/or additional information/documentation is required, the requested documents must be returned to the CAU within 30 calendar days. If the documents are not returned within the time allotted, the over-threshold request will be administratively denied and a *Notice of Adverse Benefit Determination* (NOABD) letter will be issued (Refer to Authorization for Over-Threshold Services Policy and Procedure No. 313.40 & Section XVII: Notice of Adverse Benefit Determination).
- The "Service Request Begin Date" must be the anticipated ninth session, not the first date of the trimester period. The "Service Request End Date" must be the last day of the trimester period.
- In order to complete the request for over-threshold services, the network provider completes the OTAR form and electronically transmits to the CAU; however, the supporting documentation must be faxed. The supporting documentation must include the progress notes from the current trimester period and the initial assessment. Multiple requests within a trimester period may require an updated assessment. Providers will need their own unique logon ID and password to access this system.
- The CAU will review the documentation, and approve, deny, delay, or modify the request via electronically via facsimile to the CAU. The network provider will also be able to view the results of their request via the same system. Contact the CAU at (213) 738-2466 for assistance in using the system.
- When an OTAR is approved by the CAU, the decision must be communicated to the requesting provider initially by telephone within 24 hours of the decision, followed by a fax. The CAU reviewer will post the approved action in the IBHIS real-time AVATAR Provider/Connect system. CAU also completes a Treatment Authorization Request Response (TARR) form (Attachment II) which will be transmitted by facsimile to the provider for electronic billing purposes. The TARR form which will contain the IBHIS Approval number, the number of over-threshold session authorized, and the time frame for over-threshold sessions to be completed. The Network Provider completes and electronically submits a Service Authorization Request for OTAR in the IBHIS/Provider/Connect system. The CAU will authorize payment by approving the IBHIS Authorization Number.
- If further over-threshold sessions are required, an additional OTAR form must be submitted electronically via facsimile to the CAU. The CAU will consider approval of a second OTAR in a trimester period only when the need for continued services is clearly documented.
- Over-threshold services authorized but not utilized by the network provider will not carry over to the next trimester period.
- When OTAR services are denied or modified the provider will be notified initially by a telephone call within 24 hours, followed by a fax of the Notice of Adverse Benefit Determination (NOABD) and the Treatment Authorization Request Response (TARR) form. The TARR form is a response informing the provider that the OTAR has been denied and the reason(s) for the denial. In addition, a written NOABD notice will be mailed with a return receipt within two business days of the adverse benefit notice for OTAR to the provider and the beneficiary. The NOABD letter must include the enclosures: NOABD Your Rights, Nondiscrimination Notice, and Language Assistance. These enclosures are required to ensure that the beneficiary is informed of civil rights laws and the right to appeal a NOABD

(Refer to Authorization for Over-Threshold Services and NOABD Policy and Procedure No. 313.41).

Note: The NOABD letter will explain the following: The adverse benefit determination the plan has made; a clear and concise explanation for the reason for the decision (determinations based on Medical Necessity Criteria must include the clinical reasons for the decisions and state why the beneficiary condition does not meet Specialty Mental Health Services); a description of the criteria used. For example, Medical necessity Criteria, and any processes, strategies or evidentiary standards used in making the determination; the beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the beneficiary's adverse benefit determination; and the name and direct telephone number of the decision maker shall be included in the NOABD.

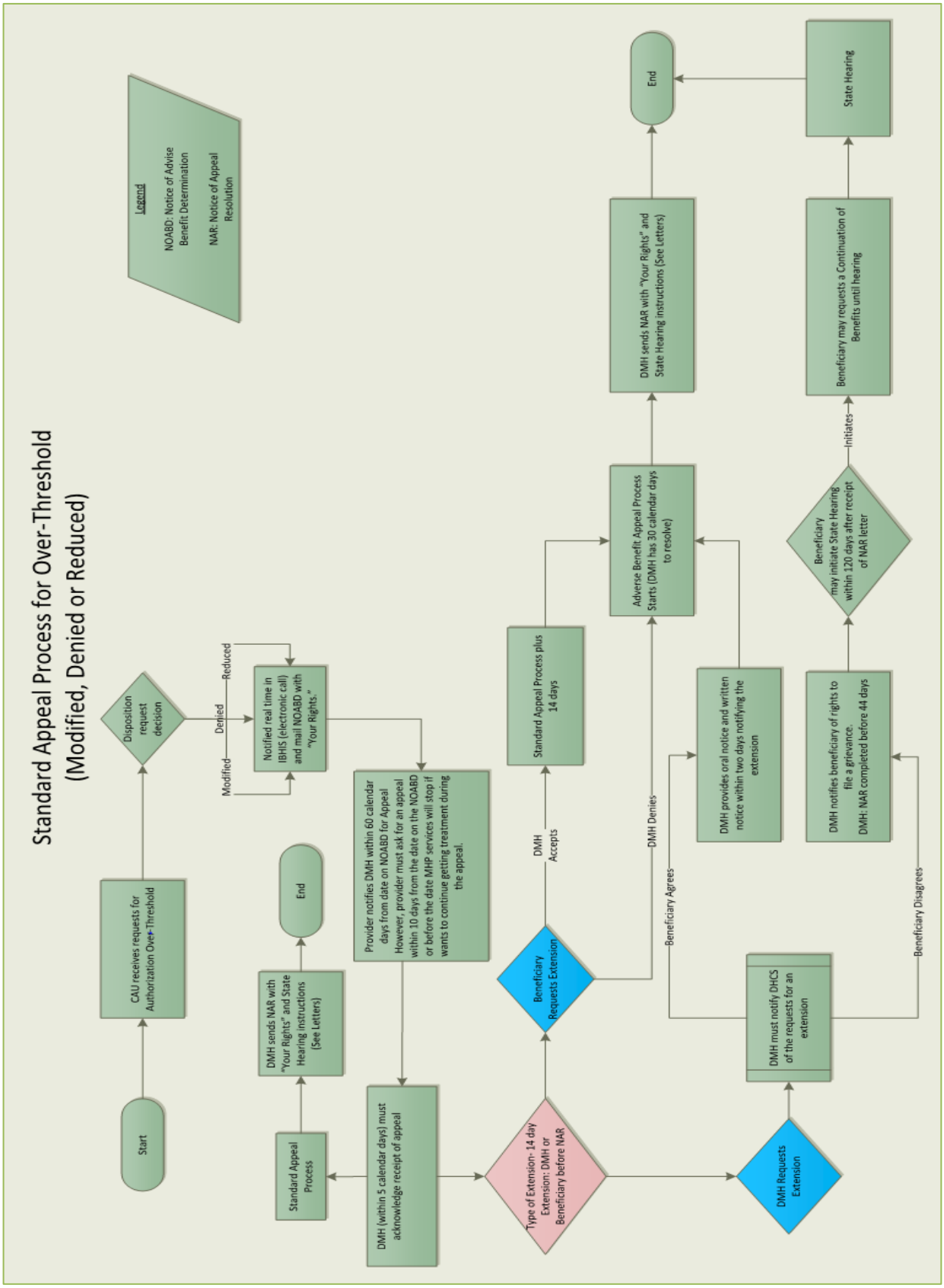
- When OTAR services are delayed, the provider and beneficiaries will be notified initially by telephone within 24 hours of the decision, followed by a fax of the NOABD letter and Treatment Authorization Request Response (TARR). The TARR form informs the provider that the OTAR has been delayed and the specific additional information is required. In addition, a written NOABD notice and the TARR form will be mailed with a returned receipt within two business days of the adverse benefit notice to the provider and the beneficiary. The Provider and beneficiaries will be mailed with a return receipt within two business days of a written Notice of Adverse Benefit Determination Authorization Delay, which is a "Pending" status in IBHIS/ Provider Connect. This is when a decision about the OTAR Authorization Request (PTAR) has not been made because there is a need for additional information and the delay is in the beneficiary's best interest. The NOABD Authorization Delay notice is an apology to the Provider for the delay in processing the request for services in a timely manner, including the reason for the delay. As a result, the CAU has not authorized the request, and the decision is delayed as indicated in the IBHIS/ Provider Connect OTAR screen. In no event shall the event extend beyond the 14 calendar day extension. The CAU shall include with the NOABD Authorization Delay notice the enclosure: "NOABD Your Rights" notice which tells the requesting provider and beneficiary about the right to an appeal and timelines to follow to file an appeal if the beneficiary disagrees with the extension regarding the NOABD
- Authorization Delay (Refer to Authorization for Over-Threshold Services and NOABD Policy and Procedure No. 313.41).
- The network provider must send all requested documentation to the CAU at:

Intensive Care Division/Over-Threshold Requests
Los Angeles Department of Mental Health
550 Vermont Ave., Room 703-A
Los Angeles, CA 90020
Fax: (213) 738-4412

APPEAL PROCESS

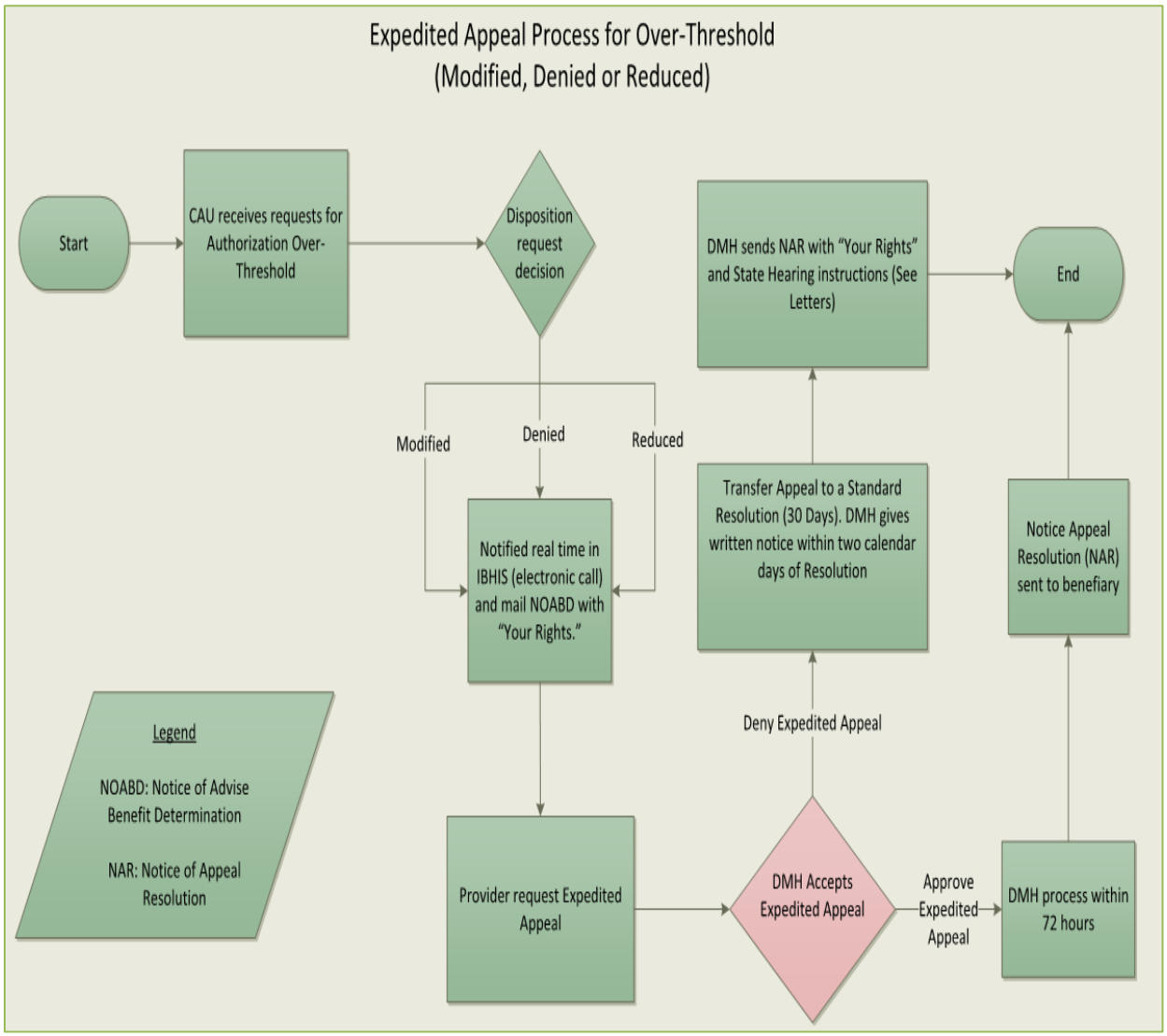
After receipt of the NOABD letter, the network provider may request an internal appeal of a denied, delayed, or modified request within 60 calendar days from the date on the NOABD letter (Refer to Figure B).

FIGURE B


Standard Appeal Process for Over-Threshold
(Modified, Denied or Reduced)
Legend
NOABD: Notice of Advise Benefit Determination
NAR: Notice of Appeal Resolution
Start
CAU receives requests for Authorization Over-Threshold
Disposition request decision
Reduced
Denied
Modified
Notified real time in IBHIS (electronic call) and mail NOABD with "Your Rights."
Provider notifies DMH within 60 calendar days from date on NOABD for Appeal However, provider must ask for an appeal within 10 days from the date on the NOABD or before the date MHP services will stop if wants to continue getting treatment during the appeal.
End
DMH sends NAR with "Your Rights" and State Hearing instructions (See Letters)
Standard Appeal Process
DMH (within 5 calendar days) must acknowledge receipt of appeal
Type of Extension- 14 day Extension: DMH or Beneficiary before NAR
Beneficiary Requests Extension
DMH Accepts
Standard Appeal Process plus 14 days
DMH Requests Extension
DMH must notify DHCS of the requests for an extension
Beneficiary Agrees
DMH provides oral notice and written notice within two days notifying the extension
DMH Denies
Adverse Benefit Appeal Process Starts (DMH has 30 calendar days to resolve)
DMH sends NAR with "Your Rights" and State Hearing instructions (See Letters)
End
Beneficiary Disagrees
DMH notifies beneficiary of rights to file a grievance. DMH: NAR completed before 44 days
Beneficiary may initiate State Hearing within 120 days after receipt of NAR letter
Initiates
Beneficiary may requests a Continuation of Benefits until hearing
State Hearing

Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. If an oral appeal is made then it shall be followed by a written appeal signed by the beneficiary, unless the beneficiary or provider have requested an expedited appeal (Refer to Figure C). The oral appeal is the filing date for the appeal. In the event the MHP does not receive a written appeal from the beneficiary, the MHP must neither dismiss nor delay resolution of the appeal and must send a Notice of Appeal Resolution (NAR) to the beneficiary (Refer to Authorization for Over-Threshold Services and NOABD Policy and Procedure No. 313.41).

FIGURE C



The MHP must adhere to the 30 calendar day timeline; if the MHP fails to resolve the appeal within 30 day timeline then the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State Hearing (Refer to Authorization for Over-Threshold Services and NOABD Policy and Procedure No. 313.41).

INPATIENT PROFESSIONAL SERVICES

Clients receiving acute psychiatric inpatient services must also be electronically enrolled in the IBHIS. (Refer to Section V: Confirmation of Medi-Cal Eligibility and Electronic Medi-Cal Beneficiary Enrollment).

Reimbursement for inpatient professional services delivered in acute inpatient hospital settings (a psychiatric hospital or a mental health unit of a general acute care fee-for-service hospital) is linked to approved inpatient hospital days determined by State medical necessity criteria and Treatment Authorization Request (TAR) approval guidelines. Therefore, the claim submitted for inpatient professional services must include the TAR number and the name of the inpatient facility. The TAR number will be used to determine the number of approved hospital days eligible for reimbursement of inpatient professional services.

It is, therefore, imperative that the network provider be notified by the inpatient acute facility of DMH action on all TARs. The specific manner of communication between facility and network provider is to be established by each inpatient facility.

Inpatient professional services provided in a psychiatric hospital, a mental health unit of a general acute care hospital facility or a general medical/surgical hospital facility are excluded from the threshold limit, and therefore do not require prior authorization for services that exceed the threshold. A TAR is not required for inpatient professional services delivered in a general medical/surgical hospital unit.

In adult and child/adolescent residential care settings, including board and care and skilled nursing facilities, specialty mental health services are authorized in the same manner and under the same guidelines as when delivered in other outpatient settings.

Note: Inpatient professional services rendered in a Short-Doyle/Medi-Cal mental health unit of a psychiatric or general acute care hospital facility will **not** be reimbursed by the LMHP.

CLIENT PLAN/
OVER-THRESHOLD AUTHORIZATION REQUEST (OTAR)

For initial requests, include the Child/Adolescent or Adult Assessment.
Include the Change of Diagnosis form whenever there has been a change from the assessment of last Client Plan.

Desired outcome(s) as stated by: ☐ **Client and/or** ☐ **Parent/Responsible Adult** **Initial Date of Service** _____

Major Barriers/Impairments (functional or skill) to attaining outcome(s):

Need for additional services and Risk Factors (attach supporting documentation; i.e., summary or relevant progress notes from clinical record):

Diagnosis Code:_____ Nomenclature:_____
☐ Severe life crisis: _____
☐ Decompensation/marked decline in functioning: _____
☐ Use of more costly/restrictive setting: _____
☐ Other: _____

Goal(s) (please number; must be specific, observable or quantifiable): Date: _____

Intervention Plan for requested services (must be consistent with diagnosis and client goals):
Client Role:

Participation of Significant Other:
☐ Not desired by client

Provider's principal modalities/intervention(s): Medication Evaluation: ☐Yes ☐ No Date: _____

Intervention Partner(s) (Note any other professionals currently providing services and their role(s)):

Progress toward goals since date of last service plan **Date:** _____

Service Request Begin Date:_____ End Date:_____ Code: _____No.:_____ Code:_____ No.:_____

Code:_____ No.:_____ Code:_____ No.:_____ Total # of svcs. Remaining in current request _____

Signatures

_____ _____ _____
Client and/or Parent/Guardian/Responsible Adult Date Significant Other or Minor

If client is unwilling/unable to sign, give reason _____ _____ _____
Provider's Signature and Discipline Date

This confidential information is provided to you in accord with applicable Welfare and Institutions Code Section. Duplication of this information for further disclosure is prohibited without the prior written consent of patient/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request if fulfilled.

Client Name: **Birth date:**

Medi-Cal #:

DMH Client ID #

Facility/Provider:

MC Provider #:
Los Angeles County – Department of Mental Health

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION
Medi-Cal Professional Services and Authorization Division

TREATMENT AUTHORIZATION REQUEST RESPONSE (TARR)

To: _____ Provider #: _____ Fax or Address: _____

From: *CENTRAL AUTHORIZATION UNIT* Phone: _____

Reporting Unit: _____

Re: Request for Treatment Date Client Plan/ OTAR Request Received: _____

Date of OTAR Request: _____ Beneficiary Name: _____

DMH Client ID No: _____ MEDS ID No.: _____

Primary Diagnosis: _____

Signature: _____ Print Staff Code: _____

Treatment Review

Criteria met for over threshold services as requested: ☐ Yes With modification: ☐ Yes ☐ No

Request approved for sessions beginning ____/____/____ and ending ____/____/____

CPT Code: _____ No. Units: _____

- ❑ Severe Life Crisis
- ❑ Decompensation/marked decline in functioning
- ❑ Use of more costly/restrictive setting
- ❑ Other: _____

If No:

- ❑ No medical necessity for treatment at this time
- ❑ Goals met, no need for further treatment
- ❑ Client has not demonstrated to have previously benefited from this type of service
- ❑ Prior over threshold authorization(s) indicate chronic condition not responsive to time limited intervention
- ❑ Excluded diagnosis
- ❑ Requires level of care other than outpatient services
- ❑ Other: _____

Additional information required as follows:

- ❑ Medical necessity for treatment has not been adequately established or documented
- ❑ Goals are not clearly defined
- ❑ Goals are inconsistent with desired outcome and/or referral request
- ❑ Intervention plan inconsistent with diagnosis, level of functioning, goals, or prior client plan/OTAR requests
- ❑ Other: _____

Comments: _____

_____

Reviewer: _____ Date: _____

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable Federal or State Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you have received this message in error, please telephone the originator of this message immediately.

TAR # 1 9 0 0 0 __ __ __ __ __ 0

SECTION XVI – PSYCHOLOGICAL TESTING AUTHORIZATION

All psychological testing administered by network providers requires the completion of a *Psychological Testing Authorization Request* (PTAR) form (Attachment I) and prior authorization by the Central Authorization Unit (CAU). The Local Mental Health Plan (LMHP) will reimburse network providers only after psychological testing has been authorized and the psychological testing reports have been reviewed and approved for payment.

GOALS OF THE PSYCHOLOGICAL TESTING AUTHORIZATION PROCESS

- Ensure the timely delivery of psychological testing to clients;
- Ensure the quality of psychological test reports by using standardized quality control procedures;
- Increase interdisciplinary access to psychological testing;
- Improve the process of determining the need for psychological evaluations;
- Facilitate access by clients to appropriate mental health services;
- Facilitate the coordinated delivery of mental health services between service providers; and
- Promote case consultation to improve mental health outcomes for clients.

RESPONSIBILITIES OF THE CENTRAL AUTHORIZATION UNIT

- Authorize individual network providers to perform psychological testing for clients;
- Refer and facilitate service coordination between network providers, local community mental health centers, and protective services for clients requiring psychological testing;
- Consult, train and support network providers, community mental health centers and referral sources to establish and maintain practices relevant to psychological testing, assessment and service planning for clients; and
- Promote community wide practice guidelines and standards for psychological testing consistent with the California Board of Psychology.

CRITERIA FOR APPROVAL OF PSYCHOLOGICAL TESTING

One of more of the following criteria must be met for approval of psychological testing:

1. The client must meet medical necessity criteria in order to be considered for psychological testing;
2. Psychological testing must be an adjunct to ongoing mental health treatment;
3. There is a need to clarify the client's diagnosis in order to further the treatment process;
4. An intervention or multiple interventions have failed;
5. A non-verbal client must be assessed in the absence of historical data;
6. To evaluate the client's capacity for informed consent, to emancipate successfully, and/or to ascertain benefits for Supplemental Security Income (SSI);
7. There is an unaccountable decline in the client's functioning;
8. The client presents with an unusual or high-risk behavior;
9. The client presents with a risk of non-emergency harm to self or others that is denied by the client; or
10. Other special circumstances. The CAU does not authorize psychological testing for:

- General assessments unrelated to psychological treatment;
- Learning disabilities;
- Intellectual Disability ;
- Pre-adoption studies;
- General intelligence testing;
- Diagnosing Attention-Deficit/Hyperactivity Disorder (ADHD);
- Court ordered testing;
- Ruling out dementias or other neurologically-based disorders prior to an evaluation by an appropriate medical specialist; and
- Determining if medication is warranted.

GUIDELINES FOR REVIEW OF PSYCHOLOGICAL TESTING

The CAU psychologists utilize the following guidelines in approving requests for psychological testing:

1. The PTAR form must include information that provides a compelling rationale for psychological testing;
2. The client must meet medical necessity criteria in order to be considered for psychological testing;
3. Psychological testing must be an adjunct to ongoing mental health treatment;
4. Neuropsychological testing requires a referral from a physician;
5. Psychological testing is not to be performed during a crisis;
6. Psychological testing shall not be performed to make decisions as to whether the client is to be on medication;
7. Referral questions are specific, relevant and individualized to the client and the treatment plan;
8. The request for psychological testing must clearly demonstrate that testing is necessary at this time;
9. Children and adolescents seven years and older, have not been tested within the last two years;
10. Children six years and younger have not been tested within the last year; and

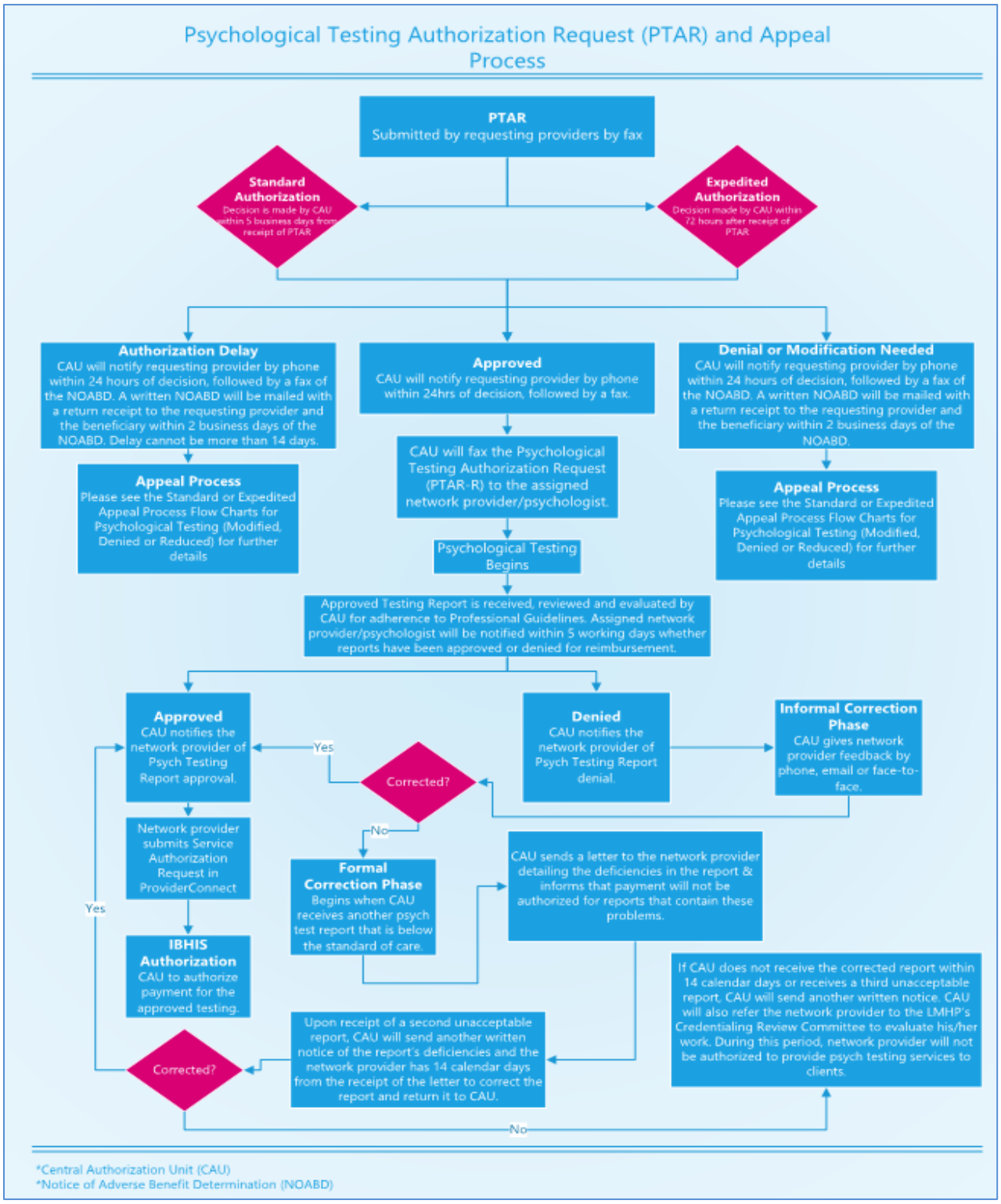
All requests to test minors under the supervision of the Department of Children and Family Services (DCFS) should be initiated by the Children's Social Worker (CSW) using DCFS form 5005. The form is completed by the CSW and then faxed directly to the CAU. The 5005 form must also be signed by the CSW's Supervising Children's Social Worker (SCSW).

OBTAINING AUTHORIZATION FOR PSYCHOLOGICAL TESTING

In order to submit a request for Psychological Testing, the provider must submit the PTAR by faxing the completed PTAR to CAU at (213) 738-4412. The CAU will approve, modify, delay or deny PTARs (Refer to Figure A).

The CAU will approve, modify, delay or deny PTARs. Only the CAU psychologists are authorized to select and assign testing to a network provider. However, the referring party may suggest a network provider.

FIGURE A



The CAU psychologists must make authorization decisions in a timely fashion, appropriate for the nature of the beneficiary's condition, and not to exceed five (5) business days from the receipt of the request for authorization. For cases in which a provider indicates, or the psychologists determine, this standard timeframe could seriously jeopardize the beneficiary's life or health or

ability to attain, maintain, or regain maximum function, the psychologists must make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (Refer to Psychological Testing Authorization Process Policy and Procedure No. 313.42).

Decisions to approve, modify, delay or deny provider requests for authorization prior to the provision of services to beneficiaries must be communicated initially by telephone to the requesting provider within 24 hours of the decision, followed by a fax. Decisions resulting in denial or delay of all or part of the requested service shall be communicated to the beneficiary and the requesting provider, in writing and must be mailed to the beneficiary and the requesting provider within two (2) business days of the decision.

When testing is approved by the CAU, the decision must be communicated to the requesting provider initially by telephone within 24 hours of the decision, followed by a fax. CAU Psychologist will designate the type of psychological testing that should be administered, based upon the needs of the Medi-Cal beneficiary. Then, a *Psychological Testing Authorization Request – Response* (PTAR-R) form (Attachment II) is electronically transmitted via facsimile to the network provider. The PTAR-R is formal notification of the network provider accepting the case and agreeing to do the testing. The PTAR-R also gives the network provider the number of hours authorized for testing and the time frame for testing to be completed.

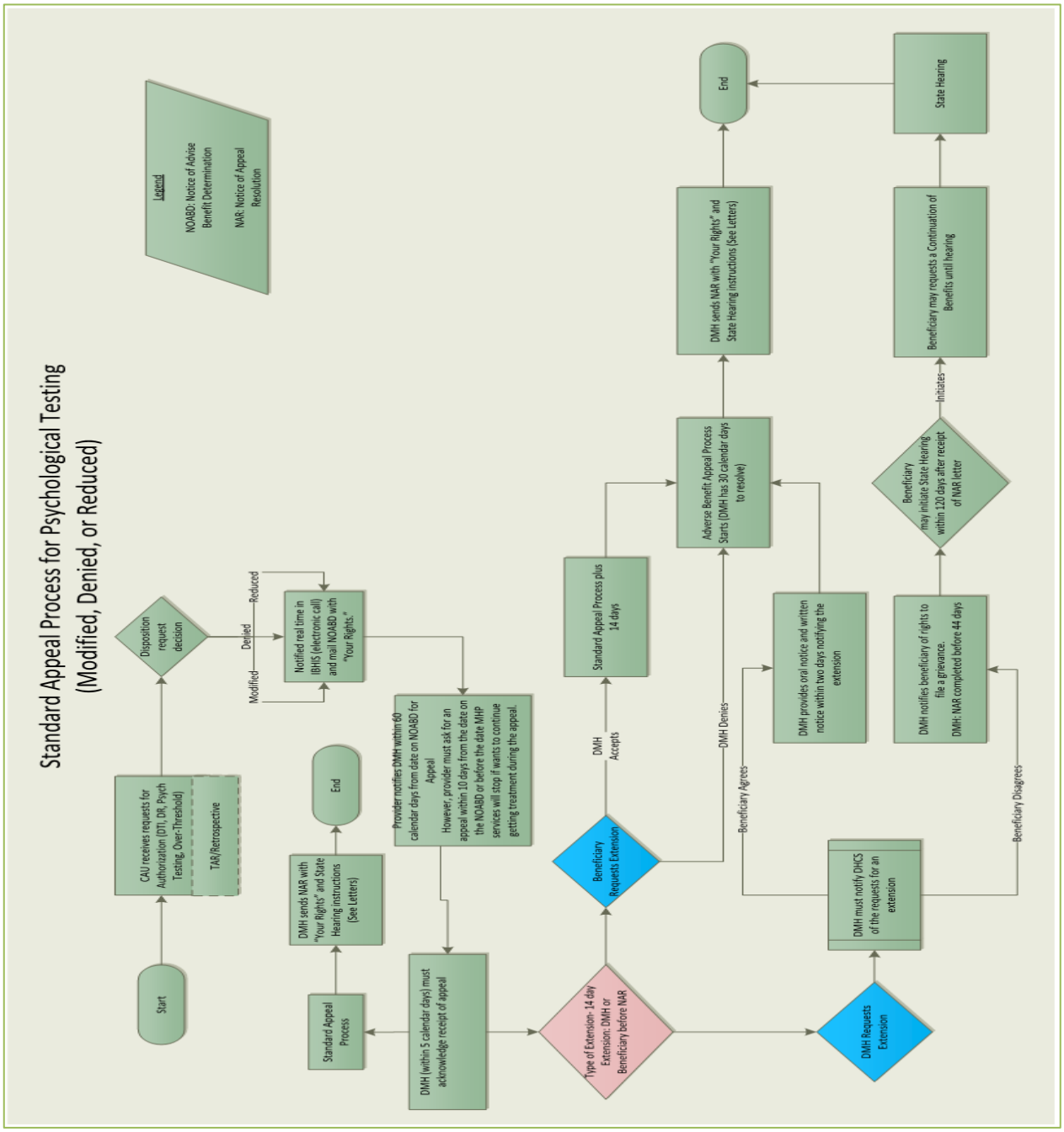
When psychological testing services are denied or modified, the provider will be notified initially by a telephone call within 24 hours, followed by a fax of the Notice of Adverse Benefit Determination (NOABD). In addition, a written NOABD notice will be mailed with a return receipt within two (2) business days of the adverse benefit notice for psychological testing to the provider and the beneficiary. The NOABD letter must include the enclosures: *NOABD Your Rights, Nondiscrimination Notice, and Language Assistance*. These enclosures are required to ensure that the beneficiary is informed of civil rights laws and the right to appeal a NOABD (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43 & Section XVII: Notice of Adverse Benefit Determination).

When psychological testing services are delayed, the provider and beneficiaries will be notified initially by telephone within 24 hours of the decision followed by a fax of the NOABD letter. In addition, a written NOABD notice will be mailed with a returned receipt within two business days of the adverse benefit notice for psychological testing to the provider and the beneficiary. The Provider and beneficiary will be mailed with a return receipt within two (2) business days of a written Notice of Adverse Benefit Determination Authorization Delay, which is a "Pending" status in IBHIS/ Provider Connect. This is when a decision about the Psychological Testing Authorization Request (PTAR) has not been made because there is a need for additional information and the delay is in the beneficiary's best interest. The NOABD Authorization Delay notice is an apology to the Provider for the delay in processing the request for services in a timely manner, including the reason for the delay. As a result, the CAU psychologist has not authorized the request, and the decision is delayed as indicated in the IBHIS/ Provider Connect Psychological Testing Authorization screen. In no event shall the event extend beyond the 14 calendar day extension. The CAU Psychologist shall include with the NOABD Authorization Delay notice the enclosure: "*NOABD Your Rights*" notice which tells the requesting provider and beneficiary about the right to an appeal and timelines to follow to file an appeal if the beneficiary disagrees with the extension regarding the *NOABD Authorization Delay* (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

APPEALS PROCESS

The referring party or provider may ask for reconsideration of a denied or modified request for psychological testing authorization and/or payment approval within 60 calendar days of the date from the date on the NOABD letter. The request for reconsideration may be initiated through an internal MHP Appeal process (Refer to Figure B).

FIGURE B



Internal MHP Appeal Process for Beneficiary, Provider or Beneficiary Representative After Receipt of a Notice of Adverse Benefit Determination (NOABD) (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

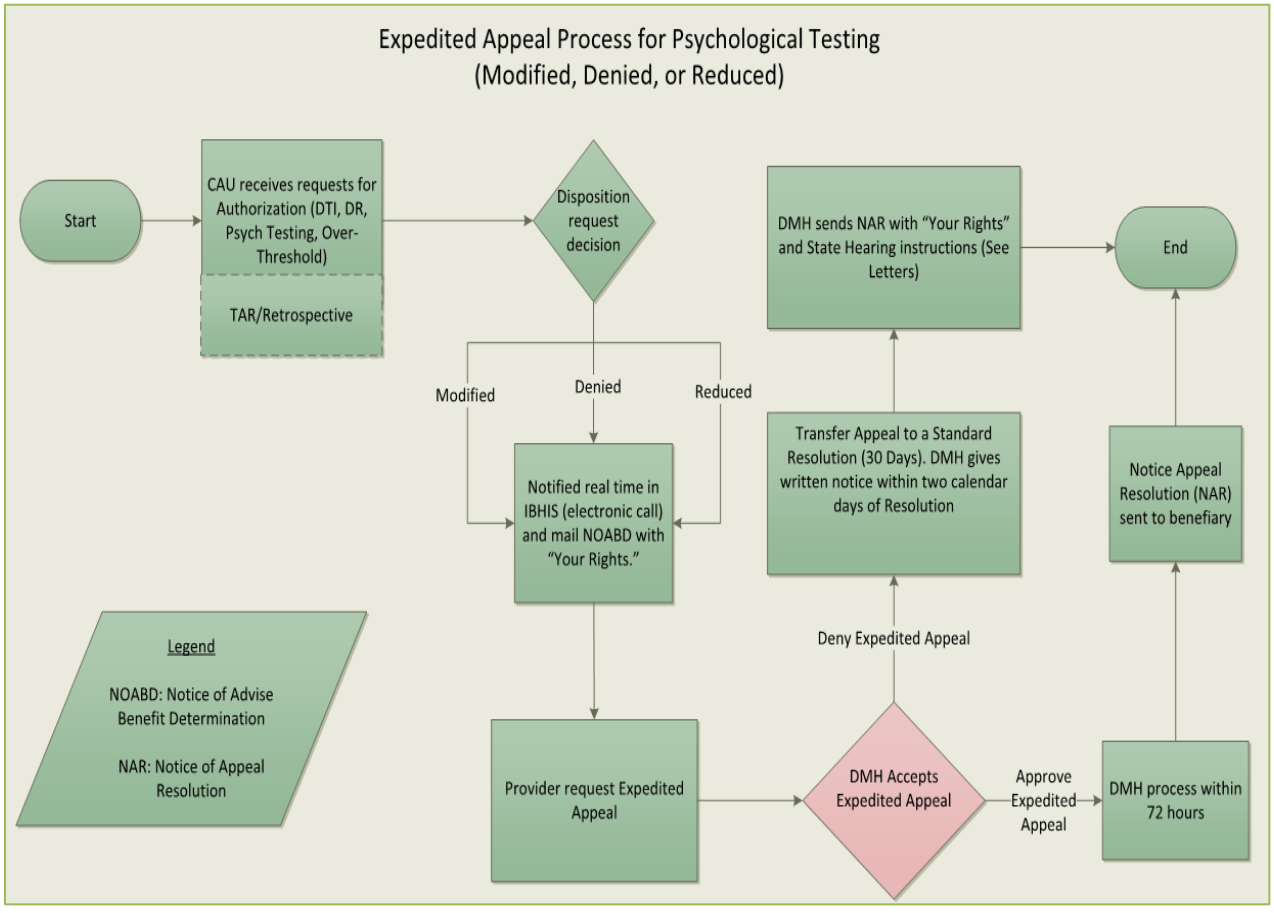
Beneficiaries must exhaust the MHP's appeal process prior to requesting a State Hearing. A beneficiary has the right to request a State Hearing only after receiving notice that the Plan is upholding an adverse benefit determination or the MHP's initial decision remains (Refer to Psychological Testing Policy and Procedure NOABD No. 313.43).

After receipt of the NOABD letter, the beneficiary may request an internal appeal with the MHP. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

The providers and authorized representatives cannot request continuation of benefits during the appeal. However, the beneficiary must state in the appeal request that he or she wants to continue getting treatment during the appeal. In this event, the beneficiary must ask for an appeal within 10 days from the date on the NOABD letter or before the date MHP services will stop.

The beneficiary's standard appeal request must be submitted within 60 calendar days from the date on the NOABD letter. An oral appeal shall be followed by a written appeal signed by the beneficiary, unless the beneficiary or provider have requested an Expedited Appeal (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43) (Refer to Figure C).

FIGURE C



The MHP/CAU must send a written Acknowledgment of Receipt of the appeal of the beneficiary's request postmarked within five (5) calendar days of receipt of the appeal.

The MHP/CAU shall maintain a log of oral appeals made by the provider or the beneficiary. The oral appeal is the filing date for the appeal. In the event the MHP/CAU does not receive a written appeal from the beneficiary, the MHP must neither dismiss nor delay resolution of the appeal and must send a Notice of Appeal Resolution (NAR) to the beneficiary).

Notice of Appeal Resolution (NAR) After Receipt of a Notice of Adverse Benefit Determination (NOABD (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43)

The Notice of Appeal Resolution (NAR) is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld. Beneficiaries must exhaust the MHP's appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Plan is upholding an adverse benefit determination.

The NAR review process is not completed by the initial CAU/ Psychologist. The NAR review process is conducted by a different an impartial CAU Clinical Reviewer to determine a resolution.

The Notice of Appeal Resolution (NAR), letter must include the enclosures "NAR Your Rights", "Nondiscrimination Notice" and "Language Assistance Notice". The NAR letter must include the criteria, clinical guidelines, or policies used in reaching the determination, the right to request a State hearing and how to request it, the right to request and receive benefits while the hearing is pending, how to make the request and notification that the beneficiary may be held liable to the cost of those benefits if the hearing decision upholds the MHP's benefit determination.

The MHP/CAU Clinical Reviewer must adhere to the 30 calendar day timeline; if the MHP fails to resolve the appeal within the 30 calendar day timeline then the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State hearing. The CAU Clinical Reviewer shall determine whether an Adverse Benefit Determination has been overturned or upheld. Refer to Definitions under section 1.6 in this policy.

THE MHP/CAU Clinical Reviewer has determined that a resolution has been made, and it is not resolved wholly in favor of the beneficiary. The result is that an Adverse Benefit Determination NAR, Upheld, is final. The request is still denied.

The *NAR Adverse Benefit Decision Upheld*, shall include: the results of the resolution and the date it was completed, including the reasons for the MHP's determination, the criteria, clinical guidelines, or policies used in reaching the determination, the right to request a State hearing, no later than 120 calendar days from the date on NAR and how to request it, the right to request and receive benefits while the hearing is pending, (including the timeframe in which the request shall be made, within ten (10) from the date the letter was post-marked and delivered to the beneficiary), how to make the request and notification that the beneficiary may be held liable to the cost of those benefits if the hearing decision upholds the MHP's benefit determination.

THE MHP/CAU Clinical Reviewer has determined that a resolution has been made, and it is resolved wholly in favor of the beneficiary. Appeals resolved wholly in favor of the beneficiary are *NAR Adverse Benefit Decision Overturned* The NAR Adverse Benefit Decision Overturned reads: The MHP/CAU has reviewed the appeal and has decided to overturn the original decision. The request is now approved. The Fee-For-Service Network Provider specializing in psychological testing can find that the IBHIS/Provider Connect decision will reflect an Approved decision.

Other providers who conduct psychological testing and are not a MHP Network Provider will receive the NAR Overturned decision within 72 hours by telephone, fax and by mail with a return receipt.

The NAR shall include the results of the resolution with a clear and concise explanation of the reasons, including why the decision was overturned and the date it was completed. The MHP/CAU must authorize the disputed services promptly and as expeditiously as the beneficiary's condition requires if the MHP reverses the decision to deny Psychological Testing services that were not furnished while the appeal was pending.

MHP/CAU shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

Beneficiary, Provider or Beneficiary Representative May Request an Expedited Resolution of an Appeal After Receipt of a Notice of Adverse Benefit Determination (NOABD (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43)

The MHP Internal Appeal Process includes an Expedited Resolution of an Appeal.

An Expedited Resolution Appeal is available to the beneficiary if the beneficiary thinks waiting 30 days will hurt their health. The beneficiary may request or the provider may indicate that taking time for a standard resolution could seriously jeopardize the beneficiary's mental health or substance use disorder condition and/or the beneficiary's ability to attain, maintain, or regain maximum function.

The provider or beneficiary representative may request an Expedited Resolution, after receipt of a Notice of Adverse Benefit Determination (NOABD).

The MHP/CAU must resolve the appeal within 72 hours from receipt of the appeal. The CAU Psychologist must log the time and date of the appeal receipt when an expedited resolution is requested, as this specific time of receipt drives the timeframe for resolution.

The MHP/CAU denial of the request for an Expedited Appeal requires reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution should be made by the MHP. The MHP shall provide written notice within two (2) calendar days of making this decision and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with extension.

The MHP/CAU can extend the standard resolution timeframes for resolving Expedited Appeals by up to 14 calendar days.

For an extension not requested by the beneficiary, but the MHP has requested the extension then the MHP is required to provide the beneficiary with written notice of the reason for the delay including: make reasonable efforts to provide the beneficiary with prompt oral notice of the extension; to provide written notice of the extension within two (2) calendar days of making the decision to extend the timeframe; and to notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

If there is no grievance from the beneficiary regarding the MHP's request for an extension of the time line, then the MHP shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the 14 calendar day extension.

If the beneficiary does not receive a notice from the MHP within the timeline of 30 days, then the Plan has fail to adhere to the federal timeline and the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State Hearing (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

The MHP must inform the beneficiary that a request for a State Hearing must be made within 120 days from the date of the Notice of Appeal Resolution (NAR), and only after the MHP has notified the beneficiary that the MHP has decided to "Uphold" the adverse benefit determination decision). The NAR ABD Upheld letter will include the attachment NAR "Your Rights, Nondiscrimination Notice and Language Assistance Notice. The MHP shall notify the beneficiary that to continue treatment during the appeal for a State Hearing, a request for a State hearing must be made within 10 days from the date that the NAR was postmarked or delivered to the beneficiary or before the date the MHP reported that services will be stopped or reduced. The State must reach its decision on the hearing within 90 calendars of the date of the request for the hearing (Refer to Psychological Testing NOABD Policy and Procedure No. 313.43).

The parties to State hearings include the MHP, as well as the beneficiary and his or her authorized representative or the representative of a deceased beneficiary's estate.

NOABD, Appeals, and Grievances on NOABD and any other Communications should be mailed to:

Intensive Care Division/ Psychological Testing Requests
Los Angeles Department of Mental Health
550 S. Vermont Avenue, 7th Floor, Room 703-A
Los Angeles, CA 90020
Fax (213) 738-4412

PSYCHOLOGICAL TESTING REPORT

The network provider must send all completed psychological test reports to the CAU at:

Intensive Care Division/ Psychological Testing Requests
Los Angeles Department of Mental Health
550 S. Vermont Avenue, 7th Floor, Room 703-A
Los Angeles, CA 90020
Fax (213) 738-4412

Reports must be completed in a timely manner as specified in the PTAR-R. This will generally be within six weeks (Calendar days) of authorization unless otherwise approved. The CAU psychologists will perform a standardized review of the test reports to promote and ensure report quality acceptability. Within five working days, the CAU will notify the network provider whether reports have been approved for reimbursement. Only reports meeting quality standards will be approved for reimbursement.

The CAU psychologists may obtain consultation and/or peer review of selected reports from members of the psychological community. *The Quality Assurance: The Clinical Evaluation* form (Attachment III) may be used to evaluate psychological test reports.

Note: Psychological testing reports submitted without prior authorization, completed in an untimely manner, or of substandard quality will not be approved for payment. Psychological test reports must be sent to the CAU as well as to the referring party.

All testing must be:

1. Per American Psychological Association (APA) guidelines;
2. Clinically adequate; and
3. Placed in the Medi-Cal beneficiary's clinical record.

QUALITY ASSURANCE PROCESS FOR PSYCHOLOGICAL TESTING REPORTS

The CAU expects that network providers will comply with the Ethical Principles and Code of Conduct (June 2003 with amendments effective June 1, 2010 and January 1, 2017) of the *American Psychological Association* (APA). Network providers who conduct psychological testing and prepare psychological test reports should be familiar with the *Standards for Educational and Psychological Testing* (2014) adopted by the APA, in particular, Chapter 12 *Psychological Testing and Assessment* [American Educational Research Association (2014) *Standard for Educational and Psychological Testing* Washington, DC: APA].

The CAU also expects that network providers who conduct psychological testing and prepare psychological test reports for minors who are dependents (WIC300) of the Juvenile Court, will be familiar with the *Guidelines For Psychological Evaluations In Child Protection Matters* (2011) approved by the Council of Representatives of the APA [American Psychological Association Committee on Professional Practice and Standards (2011). *Guidelines for Psychological Evaluations in Child Protection Matters* Washington, DC: APA].

For these reasons, the CAU expects that network providers will answer referral questions that are within the scope of practice for a licensed psychologist. Furthermore, the CAU expects network providers not to answer referral questions that are outside the particular field or fields of competence as established by his or her education, training and experience.

The CAU will not accept or recommend payment for psychological test reports that:

1. Do not answer or address the reason(s) for referral;
2. Do not make clear whether the client's test-taking behavior did or did not allow the psychologist to arrive at a valid assessment of the client's functioning;
3. Do not offer a coherent psychological explanation for the behavior(s) of the client and how best to treat the behavior(s);
4. Do not employ a norm-referenced measure of adaptive behavior to assess the role of a still active developmental delay in the client's Axis I diagnosis;
5. Do not use age-related norms to describe test behavior when such norms are available;
6. Do not include a norm-referenced measure of cognitive functioning without an explanation as to why the use of such a measure would not be in the best interests of the client;
7. Do not include appropriate measures of academic achievement when school-related placement decisions are part of the referral process;
8. Do not offer diagnoses consistent with ICD-10 CM Codes criteria, or, offer diagnoses that do not meet the definition of mental disorders found in the ICD-10 CM manual.

This is especially relevant to the severe and incapacitating developmental/behavioral deficits typically associated with the criteria that define the diagnosis of "Other Specified Early Childhood Psychoses" in the manual;

9. Do not consider diagnoses other than Oppositional Defiant Disorder for minors under the age of three years, or reports that offer a diagnosis of Oppositional Defiant Disorder to minors between the ages of three and five years without using carefully documented, behaviorally-based, norm-referenced criteria;
10. Do not consider diagnoses other than Attention-Deficit /Hyperactivity Disorder for children under the age of three years, or reports that offer a diagnosis of Attention-Deficit/ Hyperactivity Disorder to minors between the ages of three and five years without using carefully documented, behaviorally-based, norm-referenced criteria;
11. Do not offer new understandings about the functioning of the client beyond what could be achieved without the use of psychological tests;
12. Do not use the most recent edition of a specific test;
13. Do not offer a diagnosis of Intellectual disability using norm-referenced instruments that address ICD-10 CM Code and DSM V criteria. (A. Deficits in intellectual functions, such as, reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing. B. Deficits in adaptive functioning that result in failure to developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily living, such as communication, social preparation, and independent living, across multiple environments such as home, school, work, and community. C. Onset of intellectual and adaptive deficits during the developmental period); and
14. Does not report test results consistent with the administration of a full test battery, whether a development inventory, a measure of cognitive functioning, or other psychological measure.

COMMUNICATION TO NETWORK PROVIDERS CONCERNING QUALITY OF REPORTS

The CAU will review all psychological test reports conducted by network providers on behalf of clients, including those that are not submitted to the LHMP for payment.

Informal Correction Phase

On receiving a report considered unacceptable according to the *Quality Assurance: The Clinical Evaluation* form, the network provider will receive informal feedback from the professional staff of the CAU prior to any formal notice. This informal consultation, usually performed by telephone or email, is designed to explore those areas within the test report that need improvement and how best to accomplish the correction. A face-to-face conference with the network provider to review problem areas in more detail may also be suggested.

Formal Correction Phase

This phase begins when the CAU receives another test report from a previously counseled network provider that is again below the standard of care. Step one of this three step process is a letter to the network provider that details the deficiencies in the test report and informs the network provider that, in the future, payment will not be authorized for reports that contain these problems.

Upon receipt of a second unacceptable report, the network provider again receives written notice of the report's deficiencies and that he/she will have 14 calendar days from receipt of the letter to correct the report and return it to the CAU. Until a corrected report is received, the network provider may not be authorized to provide psychological testing service to clients.

The network provider will be sent written notice specifying the deficiencies, when the CAU does not receive a corrected report within 14 calendar days, receives a corrected report that remains unacceptable, or receives a third unacceptable report thereafter. At that time, the network provider will be referred to the LMHP's Credentialing Review Committee to evaluate his/her work with respect to quality of care. During this period, the network provider will not be authorized to provide psychological testing services to clients.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)

Client Name: _____ DOB: _____ Primary Language: _____

Client Address: _____ City/State/Zip: _____

Phone No(s): _____

Social Worker's Name: _____ Contact No: _____
(Form 5005 is **required** if under DCFS supervision. Please fax directly to the Psychological Testing Authorization Unit)

Psychological Testing Referred by: Phone No.:

Primary Therapist/Physician: _____ Agency: _____

Address: City/State/Zip:

Phone: _____ Fax: _____ Email: _____

Prior Psychological Testing: ☐ No ☐ Yes Date tested: _____ By Whom: _____

Specific referral questions:
Test referral questions must relate to mental health treatment. Attach additional pages if necessary.

_____

_____

_____

_____

_____

_____

_____

How long has your client been in treatment with you: _____

Select One: ☐ Assign to psychologist selected by the Psychological Testing Authorization Unit

☐ Name of psychologist suggested for testing: _____

Contact Phone: _____ Fax: _____

Please note:
- **The Psychological Testing Authorization Unit reserves the right to assign specific psychologists.**
- **Fax this request to 213-738-4412. Please use HIPPA compliant faxing procedures.**
- **This client should be tested only after written authorization from the Psychological Testing Authorization Unit.**

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential under applicable Federal or State Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you have received this message in error, please telephone the originator of this message immediately.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST-RESPONSE (PTAR-R)

Date: _____

Medi-Cal status must be verified prior to performing psychological testing.

Request for Testing of:
Client Name: _____ DMH ID#: _____ MEDS ID number: _____

Client Address: _____

Assigned Psychologist's Name: _____ Phone: _____

Fax: _____ Email: _____

I agree to:

1) Test this beneficiary only after receiving written authorization;
2) Consult with beneficiary's therapist/DMH Case Manager prior to testing, and to provide documentation of the consultation in the psychological report;
3) Conduct a comprehensive psychological evaluation that includes: history, test behavior, mental status examination, along with individually administered measures of intelligence, achievement, neuropsychological screening, psycho-diagnosis, and personality;
4) Provide a report to the referring source that integrates current test results and prior test results, as well as directly answering the referral questions which are specific and unique to this beneficiary;
5) Forward a copy of the test report to the Psychological Testing Authorization and Quality Assurance Section before a copy is given to the referring party.

Signature of Testing Psychologist: _____ **Date:** _____

DMH USE ONLY BELOW THIS LINE

Psychological Testing Authorization

☐ Testing request approved for a maximum of _____hours of psychological testing between ____ - ____ - ____ and ____ - ____ - ____

Request Pending

☐ **Testing request pending (testing authorization withheld till the following conditions are met):**

- ☐ Receipt of Form 5005 ***directly*** from CSW with SCSW signature.
- ☐ Receipt of permission to test from conservator.
- ☐ Client must be examined by a medical specialist prior to psychological testing. Please inform this office when the exam has occurred.
- ☐ Other _____

Reviewer: _____ Date: _____

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential under applicable Federal or State Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you have received this message in error, please telephone the originator of this message immediately.

PTAR – RESPONSE
DMH Fax: 213-738-4412

COUNTY LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
Psychological Testing Authorization Unit

Quality Assurance: The Clinical Evaluation

Evaluator's Name: _____ Date of Eval: _____ Test Report? Y N

Reviewing Psychologist Name: _____ Date of Review: _____ Total Score _____

Beneficiary's Name: _____ Beneficiary's Age: _____

DIRECTIONS FOR THE REVIEWER: Circle the number that best describes the psychological report where "4" is high and "1" is low.

REFERRAL QUESTIONS ARE SPECIFIC AND UNIQUE	**4**	**3**	**2**	**1**
❑ Specific referral questions are listed				
❑ Referral questions are unique to this beneficiary				
ASSESSMENTS ARE SPECIFIC AND UNIQUE	**4**	**3**	**2**	**1**
❑ Methods are appropriate and sufficient to address the referral questions				
❑ Conditions effecting the reliability and validity of the data are considered				
❑ Quantitative procedures are appropriately scored and data presented in tabular form				
❑ Diagnoses are documented, behaviorally-based, and consistent with DSM-V or ICD-10 Code criteria				
DATA ARE APPROPRIATELY INTERPRETED	**4**	**3**	**2**	**1**
❑ Data address the referral questions				
❑ Interpretations of data are empirically and logically sound				
❑ Inconsistencies in the data are noted and discussed				
❑ Alternative interpretations of the data are considered				
CONCLUSIONS INTEGRATE DATA FROM MULTIPLE SOURCES	**4**	**3**	**2**	**1**
❑ Arise from consistent patterns of data found throughout the evaluation				
❑ Integrate data from all sources, e.g., history, significant others, observed behavior, self-report and quantitative measures				
❑ Integrate beneficiary's cognitive, perceptual-motor, emotional and social-adaptive behavior				
❑ Incorporate current behavioral science to generate a coherent psychological explanation of the beneficiary's behavior				

REPORT IS UNIQUE TO THIS BENEFICIARY **4 3 2 1**

- ❑ Is organized around the beneficiary, not around the tests
- ❑ Provides reader with a sense of the beneficiary as a whole person, a good "word-picture"
- ❑ Interprets data consistent with the beneficiary's developmental level, ethnic and cultural background, and, unique needs and abilities
- ❑ Describes beneficiary's unique inner world, motivation, needs, and, coping skills

REPORT IS RESPECTFUL OF THE BENEFICIARY **4 3 2 1**

- ❑ Addresses beneficiary's strengths as well as weaknesses; does not "pathologize" beneficiary
- ❑ Compares beneficiary's behavior with that of others in a constructive way
- ❑ Is written in language that is easy to understand
- ❑ Protects privacy of beneficiary's family

RECOMMENDATIONS ARE CONSISTENT WITH THE FINDINGS **4 3 2 1**

- ❑ Address the referral questions
- ❑ Follow logically from conclusions
- ❑ Are consistent with behavioral science
- ❑ Are appropriately comprehensive

RECOMMENDATIONS ARE USEFUL TO THE BENEFICIARY **4 3 2 1**

- ❑ Address the beneficiary's unique needs
- ❑ Are practical and can be implemented given the beneficiary's situation
- ❑ Are prioritized in terms of urgency
- ❑ Specify treatment/intervention resources

A D D I T I O N A L C O M M E N T S

SECTION XVII– NOTICE OF ADVERSE BENEFIT DETERMINATION

WHAT IS A NOTICE OF ADVERSE BENEFIT DETERMINATION?

Prior to implementation of the Final Rule, (Title 42, Code of Federal Regulations, part 438, Subpart F), five (5) types of Notice of Actions, referred to as NOA-A, NOA-B, NOA-C, NOA-D, and NOA-E, were the responsibility of the Network Providers to issue to beneficiaries. However, since the implementation of the Final Rule, these NOAs are obsolete and are replaced by Notices of Adverse Benefit Determination (NOABD) letters developed by the Department of Health Care Services and under the authority of the MHP for determinations on Specialty Mental Health Services.

A Notice of Adverse Benefit Determination (NOABD) is a determination made by the Mental Health Plan (MHP) to include: denial or limited authorization of a requested service, including determinations based on level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of a payment for a service; the failure to provide services in a timely manner; the failure to act within the required timeframes for standard resolution of grievances and appeals; and the beneficiary's right to dispute an extension of time proposed by the LMHP to make an authorization, and the denial of a beneficiary's request to dispute financial liability.

In accordance with federal regulations grievances and appeals system (42 CFR Sections 438.400 et al), and State of California Department of Health Care Services (DHCS) grievances and appeals regulations described in Title 22, CCR Sections e (3) and (4), 42 CFR, 438.10, DHCS Information Notice No. 18-010, the Los Angeles County Department of Mental Health (LAC-DMH), the Mental Health Plan, Intensive Care Division, shall adhere to actions that include: denial or limited authorization of a requested service, including determinations based on level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner; the failure to act within the required timeframes for standard resolution of grievances and appeals; and the beneficiary's rights to dispute an extension of time proposed by the MHP to make an authorization decision.
The Notice of Adverse Benefit Determination (NOABD) letter shall include the enclosures: NOABD Your Rights, Nondiscrimination Notice, and Language Assistance. These enclosures are required to ensure that the beneficiary is informed of civil rights laws and the right to appeal a NOABD (Refer to Attachment II).

The NOABD letter must explain the following:

The adverse benefit determination the plan has made; a clear and concise explanation for the reason for the decision (determinations based on Medical Necessity Criteria must include the clinical reasons for the decisions and state why the beneficiary condition does not meet Specialty Mental Health Services); a description of the criteria used. For example, Medical necessity Criteria, and any processes, strategies or evidentiary standards used in making the determination; the beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the beneficiary's adverse benefit determination; and the name and direct telephone number of the decision maker shall be included in the NOABD.

An expression of dissatisfaction about any matter other than an Adverse Benefit Determination is a grievance.

A grievance may include, but not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the MHP to make an authorization decision. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination", as described above.

The Notice of Adverse Benefit Determination (NOABD) and the Notice of Appeal Resolution (NAR) will describe what the beneficiary and the provider may receive when an action has been determined by the MHP that results in a requested service not authorized by the MHP (Refer to Attachment I, II & III). The example letters in Attachment I, II & III describe a *Denied* request for Psychological Testing and the *Notice of Appeal Resolution*. Please see these example letters for an understanding of the NOABD process in compliance with the Department of Health Care Services.

THE BENEFICIARY GRIEVANCE

A beneficiary may file a grievance in writing or verbally when they are dissatisfied or unhappy about the services they are receiving or have any other concerns about the network provider or the LMHP. A grievance may not be filed for a problem covered by the NOABD appeal process and State Hearing.

Beneficiaries may contact the LMHP Patients' Rights Office at (213) 738-4949 for assistance in filing a grievance or appeal (Refer to Section VI: The Beneficiary Services Program and Requirements for Providing Medi-Cal Beneficiary Material to Clients, for information on obtaining additional information on Grievance and Appeals Procedures and Beneficiary Grievance forms).

STATE HEARING

A State Hearing is an independent review conducted by the California Department of Social Services to ensure you have received the specialty mental health services to which you are entitled under the Medi-Cal program.
You can file an appeal with the State of California based on the following:

- You filed an appeal and received a Notice of Adverse Benefit Determination (NOABD) letter telling you that the MHP will still not provide the services or denies your request
- You were informed by a county contracted provider that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the necessity criteria
- You were informed by your provider who thinks you need specialty mental health service and asks the MHP for approval, but the MHP does not agree and denies your provider's request or reduces the type or frequency of service
- Your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time

- Your MHP doesn't provide services to you based on the timelines (Refer to NOABD Policies and Procedures for Psychological Testing and other specialty mental health services)
- You don't think the MHP is providing services soon enough to meet your needs
- Your grievance, appeal or expedited appeal wasn't resolved in time
- You and your provider do not agree on the specialty mental health services you need

You only have 120 days to ask for a State Hearing. The 120 day begins from the date on the NOABD letter (Refer to MHP NOABD Policy & Procedures, Policy # 313.43 for Psychological Testing Authorization).

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2433
Phone: (800) 952-5253

AID PAID PENDING

Aid Paid Pending (APP) is the suspension of an agency's proposed action until a hearing and/or a decision is rendered. The network provider and the LMHP are required to provide APP to Medi-Cal beneficiaries who want to continue to receive mental health services while in the process of resolving their dispute through an Appeal or State Hearing when the following criteria are met:

- The request for APP was filed 10 days from the date the NOABD was mailed, 10 days from the date the NOABD was personally given to the beneficiary, or before the effective date of the change, whichever is later;
- The beneficiary is receiving mental health services which do not require prior authorization; and
- The beneficiary is receiving mental health services under an existing service authorization which is being terminated, reduced or denied for renewal by the LMHP.

When the network provider or the LMHP receives a notice that the Medi-Cal beneficiary has requested an Appeal or State Hearing, the network provider or the LMHP is responsible for determining if the hearing request involved APP. If the criteria specified above for APP are met, the network provider and the LMHP are required to provide the APP.

EXAMPLE

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

Intensive Care Division, Central Authorization Unit
550 South Vermont Avenue., 7th Floor
Los Angeles, CA 90020

January 15, 2018

RE: ACKNOWLEDGMENT OF RECEIPT OF APPEAL REQUEST FOR PSYCHOLOGICAL TESTING FROM JOHN SMITH, Ph.D.

Mary Ann Jones
567 8th Street
Los Angeles, CA 90034

John Smith, Ph.D.
123 4th Street
Los Angeles, CA 90012

The Department of Mental Health (DMH), Intensive Care Division, Central Authorization Unit has received your request to appeal the Notice of Adverse Benefit Determination (NOABD- Denial) for the above referenced Medi-Cal beneficiary. Your request was received within the 60 calendar day regulation.

Your appeal will be reviewed by a different and impartial licensed psychologist or psychiatrist, after review you will receive a Notice of Appeal Resolution (NAR) that your Appeal has either been Upheld or Overturned. The NAR Upheld decision is not wholly in favor of the beneficiary. A NAR Overturned is resolved wholly in in favor of the beneficiary.

The Notice of Appeal Resolution shall be determined not later than 30 calendar days of receipt. If the DMH fails to resolve your appeal within the 30 calendar day regulation, then you are deemed to have exhausted the MHP's appeal process and may initiate a State hearing. Additionally, if you received a Notice of Appeal Resolution that has been Upheld or not wholly in your favor you also have a right to request a State hearing.

Thank you for your request for an appeal on the above referenced beneficiary. The Department of Mental Health, Central Authorization Unit, looks forward to reviewing your appeal.

Should you have any further questions, please contact Kary To, Ph.D at (213) 738-4889.

Sincerely,

Michael Tredinnick, Ph.D.
Program Manager III
Clinical Operations
Intensive Care Division

EXAMPLE

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

Los Angeles County Department of Mental Health
Clinical Operations
Intensive Care Division, Central Authorization Unit
550 South Vermont Ave. 7th Floor
Los Angeles, CA 90020

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

January 1, 2018

Mary Ann Jones
567 8th Street
Los Angeles, CA 90034

John Smith, Ph.D.
123 4th Street
Los Angeles, CA 90012

RE: Psychological Testing

John Smith, Ph.D. has asked DMH to approve Psychological Testing. This request is denied. The reason for the denial is the request for psychological testing was made to determine if medication is needed; The criteria used for the determination can be found in *County of Los Angeles, Department of Mental Health, Local Mental Health Plan, Medi-Cal Specialty, Mental Health Services, Provider Manual, Fifth Edition July 2014*; and The clinical reasons for the decision regarding medical necessity is that the beneficiary should be referred to a psychiatrist to support medication evaluation and management.

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

EXAMPLE

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call Kary To, Ph.D. at (213) 738-4889.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter or before the date the Plan says services will be stopped or reduced.

The Plan can help you with any questions you have about this notice. For help, you may call Intensive Care Division, Central Authorization Unit 8:00 a.m. to 5:00 p.m.at (213) 738-4889. If you have trouble speaking or hearing, please call TTY/TTD number (213) 738-4888, between 08:00 a.m. to 5:00 p.m. for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact DMH ACCESS Center by calling (800) 854-7771.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

Kary To, Ph.D.

Enclosures: "Your Rights"
Language Assistance Taglines
Beneficiary Non-Discrimination Notice

Enclose notice with each letter

ENCLOSURE "YOUR RIGHTS"

For Mental Health Plans and DMC-ODS County Plans "NAR YOUR RIGHTS"

YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact ACCESS Center by calling (800) 854-7771.

If you still do not agree with the plan's decision, you can ask for a **"State Hearing"** and a judge will review your case.

You must ask for a State Hearing within **120 days** from the date of this letter. However, **if you are currently getting treatment and you want to continue your treatment while you appeal, you must ask for a State Hearing within 10 days** from the date this letter was postmarked or delivered to you OR before the date your health plan says services will be stopped or reduced. When you ask for a State Hearing, you must say that you want to keep getting your treatment. You will not have to pay for a State Hearing.

You can ask for a State Hearing by phone, electronically, or in writing:

- By phone: Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- Electronically: You may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx
- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will harm your health, you might be able to get an answer within 72 hours. You may wish to ask your doctor or mental health plan to write a letter for you or you may write your own. The letter must explain

For Mental Health Plans and DMC-ODS County Plans

in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an "**expedited hearing,**" and provide the letter with your request for a hearing.

Authorized Representative

You may speak for yourself at the State Hearing or have another person speak for you, such as a relative, friend, advocate, doctor, or attorney. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak on your behalf. This person is called an "authorized representative."

Legal Help

You may be able to get free legal help. You may call the local Legal Aid program in your county at 888-804-3536.

ENCLOSURE 'LANGUAGE ASSISTANCE TAGLINES'

Send with all notices

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (800) 854-7771) (TTY: (213)738-4888).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call (800) 854-7771). (TTY: (800)854-7771).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 854-7771). (TTY: (800) 854-7771).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 854-7771). (TTY:(800) 854-7771).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 854-7771
(TTY: (800) 854-7771).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(800) 854-7771 (TTY: (800) 854-7771)번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 854-7771
(TTY: (800) 854-7771)。

Send with all notices

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (800) 854-7771 (TTY (հեռատիպ)՝ (800) 854-7771):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 854-7771). (телетайп: (800) 854-7771).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با ((800) 854-7771). (TTY: (800) 854-7771 تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
(800) 854-7771 (TTY: (800) 854-7771) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 854-7771 (TTY: (800) 854-7771).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
(800) 854-7771 (TTY: (800) 854-7771) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 854-7771

(رقم هاتف الصم والبكم: (800) 854-7771).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
(800) 854-7771 (TTY: (800) 854-7771) पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 854-7771 (TTY: (800) 854-7771).

Send with all notices

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា ហយមិនគិត្ឆ្ឆ ន
គឺអាចមានសំវា ំ ំរ អុ ើ នក។ ចូ ទូ ស័ព្ទ (800) 854-7771 (TTY: (800) 854-7771)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສັ່ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 854-7771 (TTY: (800) 854-7771).

ENCLOSURE 'BENEFICIARY NON-DISCRIMINATION NOTICE'

NONDISCRIMINATION NOTICE

Discrimination is against the law. Los Angeles County Department of Mental Health (LMHP) follows Federal civil rights laws. LMHP does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

LMHP provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact ACCESS Center 24 hours a day, 7 days a week by calling (800) 854-7771: Or, if you cannot hear or speak well, please call (800) 854-7771.

Send with all notices

HOW TO FILE A GRIEVANCE

If you believe that LMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LMHP Patient's Rights. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Patient's Rights between 8:00 am through 5:00 p.m. by calling (213)738-4888 or (800) 700-9996. Or, if you cannot hear or speak well, please call ACCESS Center at (800) 854-7771.

- In writing: Fill out a grievance form, or write a letter and send it to:

  Los Angeles County, Department of Mental Health, Patients' Rights Office
  550 South Vermont Avenue, Los Angeles, CA 90020

- In person: Visit Los Angeles County, Department of Mental Health, Patients' Rights Office 550 South Vermont Avenue, Los Angeles, CA 90020 and say you want to file a grievance.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

EXAMPLE

Los Angeles County
DEPARTMENT OF MENTAL HEALTH
"ABD Upheld"

NOTICE OF APPEAL RESOLUTION

January 18, 2018

Mary Ann Jones
567 8th Street
Los Angeles, CA 90034

John Smith, Ph.D.
123 4th Street
Los Angeles, CA 90012

RE: Psychological Testing

John Smith, Ph.D., on your behalf, appealed the denial of Psychological Testing. DMH has reviewed the appeal and has decided to uphold the decision. This request is still denied. This is because the use of psychological testing to determine if medication is needed is exempt from the criteria for testing; The guidelines used can be found in the County of Los Angeles, Department of Mental Health, Local Mental Health Plan, Medi-Cal Specialty mental Health Services, Provider Manual Fifth Edition, July 2014; and the clinical reasons for the decision for medical necessity should be referred to a psychiatrist to support medication evaluation and management.

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria on which we based our decision. To ask for this, please call DMH at (213) 738-4889.

You may appeal this decision by requesting a State Hearing. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send in any information that could help your case. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The Plan can help you with any questions you have about this notice. For help, you may call Intensive Care Division, Central Authorization Unit, from 8:00 a.m. to 5:00 p.m. at (213) 738-4889. If you have trouble speaking or hearing, please call TTY/TTD number (213) 738-4888, between 8:00 a.m. to 5:00 p.m. for help.

EXAMPLE

Los Angeles County
DEPARTMENT OF MENTAL HEALTH
"ABD Upheld"

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact DMH ACCESS Center by calling (800) 854-7771.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

Michael Tredinnick, Ph.D.
Program Manager III
Clinical Operations
Intensive Care Division

Enclosed: "Your Rights"

Enclose notice with each letter

SECTION XVIII – MEDICATION, PHARMACY, LABORATORY AND MEDICARE PART D

DRUG FORMULARIES

Many Medi-Cal beneficiaries have their physical health care needs met by one of the participating plan partners of L.A. Care or Health Net while other Medi-Cal beneficiaries receive their physical care directly through other physical health care providers.

If a Medi-Cal beneficiary is enrolled in a plan partner of L.A. Care or Health Net, medications are handled in one of two ways. Carved out medications, specifically psychotropic medications and mainly anti-psychotic and anti-manic medications are paid by the California Department of Health Care Services. All medications not specifically carved out, including psychotropic medications, are the responsibility of the plan partners of L.A. Care and Health Net.

The California Department of Health Care Services (DHCS) is responsible for all medications for Medi-Cal beneficiaries who are not enrolled in a participating plan partner of L.A. Care or Health Net.

The DHCS Drug Formulary and the drug formularies of the participating plan partners of L.A Care and Health Net are available online.

The DHCS Drug Formulary is located at the following website:

1. http://www.dhs.ca.gov
2. Select “Department of Health Care Services.”
3. On the left column under “Quick Links” select “A-Z Index.”
4. Scroll down to “Formulary/List of Contract Drugs, Medi-Cal.”

The formularies of the plan partners of L.A. Care and Health Net are located at the following website:

1. http://dmh.lacounty.gov/Exec_Team.asp
2. Under” Medical Director”, select “OMD Website.”
3. Scroll down to the section titled “Pharmacy.”
4. Select “A Link to Health Plan Formularies.” This replaces the former DMH Multi-Plan Formulary List

The “A Link to Health Plan Formularies” website contains information on drug formularies for the State of California only and will allow network providers to:

1. Search formularies based on the drug name. Upon entering the drug name, this website will provide a listing and classification of the drug coverage for each formulary in the State of California.
2. Determine carve out drugs. These are the responsibility of the California Department of Health Care Services Fee-for-Service Medi-Cal program. Carve out drugs will be reimbursed by any pharmacy which accepts Medi-Cal as payment for medications.

3. Determine non-carve out drugs. For Medi-Cal beneficiaries enrolled in a Medi-Cal physical health care plan, select medications on the formularies of the various plan partners of L.A. Care or Health Net. The procedures will show the medication selected and which plan partner will reimburse for those drugs. You may use only those medications indicated for the plan partner to which the Medi-Cal beneficiary belongs. Remember, for non-carve out drugs, clients must use the pharmacies designated by the plan partner.

Attachment I is a quick reference guide to obtain the authorization phone numbers of the participating plan partners of L.A. Care and Health Net

LINK TO MEDICATION INFORMATION

Information on medications is located at the following website:

1. http://dmh.lacounty.gov/Exec_Team.asp
2. Under “Medical Director”, select “OMD Website.”
3. Scroll down to the section titled “Pharmacy.”
4. Enter a medication next to “Drug Lookup.”
5. The information will be displayed on the screen.

LOCAL MENTAL HEALTH PLAN CONTRACTED PHARMACIES

Pharmacies contracted with the Local Mental Health Plan that accept Medi-Cal are located at the following website:

1. http://dmh.lacounty.gov
2. Select “Provider Tools.”
3. Select “Pharmacy.”
4. Click on link under “Pharmacy List.”
5. The information will be displayed alphabetically.

Note: Prescriptions will be filled by any pharmacy that accepts Medi-Cal payment.

LABORATORY

All laboratory services are included as part of the pre-paid health plan benefit and therefore, Medi-Cal beneficiaries should be directed to a laboratory contracted with their Medi-Cal health plan. Network providers can continue to direct Medi-Cal beneficiaries to laboratory services that accept Medi-Cal.

MEDICARE PART D

The Medicare Part D drug benefit, which was effective January 1, 2006, offers voluntary coverage of outpatient Prescription Drug Plans (PDPs) and Medicare Advantage (MA) drug plans. Individuals dually eligible for both Medicare and Medi-Cal are required to enroll in Medicare Part

D. Dually eligible beneficiaries formally called Medi-Medi, who did not enroll on their own prior to December 31, 2005, were "auto-enrolled" in a drug plan.

Dually eligible beneficiaries were also "auto-enrolled" into the "Extra Help" Low Income Subsidy (LIS) to help offset the costs of the new prescription drug plans. Applications can be obtained at any Social Security Office, completed online at the following website address: www.ssa.gov or mailed upon request by calling the Social Security Administration at (800) 772-1213. The applications are also available at any County of Los Angeles Department of Public Social Services office, or by calling (877) 481-1044.

The most important change for dually eligible beneficiaries is that they began receiving their prescription drug coverage through Medicare, not Medi-Cal. To obtain access to drug coverage they must be enrolled in a PDP or MA-PD. As a network provider, it is beneficial to know what plan your client is enrolled in to determine which prescribed medications are covered by their health plan. Dually eligible beneficiaries or the network provider should also contact the pharmacy of choice to determine if the pharmacy is enrolled in the client's health plan.

For more information:

1. Visit www.medicare.gov or call (800) MEDICARE (633-4227) for:

    - Medicare prescription drug coverage information;
    - Plan choices under Medicare, including Medicare Advantage Plans;
    - Plan formularies, requirements including required drugs and excluded drugs; and
    - To order Medicare publications

2. Contact the following advocacy resources:

    - www.healthconsumer.org
    - www.cahealthadvocates.org
    - www.calmedicare.org
    - www.wclp.org
    - www.healthlaw.org
    - www.nsclc.org

3. Contact the State Health Insurance Assistance Program for California at (800) 434-0222.

You may contact Pharmacy Services at (213) 738-4725 for questions or assistance with any information provided in this section.

Listed below are the telephone numbers of the two health care plans: L.A. Care and Health Net and their Plan Partners. Most Los Angeles County Medi-Cal beneficiaries are enrolled in L.A. Care or Health Net.

L.A. CARE AND L.A. CARE PLAN PARTNERS		
• L.A. Care	Medi-Cal Referral Information: Fax: Pharmacy Prior Authorization:	(877) 431-2273 (213) 438-5777 (800) 788-2949
• Anthem Blue Cross	Member Services:	(888) 285-7801
• Community Health Plan	Member Services: TTY: Pharmacy Prior Authorization:	(800) 440-1561 (866) 816-2479 (888) 256-6132
• Kaiser Permanente	Member Services:	(800) 464-4000
• Care 1st	Member Services: Pharmacy Prior Authorization: Questions Re: Prior Authorization:	(800) 605-2556 (866) 712-2731 (877) 792-2731
HEALTH AND HEALTH NET PLAN PARTNERS		
• Health Net	Member Services: Pharmacy Prior Authorization: Prior Authorization Fax: Caremark Pharmacy:	(800) 675-6100 (800) 867-6564 (800) 977-8226 (800) 600-0180
• Molina Medical	Main number: Fax: Prior Authorization: Fax:	(800) 526-8196 Ext. 127854 (866) 508-6445 (800) 526-8196 Ext. 126400 (800) 811-4804

SECTION XIX: MEDICAL TRANSPORTATION SERVICES

All requests for client transportation services, such as ambulances or medical vans, are processed through the ACCESS Center at (800) 854-7771.

- Payment of transportation services will only be reimbursed for transports authorized by the ACCESS Center.
- Prior authorization for client transportation services from the ACCESS Center is required for payment.
- No reimbursement for client transportation service shall be made without the prior authorization of the ACCESS Center.

In a psychiatric emergency, transportation services can only be requested by appropriate LMHP administrative, clinical or contractor staff who have been certified by the LMHP to evaluate clients in psychiatric emergencies and prepare involuntary holds pursuant to Welfare and Institutions Code Sections 5150 and 5585. The ACCESS Center will authorize and activate evaluation services for hospitalization in the event of an emergency.

The LMHP is not responsible for providing, arranging or payment for transportation services, except when the purpose of the medical transportation service is to transport a Medi-Cal beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of twenty-four-hour care facility because the services in the facility to which the Medi-Cal beneficiary is being transported will result in lower costs to the LMHP.

TRANSPORTATION AUTHORIZATION FOR MEDI-CAL BENEFICIARIES ENROLLED IN PRE-PAID HEALTH PLANS

Transportation authorization or reimbursement services for Medi-Cal beneficiaries who are members of a Plan Partner of LA Care or Health Net are the responsibility of the Plan Partner. A client must be Medi-Cal eligible on the date of service in order to receive reimbursement.

For information concerning transportation for LA Care and Health Net enrollees please contact the following Plan Partners:

LA Care Plan Partners

Anthem Blue Cross	(888) 285-7801
Community Health Plan (CHP)	(800) 440-1561
Care 1st	(800) 605-2556
Kaiser Permanente	(800) 464-4000

Health Net Plan Partners

Molina Medical	(800) 526-8196

TRANSPORTATION AUTHORIZATION FOR MEDI-CAL BENEFICIARIES NOT ENROLLED IN PRE-PAID HEALTH PLANS

Transportation reimbursement for Medi-Cal beneficiaries, who are not enrolled in an LA Care or Health Net Plan Partner, is provided by the California Department of Health Care Services (DHCS). Medi-Cal covers ambulance and other medical transportation only when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private transportation is medically contraindicated and medical transportation is required for obtaining needed medical care. A client must be Medi-Cal eligible on the date of service in order to receive reimbursement.

To obtain information about the regulations governing DHCS Fee-for-Service Medi-Cal transportation services for Medi-Cal beneficiaries not enrolled in an LA Care or Health Net Plan Partner, go to the Medi-Cal website address at: www.Medi-Cal.ca.gov. Select "Provider Manuals" in the right column. Under "Allied Health" Select "Medical Transportation". Scroll down to the "Medical Transportation" link of interest.

For information concerning transportation claims contact the Medi-Cal Telephone Service Center at (800) 541-5555.

CLIENTS WITHOUT MEDI-CAL/INDIGENT CLIENTS

The ACCESS Center is responsible for all transportation services provided to indigent clients. No client will be transported unless evaluated by authorized staff of the LMHP.

CLIENTS WHO MUST BE RETURNED TO COUNTY OF RESIDENCE

The ACCESS Center will arrange transportation for psychiatric clients from surrounding jurisdictions who must be returned to their county of residence for treatment or other reasons deemed appropriate by the ACCESS Center. Call the ACCESS Center at (800) 854-7771 for consultation and authorization for ambulance services in these situations.

SECTION XX – OUT-OF-COUNTY SERVICES

Out-of-county services are services provided to a Los Angeles County Medi-Cal beneficiary outside the geographic boundaries of Los Angeles County by a provider who is not contracted with the Local Mental Health Plan (LMHP).

It is the policy of the LMHP to ensure timely and effective clinical treatment regardless of a Medi-Cal beneficiary's county of residence. Only licensed specialty mental health providers who have met the requirements established by the LMHP will be reimbursed for specialty mental health services provided to Los Angeles County Medi-Cal beneficiaries outside the geographical boundaries of Los Angeles County.

Emergency, crisis and urgent care specialty mental health services may be provided to a Los Angeles County Medi-Cal beneficiary outside the geographic boundaries of Los Angeles County by an out-of-county Medi-Cal provider without prior authorization from the LMHP.

AUTHORIZATION OF ROUTINE SERVICES

CHILDREN AND ADOLESCENTS AND NON- MINOR DEPENDENTS

Out-of-county providers contracted with the LMHP in the county in which the youth is placed that do not have a contract with LA County Department of Mental Health are able to provide routine specialty mental health services to Los Angeles County Medi-Cal beneficiaries under 21 years of age, who are placed in kinship care or with an adoptive family. The out-of-county providers are required to submit a Service Authorization Request (SAR) through the *Senate Bill 785 (SB 785) process prior to delivering the service(s). The SAR can be submitted via fax to the Continuum of Care Reform (CCR) Division, Interagency Case Management Unit (ICMU): (213) 738-6521.

Assembly Bill 1299 (AB 1299) establishes policy guidance of Presumptive Transfer, or Waiver of Presumptive Transfer, when a child in foster care is placed outside their county of original jurisdiction.

The Presumptive Transfer applies when the responsibility for the provision of, or arrangement and payment for Specialty Mental Health Services (SMHS) transfers to the Mental Health Plan in the child's new county of residence. Presumptive Transfer allows for the timely service delivery of mental health services to meet each child's individual needs. The Presumptive Transfer process is initiated and carried out by one of the placing agencies, Child Welfare or Probation. The placing agency is required to notify the Mental Health Plan in the new county of residence via email when a child has been approved for Presumptive Transfer.

The Waiver of Presumptive Transfer, made in conjunction with the Child and Family Team, applies when the responsibility for the provision of, or arrangement and payment for Specialty Mental Health Services (SMHS) remains with the original county of jurisdiction. The original county of jurisdiction must ensure that the child/youth receives the appropriate, medically necessary specialty mental health services. The Waiver of Presumptive Transfer is initiated and carried out by the placing agency. The placing agency is required to notify the Mental Health Plan in the new county of residence via email and the Mental Health Plan of the county of original jurisdiction when a child has been approved for the Waiver of Presumptive Transfer.

For any other out-of-county services to children less than 18 years of age, contact the LMHP CCR Division, ICMU at (213) 739-2357.

ADULTS

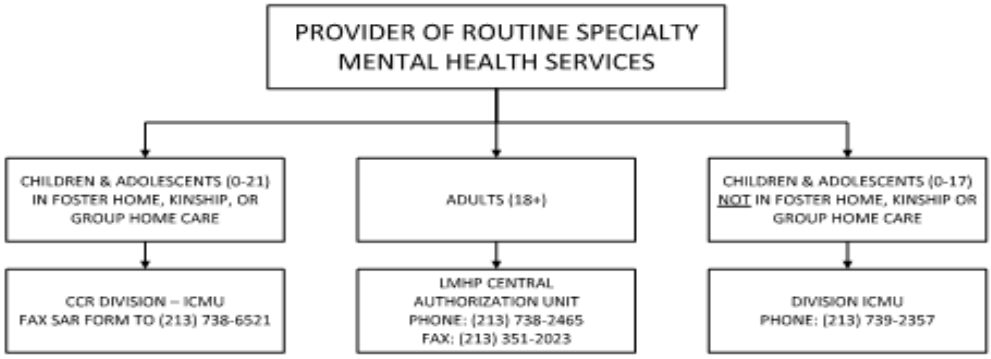
Out-of-county routine services to Los Angeles County Medi-Cal beneficiaries, 18 years of age and older, are subject to the authorization requirements of the LMHP Central Authorization Unit (CAU). Pre-authorization is required **before** the service is delivered in order for a provider to receive reimbursement. The CAU can be reached by calling (213) 738-2465 or by faxing to (213) 351-2023.

SERVICES PROVIDED TO OUT OF COUNTY MEDI-CAL BENEFICIARIES WITHIN LOS ANGELES COUNTY

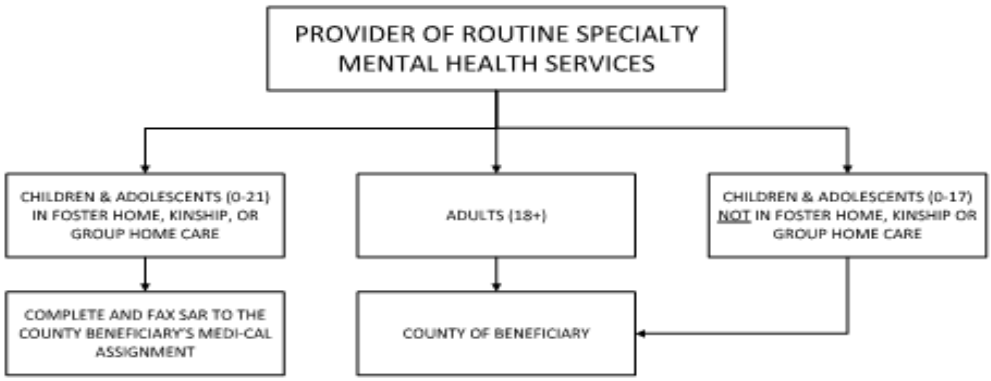
All Medi-Cal beneficiaries will receive emergency, crisis and urgent specialty mental health services regardless of their county of residence. LMHP network providers are to contact the respective county of the Medi-Cal beneficiary to receive authorization for routine mental health services for children and adolescents who are not Los Angeles County beneficiaries. LMHP network providers are to contact the respective county of the Medi-Cal beneficiary for authorization to provide routine mental health service to adult Medi-Cal beneficiaries (Refer to Figure C- Out-of-County Flow Chart)

FIGURE C: OUT-OF-COUNTY FLOW CHART

LOS ANGELES COUNTY MEDI-CAL BENEFICIARY / OUT-OF-COUNTY PROVIDER



OUT-OF-COUNTY BENEFICIARY / LMHP NETWORK PROVIDER



GLOSSARY OF TERMS

Appeal	A request by a beneficiary or a beneficiary's representative for review of any action.
Access Center	Operates 24 hours/day, 7 days/week as the entry point for mental health services in Los Angeles County. Services include deployment of crisis evaluations teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services and patient transport.
Advance Directive	Legal documents or statements, including a living will, which are witnessed and allow an individual to convey in expressed instructions or desires concerning any aspect of an individual's health care, such as the designation of a health care surrogate, the making of an anatomical gift, or decisions about end-of-life care ahead of time. An Advance Directive provides a way for an individual to communicate wishes to family, friends and health care professionals, and to avoid confusion about end-of-life care ahead of time.
Annual Liability	Also known as UMDAP liability, is based on a sliding scale fee and applies to services extended to the client and dependent family members.
Assessment	A service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status, determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
Assessment	A professional review and evaluation of an individual's mental health needs and conditions, in order to determine the most appropriate course of treatment, if indicated, and may ascertain eligibility for specific entitlement or mandated programs
Beneficiary	Any person certified as eligible under the Medi-Cal program.
Board of Supervisors (BOS)	Los Angeles County Board of Supervisors that oversee all county departments, including LACDMH. This Board is an elected body.
Border Community	A community located outside of the State of California that is not considered to be out of state for the purpose of excluding coverage by the MHP's because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.
California Institute for Mental Health (CIMH)	The mission of CIMH is to promote excellence in mental health services through training, technical assistance, research, and policy development

California Behavioral Mental Health Director's Association (CBHDA)	CBHDA provides assistance, information, training, and advocacy to the public mental health agencies that are its members. The mission of the Association is to provide leadership, advocacy, expertise and support to California's county and city mental health programs (and their system partners) that will assist them in serving persons with serious mental illness and serious emotional disturbance.
Centers for Medicare and Medicaid Services (CMS)	US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.
Central Authorization Unit	A unit of the Intensive Care Division in the DMH office of the Medical Director that conducts monitoring and authorization of services. Specific service authorizations include Over Threshold Authorization, psychological testing, day treatment and requests for authorization of out-of-county services.
Collateral	A service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.
Co-Occurring Disorders (COD)	Two disorders occurring to one individual simultaneously. Clients said to have COD have more than one mental, developmental, or substance-related disorder, or a combination of such disorders. COD exists when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.
Co-occurring/Comorbidity	The existence of two or more illnesses – whether physical or mental – at the same time in a single individual
Coordination of Benefits	A process for determining the respective responsibilities and priority order of two or more insuring entities that have some financial responsibility for a medical claim
Crisis Intervention	A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements.

Crisis Stabilization	A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site and staffing requirements.
Cultural Competence	A set of congruent practice skills, behaviors, attitudes and policies in a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross cultural situations.
Cultural Competency	The practice of continuous self-assessment and community awareness by service providers to ensure a focus on the specific needs regarding linguistic, socioeconomic, educational, spiritual and ethnic experiences of consumers and their families/support systems relative to their care.
Day Rehabilitation	A structure program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
Day Treatment Intensive	A structure, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
Day Treatment Rehabilitation	A structured program of therapeutic services and activities, in the context of a therapeutic milieu, designed to improve, maintain and restore personal independence and functioning consistent with age-appropriate learning and development. It provides services to a distinct group of clients. Day Rehabilitation is a packaged program with services available at least three (3) hours and less than twenty-four (24) hours each day the program is open. In Los Angeles County these services must be authorized by the Central Authorization Unit**.**
Department of Health Care Services	State Department of Health Care services that includes Mental Health component

Dual Diagnosis	Occurs when an individual has two separate but interrelated diagnoses of a mental illness and a chemical dependency.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Mental Health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age, that have been determined by the State Department of Health Services.
Early Intervention	Diagnosing and treating mental illnesses early in their development.
Electronic Data Interchange (EDI)	A set of standards for structuring information to be electronically exchanged between and within businesses, organizations, government entities and other groups.
Evidence-based Practices (EBP)	Practices that have quantitative and qualitative data showing positive outcomes. These practices have been subject to expert/peer review that has determined that a particular approach or program has a significant level of evidence of effectiveness in public health research literature.
Expedited Appeal	An appeal to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.
Fair Hearing	The State hearing provided to beneficiaries
Federal Financial Participation (FFP)	Federal matching funds available to services provided to Medi-Cal beneficiaries under the Medi-Cal program
Fee-For-Service/Medi-Cal Hospital	A hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the fiscal intermediary
Full-time equivalent (FTE)	A way to measure a worker's completed weekly hours. An FTE of 1.0 means that the person is equivalent to a full-time worker (40 hours/ week), while an FTE of 0.5 signals that the worker is only half-time (20 hours/week)
Grievance	An expression of dissatisfaction by a beneficiary/client.
Group Provider	An organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics
Health Insurance Portability and Accountability Act (HIPAA)	HIPAA defines numerous offenses relating to health care and sets civil and criminal penalties for them. It also creates several programs to control fraud and abuse within the health care system.
HIPAA Final Security Rules	Rules dealing specifically with electronic protected health information, which lay out three types of security

	safeguards required for compliance: administrative, physical, and technical.
Hospital	An institution that has been certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services. Hospital includes general acute care hospitals of the Health and Safety Code, and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.
Individual Provider	Licensed mental health professionals who scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.
Intake Period	Initial clinical evaluations must be completed within 60 days of intake for a new admission (no open episodes), or within 30 days when the client is being opened to a new service but has other open episodes.
Intervention	The act of intervening, interfering or interceding with the intent of modifying the outcome. In health and mental health, an intervention is usually undertaken to help treat or cure a condition.
Licensed Mental Health Professional	Licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.
Managed Care	The organized system for delivering comprehensive mental health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment.
Medi-Cal Managed Care Plan	An entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries.
Medicare Fiscal Intermediary	Private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the administration of claims payment.
Medication Support Services	Services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biological that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication;

	evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
Megan's law	California's Megan's Law provides the public with certain information on the whereabouts of sex offenders so that members of local communities may protect themselves and their children.
Memorandum of Understanding (MOU)	A written agreement between mental health plans and Medi-Cal managed care plans describing their responsibilities in the delivery of specialty mental health services to beneficiaries who are served by both parties.
Mental Health Plan (MHP)	An entity that enters into a contract with the Department to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.
Mental Health Services	Individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
MHP of Beneficiary	The MHP responsible for providing or arranging and paying for specialty mental health services for a beneficiary. The responsible MHP is the MHP serving the county that corresponds to the beneficiary's county of responsibility code as listed in the Medi-Cal Eligibility Data System (MEDS), unless another MHP is determined responsible.
MHP Payment Authorization	The written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary.
National Provider Identifier (NPI)	A unique, ten-digit numeric identifier assigned to covered health care providers by the National Plan and Provider Enumeration System. This identifying number does not carry any information about health care providers, such as the state in which they practice or their provider type or specialization. The intent of the NPI is to improve the efficiency and effectiveness of electronic transmission by allowing providers and business entities to submit the same identification

	number(s) to all payers, such as insurance plans, clearinghouses, systems vendors, and billing services.
Onset	The beginning of a serious psychiatric illness that can be diagnosed by the DSM IV. In this respect, onset can include the onset of depression in an older adult or a new mother experiencing the onset of post-partum depression. Onset can apply to any psychiatric illness. Individuals may experience onset of a serious psychiatric illness a number of times.
Outreach & Engagement (O&E)	A component within the Mental Health Services Act (MHSA), which aims to inform the public about MHSA, gather community input, and integrate feedback into the planning process. O&E activities focus on organizing the wide diversity of backgrounds and perspectives represented within the county, with a special emphasis on underserved and unserved populations. It seeks to facilitate the creation of an infrastructure that supports partnerships with historically
Patient's Rights Office	The Patients' Rights Office of the Los Angeles County Department of Mental Health was created in response to legislation requiring each county mental health director to appoint a patients' rights advocate(s) to protect and further the Constitutional and statutory rights of mental health care recipients. Some of the duties of this office include; investigation of complaints, representation of patients at certification review and medication capacity hearings, beneficiary services program, residential care advocacy, minors' rights program, jail advocacy program, LPS designation functions, training and consultation, monitoring Electroconvulsive treatment (ECT), data collection, legislative interaction, missing person locator and peer advocacy program.
Peer	Any individual who uses their personal or family lived experience related to mental health, mental illness services and treatment, to advance the well-being of others in a mental health supportive program setting
Prevention	The Prevention element of the MHSA PEI component includes programs and services defined by the Institute of Medicine (IOM) as Universal and Selective, both occurring prior to a diagnosis for a mental illness.
Primary Care	The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.
Primary Contact	The individual at a Billing Provider who discusses specific client service needs with the client and/or Rendering Providers and is identified in the LAC-DMH electronic database at the episode level.

Prior Authorization	The issuance of an MHP payment authorization to be provided before the requested service has been provided.
Protected Health Information (PHI)	Any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.
Provider	Person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program.
Provider	A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program.
Psychiatric Inpatient Hospital Professional Services	Specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services
Psychiatrist Services	Services provided by licensed physicians, within their scope of practice, who have contracted with MHP to provide specialty mental health services and or medication support, who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program, to diagnose or treat a mental illness or condition.
Psychologist Services	Services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition.
Public Guardian Office (PGO)	This office receives referrals from mental health professionals who wish to evaluate clients for both “grave disability” and mental disorder. The Director of the Los Angeles County Public Guardian Office acts as the conservator for individuals and their estate when the court has determined—based on the results of the evaluation—that the individual cannot provide for their basic needs of food, clothing, and shelter.

Quality Assurance Activities	Indirect activities defined by the Federal government that assist a Local Mental Health Plan in insuring and improving the quality of care delivered by its organization that are not provided as a service to or in relation to a specific client of the Department. Claiming for these services is currently paper based. Only licensed professionals may claim for QA activity.
Quality Improvement Program	DMH program involving DMH leadership management, staff, consumers and family members intended to create and sustain a culture of system wide involvement and continuous improvement to the delivery of care.
Receipt or Date of Receipt	Receipt of a Treatment Authorization Request or other document. Date of receipt means the date the document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver.
Rehabilitation	A service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.
Service Activities	Activities conducted to provide specialty mental health services when the definition of the service includes these activities. Service activities include, but are not limited to, assessment, collateral, therapy, rehabilitation, and plan development.
Service Planning Areas (SPA)	Los Angeles County is administratively divided into eight (8) geographically-based Service Planning Areas, also referred to as "Service Areas". This organizational structure facilitates closer coordination among agencies providing services in that geographic area.
Specialized Intensive Foster Care	is a community-based alternative placement for children who require out-of-home care along with therapy and specialized services including those children who are emotionally and behaviorally disturbed, developmentally disabled, and medically disabled. Specialized Intensive Foster Care programs involve the application of specific evidence-based practices designed to treat this population.
Specialty Mental Health Services	Rehabilitative mental health services, including: Mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, psychiatric health facility services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist service, EPSDT

	supplemental specialty mental health services and psychiatric nursing facility services.
Spirituality	A person's deepest sense of belonging and connection to a higher power or transcendent life philosophy which may not necessarily be related to an organized religious institution (Adapted from California Mental Health & Spirituality Initiative). Spirituality is a process of pursuing meaning and purpose in life
Stakeholder	A person or group of people who impacts or is directly impacted by mental health services or, a person who represents others' interests relative to mental health services.
Submit or Date of Submission	To transfer a document by mail, fax, or hand delivery. The "date of submission" means the date the document was submitted as indicated by the postmark date, the fax date, or the date of hand delivery as shown by the date stamp made by the receiver. For documents submitted by mail, the postmark date shall be used as the date submission.
Therapy	A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.
Third Party Liability	An amount owed for specialty mental health services on behalf of a beneficiary by any payer other that the MHP, the Medi-Cal program or the beneficiary
Threshold Language	The California Department of Mental Health tracks how many people are served in each county in mental health. If a county has 3,000 Medi-Cal consumers that speak a certain language, then that language becomes a "threshold language" and the county is required to provide services and written materials in that language. Los Angeles County has 13 threshold languages. These languages are Armenian, Cambodian/Khmer, Cantonese, Farsi, Korean, Mandarin, other- Chinese, Russian, Spanish, Tagalog, Arabic and Vietnamese.
Transition Age Youth (TAY)	Youth and young adults between the age 16 and 25.
Unit of Service	The increment unit of time used to capture the quantity of services provided (e.g. 1 minute = 1 Unit of Service) during mental health service procedure. Claims are generated based upon service provided and multiplied by the rate for that procedure.

Urgent Care Centers (UCCs)	Provide intensive crisis services to individuals who otherwise would be brought to emergency rooms for up to 23 hours of immediate care and linkage to community-based solutions. UCCs provide crisis intervention services, including integrated services for co-occurring substance abuse disorders and are geographically located throughout the County. UCCs focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment.
Usual and Customary Charges	Uniform charges that are listed in a provider's established charge schedule which are in effect and applied consistently to post patients.

ACRONYMS & ABBREVIATIONS

AB	Assembly Bill
AC	Auditor Controller
ADA	Americans with Disabilities Act
AEVS	Automated Eligibility Verification System
ASCX12N	Electronic Data Interchange Standards
ATCMS	Adult Targeted Case Management Service
BES	Beneficiary Eligibility System
BIC	Benefits Identification Card
CAU	Central Authorization Unit
CCCP	Client Care/Coordination Plan
CCR	California Code of Regulations
CDAD	Contracts Development and Administration Division
CFA	Cognitive and Functional Ability
CIF	Claim Inquiry Form
DHCS	Department of Health Care Services
CGF	County General Funds
CIMH	California Institute of Mental Health
CIN	Client Index Number
CIOB	Chief Information Office Bureau
CL	Client
CMHDA	California Mental Health Directors Association
CMS	Centers for Medicare & Medicaid Services
CMS 1500	Centers for Medicare & Medicaid Services- 1500
COD	Co-Occurring Disorder
CPT Code	Current Procedural Terminology
DCFS	Department of Children and Family Services
DMH	Los Angeles County Department of Mental Health
DOS	Date of Service
DPSS	Los Angeles County Department of Public Social Services
DR	Day Rehabilitation
DSM	Diagnostic & Statistical Manual of Mental Disorders
DT, DTx	Day Treatment
DTI	Day Treatment Intensive
DX	Diagnosis
E & M	Evaluation & Management
EBT	Electronic Benefit Transfer
ECR	Error Correction Report
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
EFT	Electronic Fund Transfer
EHR	Electronic Health Record

EM	Evaluation and Management
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ERA	Electronic Remittance Advice
EVC	Eligibility Verification Confirmation
FFCC	Former Foster Care Children Program
FFP	Federal Financial Participation
FFS	Fee For Service
FH	Fair Hearing
FICA	Federal Insurance Contribution Act
FMLA	Federal Family and Medical Leave Act
FSB	Financial Services Bureau
FSP	Full Service Partnership
FY	Fiscal Year
HCFA	Health Care Financing Administration
HF	Healthy Families
HIPAA	Health Insurance Portability and Accountability Act of 1996
IBHIS	Integrated Behavioral Health Information System
ICD-10	International Classification of Diseases
IMD	Institution for Mental Disease
LA	Los Angeles
LAC	Los Angeles County
LACLMHP	Los Angeles County Local Mental Health Plan
LCSW	Licensed Clinical Social Worker
LMHP	Local Mental Health Plan
LOC	Level of Care
LPS	Lanterman-Petris-Short Act
MC	Managed Care
Medi-Medi	Medicare – Medi-Cal
MEDS	Medi-Cal Eligibility Data System
MFCC	Licensed Marriage, Family & Child Counselor
MFT	Marriage and Family Therapist
MHFFS	Mental Health Fee-for-Service
MHP	Mental Health Plan
MHS	Mental Health Services
MHSA	Mental Health Services Act
MNC	Medical Necessity Criteria
MOU	Memorandum of Understanding
NOABD	Notice of Adverse Benefit Determination
NP	Nurse Practitioner
NPI	National Provider Identifier
OHC	Other Health Coverage
OMD	Office of the Medical Director
OOC	Out of County

OTAR	Over Threshold Authorization Request
P&P	Policy & Procedure
PFAR	Provider File Adjustment Request
PHI	Protected Health Information
POS	Place of Service/ Point of Service device
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RA	Remittance Advice
SDHCS	State Department of Health Care Services
SED	Serious Emotional Disturbance
SFC	Specialized Foster Care
SFPR	Single Fixed Point of Responsibility
SGF	State General Fund
SIFT	Secure Internet File Transfer
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOC	Share of Cost
SOC	System of Care
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
STAR	System for Treatment Authorization Request
TAR	Treatment Authorization Request
TAY	Transitional Age Youth
TCM	Targeted Case Management
TFA	Therapeutic Fee Adjustment
TIN	Taxpayer Identification Number
UCC	Urgent Care Center
UMDAP	Uniform Method of Determining Ability to Pay
UR	Utilization Review
VET/ADM	Veterans Administration
W&I	Welfare & Institutions Code

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