PSYCHIATRIC HEALTH FACILITY

PROVIDER MANUAL

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Welcome

Welcome. This is the Provider Manual for Psychiatric Health Facilities that submit treatment claims for authorization to the Los Angeles County Department of Mental Health (LACDMH), Intensive Care Division (ICD). This Provider Manual provides information explaining the processes involved in partnering with the LACDMH for the delivery of quality, cost-effective mental health care.

The LACDMH, ICD, Central Authorization Unit (CAU), is assigned the task of reviewing documentation submitted by contracted Psychiatric Health Facilities for the purpose of authorizing hospital stays when the submitted documentation meets medical necessity criteria for admission and continued stay requirements.

Thank you for your interest and participation in the Psychiatric Health Facility services in Los Angeles County. If you have any questions, requests or comments regarding this manual please contact the LACDMH's Intensive Care Division CAU at 213 948-2971.

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SECTION: I

INTRODUCTION

INTRODUCTION

The Los Angeles County Department of Mental Health (LACDMH) is the State of California's Local Mental Health Plan (LMHP) for the County of Los Angeles. The LMHP is responsible for administering all Medicaid/Medi-Cal and State grant funds for mental health services through a well-managed system that is designed to ensure available, accessible, and quality mental health care for eligible Medi-Cal beneficiaries.

It is estimated that Los Angeles County is the county of residency to approximately one-third (1/3) of all Medi-Cal beneficiaries in the State of California. The county where Medi-Cal beneficiary eligibility is established is determined by the Department of Public Social Services. Due to the magnitude of acute psychiatric inpatient services provided to the residents of Los Angeles County, the former State of California Department of Mental Health (SDMH) previously approved the process of retrospective reviews of requests for authorizing reimbursement for Medi-Cal acute psychiatric inpatient services provided to Medi-Cal eligible beneficiaries of Los Angeles County by the Fee-for Service Network providers.

On May 6, 2016, the Center for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, aimed at aligning the Medicaid Managed Care regulations with requirements for other major sources of coverage. The Final Rule revised the regulations for Medicaid Managed Care in Part 438 of the Code of Federal Regulations (CFR). As a result of the Managed Care Final Rule changes, the Department of Health Care Services (DHCS) published *Information Notices (MHSUD IN) No. 19-026, Authorization of Specialty Mental Health Services* delineating new documentation requirements applicable to authorization of all Specialty Mental Health Services including Administrative Days, and *IN 18-010E, Federal Grievance and Appeal System Requirements*. The *MHSUD IN No. 19-026 and BHIN 22-017* further mandated the MHPs to change the authorization process from retrospective to concurrent reviews. Pursuant to *Welfare and Institutions Code (W&IC) §14197.1(b)*, DHCS has the authority to implement these requirements via issuance of a Behavioral Health Information Notice (BHIN) in lieu of adopting regulations. However, the MHSUD IN No. 19-026 and BHIN 22-017*Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*, now defines medically necessary services. To the extent that these requirements conflict with the *CCR, Title 9, Chapter 11,* federal regulations and state law reflected in the *BHIN, the IN* supersede those state regulations. Pursuant to *CCR, Title 9, Chapter 11, §1820.220*, the LACDMH, acting as the MHP has delegated the Intensive Care Division (ICD), Centralized Authorization Unit (CAU), as the county's Point of Authorization (POA). The CAU is the program responsible for implementing and operating the authorization and reimbursement of Psychiatric Health Facility services provided to Los Angeles County Medi-Cal beneficiaries. The CAU staff conduct concurrent reviews and authorizations on the psychiatric heath facilities as per MHSUD IN No 19-026 & BHIN 22-017. Retrospective reviews and authorizations will still be conducted as needed on limited circumstances.

LACDMH Service Planning Areas

Los Angeles County is organized into eight (8) geographic Service Planning Areas (SPAs). To identify mental health providers in your service area, go to http://dmh.lacounty.gov/ Click Services, Click Provider and Contractor Information, and Click for an interactive map with service providers by service area.

Service Planning Area (SPA) 1 Antelope Valley

SPA 1 is the largest service area geographically, yet it has the smallest population with approximately 390,938 inhabitants. Spanish is a prominent language. SPA 1 has a younger population than the other service areas, with a reported 31% of the population between the ages of 1-15. The average for the county is 25%.

No Psychiatric Health Facility (PHF) in the area:

Service Planning Area (SPA) 2 San Fernando Valley

SPA 2 is the most populous service area in Los Angeles County with a population of approximately 2,173,732. English and Spanish are the predominant languages. Although the number of children is within the county average, due to the overall population, there are more children in SPA 2 than in any other service area.

No PHF in the area

ervice Planning Area (SPA)3 San Gabriel Valley

The total population in the San Gabriel Valley is approximately 1,777,760 with Latinos being the largest ethnic group in the area, followed by Asians.

No PHF in the area

Service Planning Area (SPA) 4 Downtown/Metro

SPA 4 has a population of 1,140,742. It has the highest number of homeless persons within its boundaries. The Metro area has the second highest poverty rate in the county.

No PHF in the area

Service Planning Area (SPA) 5 West Los Angeles

SPA 5 has a population of 646,531. It has the largest number of individuals reporting to speak English as their primary language. Approximately 18% of its population are older adults, compared to 13% countywide. Its median household income is $61,000 compared to $48,000 countywide.

Psychiatric Health Facility
Exodus

Service Planning Area (SPA) 6 South

SPA 6 has the most at-risk factors in the entire county. Its total population is approximately 1,030,078; however, 48% of its population is 25 years of age or less. It has the highest poverty rate in the county – 61% of its population lives below the 200% federal poverty level (FPL). Two ethnic groups account for 94% of the population-African American and Hispanic.

Psychiatric Health Facilities

MLK – Adults
MLK – Children and Adolescents

Service Planning Area (SPA) 7 East

The population within the boundaries of SPA 7 is approximately 1,309,383. It also has a young population with 43% under the age of 26. It is reported that 70% of the population is Latino with Spanish being spoken in 54% of the households.

No PHF in the area

Service Planning Area (SPA) 8 South Bay/Long Beach

The population of SPA 8 is 1,550,198. The service area has no overall ethnic majority. It has a household income slightly higher than the county average, and the number of individuals who graduate from college is slightly higher than the county average.

Psychiatric Health Facilities

LA Casa
Starview (Children & Adolescents)

SECTION: II

LACDMH CONTRACT

Contracting with the County

State of California certified and licensed Medi-Cal Psychiatric Heath Facilities located within Los Angeles County are encouraged to contract with the *County of Los Angeles Department of Mental Health* (LACDMH).

This manual, and all subsequent Provider Alerts, provides specific information regarding the requirements and process for contracting with LACDMH and instructions concerning requesting reimbursement for Medi-Cal Psychiatric Health Facility services.

Contracting Process

- Initiate a contract by accessing details of the PHF contract at the Los Angeles County Department of Mental Health website and follow the directions: https://dmh.lacounty.gov/contract-opportunities/open-solicitations/

- Submit a completed Contract Package with the required documents for review and approval by the Los Angeles County Board of Supervisors. Contract providers will receive a contract for signature which must then be fully executed by LACDMH.

- Schedule orientation and training for contract providers to facilitate integration and incorporation of the contract provider into the LACDMH system of care.

Contract Required Notifications

It is essential that contract providers immediately inform the LACDMH of the following:

- Any/all changes affecting the provider's ability to provide contracted services
- Changes in authorized signatory(ies)
- Changes in ownership
- Mergers
- Name and/or address changes
- Financial viability as evidenced by audited financial statements submitted annually during the term of the contract
- Insurance (submitted annually during the term of the contract
- Permits
- Licenses (Submitted annually during the term of the contract
- Other dated material and changes that are required from the contract package

Failure to inform LACDMH in writing, in a timely manner, of any/all conditions affecting the contract provider's ability to provide services may constitute a material breach of

contract. Contract providers must submit all official correspondence and notices to the following:

Los Angeles County Department of Mental Health
Intensive Care Division, Fee-for-Service/Provider Relations Unit
510 S. Vermont Avenue, 20th Floor, Los Angeles, CA 90020
Hotline: (213) 738-3311

The Provider Network

Credentialing

(Information Notice 18-019) MHSUDS_Information Notice_18-019_Final Rule_Credentialing_ADA (ca.gov)

For all licensed, waivered, registered and/or certified staff, the provider (program) must verify and document the following items through a primary source (e.g. state licensing agency), as applicable. Based on the provider type, the information must be verified by the provider (program) unless the provider (program) can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board. The following requirements are not applicable to all provider types.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, the provider (program) may verify and document the following additional information.

- There should be no history of involvement in malpractice suits, arbitrations or settlements in the past five years that is not in accordance with the criteria set forth below. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.
- There can be no history within the most recent ten years of disciplinary actions affecting the applicant's professional license or other required certification.
- There should be no history of sanctions by Federally-funded health care programs, including Medicare/Medi-Cal and any other public regulatory agency.
- Any history of alcohol or chemical dependency or of substance abuse must be reported on the questionnaire/attestation portion of the credentialing/re-credentialing application.

- There can be no physical or mental condition that would impair the applicant's ability, with reasonable accommodations, to provide professional services within his/her area of practice without posing a direct threat to the health and safety of others.
- Affirmative responses to the attestation questions shall be reviewed by the provider.
- Services rendering Staff may only provide services consistent with their education/licensure (scope of practice), length of experience and/or job description.

PHF Claiming

Integrated Behavioral Health Information System (IBHIS) is LACDMH's comprehensive behavioral health clinical, administrative and financial information system. All PHF claims submissions to LACDMH must be done electronically. Refer to the following link for DMH business process requirements for transmitting claim data to the LACDMH Integrated Behavioral Health Information System (IBHIS) system. Legal Entities: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm

The following requirements apply for claiming of services based on calendar days:

- PHF claims are reimbursed based on calendar days. A day shall be billed for each calendar day in which the beneficiary receives face-to-face service and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.
- Board and care costs are not included in the claiming rate.
- The day of admission may be billed but not the day of discharge.
- The exact number of minutes used by persons providing a reimbursable service shall be reported and billed (CCR, Section 1840.316).
- Every claim must be supported by a progress note in the clinical record prior to the submission of the claim.
- All Providers must use the DMH approved forms or the DMH approved electronic health record system for documentation for their services.
- Providers must incorporate all LACDMH required documentation elements. The services provided are coded into procedure codes for reimbursement through a variety of funding sources.
- The Rendering Provider on the claim must have participated in the delivery of the service and/or clinically overseen the service. The Rendering Provider may be the staff writing the daily note (so long as all services described on the note are within scope of practice).
- Services shall not be claimable unless there is face-to-face contact between the client and a treatment staff person of the facility on the day of service

- Original Medi-Cal claims must be received by the California Medicaid Management Information System (California MMIS) Fiscal Intermediary within six months following the month in which services were rendered. Claims submitted after the six-month billing limit and received by the California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received. Claims over 12 months with no valid delay reason code will be denied.

  https://files.medi-cal.ca.gov/pubsdoco/outreach_educathttps://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/modules/bb/workbook_claimfollow_bb.pdfion/workbooks/modules/bb/workbook_claimfollow_bb.pdf

PHF Services Lockouts:

PHF Services are not reimbursable on days when the following services are reimbursed, except for day of admission to PHF Services:

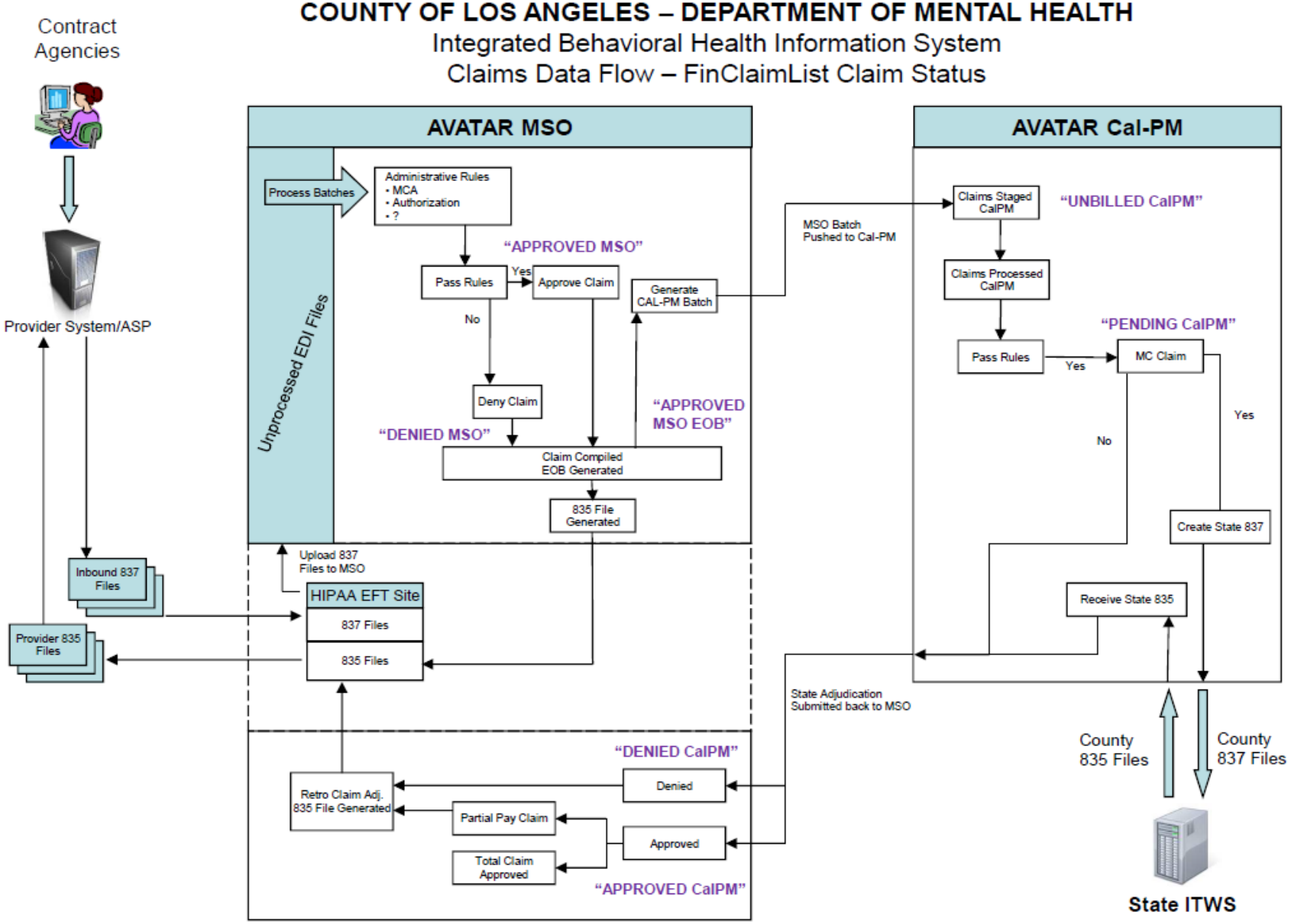
a) Adult Residential Treatment Services
b) Crisis Residential Treatment Services
c) Crisis Intervention
d) Day Treatment Intensive
e) Day Rehabilitation
f) Psychiatric Inpatient Hospital Services
g) Medication Support Services
h) Mental Health Services
i) Crisis Stabilization
j) Psychiatric Nursing Facility Services

Reference: California Code of Regulations (CCR), Title 9, Chapter 11, Section 1840.370

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

Integrated Behavioral Health Information System

Claims Data Flow – FinClaimList Claim Status



Psychiatric Health Facility Services Contact and Site Requirements

The PHF Services shall have a clearly established certified site for services. Services shall not be claimable unless there is a face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

Programs providing PHF Services must be licensed as a Psychiatric Health Facility by the Department of Health Care Services as Medi-Cal providers of inpatient hospital services.

Programs shall have written procedures for accessing emergency health services on a 24-hour basis.

SECTION: III

SINGLE POINT OF CONTACT

Single Point of Contact (SPOC)

All Fee-For-Service (FFS) Psychiatric Health Facilities submitting claims to LACDMH must designate a Single Point of Contact (SPOC). The SPOC is the person authorized by the provider to discuss or obtain any/all information concerning a specific claim and/or Medi-Cal beneficiary.

This restriction on accessing information applies only to information regarding a specific Medi-Cal beneficiary to ensure compliance with laws and regulations concerning patient confidentiality. Access is not restricted regarding Medi-Cal information only if unrelated to a specific Medi-Cal beneficiary.

All official correspondence addressed to the CAU Unit must be submitted by the provider's designated SPOC and will be acted upon only if submitted in writing to the CAU Unit for matters such as, but not limited to, the following:

- Claims Inquiry, Error Corrections
- Compliance communications
- Provider Appeals

Change of Single Point of Contact (SPOC)

Providers may change their designated SPOC at any time by notifying the LACDMH Intensive Care Division, Provider Relations Unit, in writing, on the provider's letterhead, with the full name, mailing address, email address, telephone number and fax number of the new SPOC.

Provider Alerts

The LACDMH, Intensive Care Division will issue Provider Alerts to contract providers via the SPOC. The SPOC shall be responsible in disseminating the Provider Alerts to appropriate hospital personnel. The immediate distribution of Provider Alerts upon receipt is crucial because the Alert contains information regarding clinical, administrative or financial policies and procedures that will have direct impact on authorization and reimbursement of services. Any changes described in the Provider Alerts have the authority of policy and are binding to the LACDMH provider's contract agreement with LACDMH.

SECTION: IV

Medical Necessity Criteria

Medical Necessity Criteria for Reimbursement Psychiatric Health Facility Services Pursuant to DHCS Behavioral Health Information Notice No. 22-017

- For Medi-Cal reimbursement for an admission to Psychiatric Health Facilities, the beneficiary shall meet medical necessity criteria set forth below:
- One of the included diagnoses found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5, published by the American Psychiatric Association. Please see explanation below:

Regarding the provision of diagnosis, the provider shall use the criteria sets in the DSM-5 as the clinical tool to make diagnostic determinations. Once a DSM-5 diagnosis is determined, the provider shall determine the corresponding mental health diagnosis in the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10 CM).

The provider shall use the ICD-10 CM diagnosis Code(s) to submit a claim for specialty mental health services to receive reimbursement of Federal Financial Participation (FFP).

Referrals

Prior authorization is not a requirement for services in a Psychiatric Health Facility. However, the MHP may facilitate the referrals of patients who may meet criteria for inpatient acute psychiatric services.

MEDICAL NECESSITY

Pursuant to Welfare and Institutions Code section 14184.402(a), **for individuals 21 years of age or older,** a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain**.**

For **individuals under 21 years of age**, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT.

Psychiatric Health Facilities have the following limitations on admission:

- shall not admit and treat patients with the primary diagnosis of an eating disorder.
- shall not admit and treat patients when the primary diagnosis is chemical dependency, chemical intoxication or chemical withdrawal.
- shall not admit patients if their treatment requires medical interventions beyond the level appropriate to a psychiatric health facility including detoxification from substance abuse
- shall not admit patients for treatment of substance-induced delirium.
- shall accept and retain only those patients for whom it can provide adequate care, including but not limited to the provisions of *WIC Section 77135*:
    - Reportable communicable diseases such as active treatment resistant infections (MRSA) and tuberculosis, etc.
      (CCR, Title 17, Section 2500)

AUTHORIZATION PROCESS

The authorization procedures shall be based on medical necessity and consistent with current evidence-based clinical practice guidelines, principles and processes.

a) Notification of beneficiary admission and request for treatment authorization.

Providers will enter all new episodes into ProviderConnect and contact the Central Authorization Unit to notify reviewers of submission at **DMH_CAU@dmh.lacounty.gov**

1. Providers will submit via ProviderConnect the following documentation **within one business day of admission** (Reference: *DHCS BHIN 22-017*):

    - the beneficiary's admission orders,
    - initial plan of care,
    - a request to authorize the beneficiary's treatment, and
    - a completed face sheet.

The face sheet shall include the following information (if available):

- Hospital name and address
- Patient name and DOB
- Insurance coverage
- Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System
- Current address/place of residence
- Date and time of admission

- Working (provisional) diagnosis
- Date and time of admission
- Name and contact information of admitting, qualified and licensed practitioner
- Utilization review staff contact information

Note: Regarding the beneficiary's admission orders and initial plan of care, please refer to *Title 42, Code of Federal Regulations (CFR), Subpart D, Sections 456.170* and *456.180* respectively. The Plan of Care and Required Evaluations sections of this manual will also discuss the required components.

b) Review of initial authorization request

1. The CAU shall decide whether to grant or deny the PHF's initial treatment authorization request.
2. MHP will respond to the provider's authorization request within 24 hours with an email notification of authorization status.
3. Once approved services may be authorized for up to 5 business days, at which point the provider will submit documentation for further continuing days.

CONTINUED STAY SERVICES

Note: "Continued Stay Services" means psychiatric inpatient hospital services for beneficiaries that occur after admission (CCR, Title 9, Chapter 11, § 1820.200 (b).

When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the PHF shall submit a continued stay authorization request for up to 5 business days to the CAU via email notification at DMH_CAU@dmh.lacounty.gov

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The exchange of reasonably relevant client and clinical information between the PHF and the LACDMH CAU is needed to complete concurrent review procedures and for discharge planning and aftercare support.

Clinical information to be exchanged includes:

- Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms, and current response to treatment.
- Risk assessment to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.

- Precipitating events if further identified or clarified by the treating hospital after MHP admission notice.
- Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results) of the treating hospital.
- Hospital information on prior episode history that is relevant to current stay.
- MHP information of relevant and clinically appropriate client history.
- Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.
- Substance use information to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.
- Known medical history to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.
- Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.
- Discharge and aftercare plan to include recommended follow-up care, social, and community supports, and a recommended timeline for those activities.
- Number of continuing stay days requested, typically 5 business days.

MHP will respond to the provider within one business day with the continuing days authorization status.

Payment for acute services will end under the following circumstances:

- The existing treatment authorization expires, and the hospital discharges the beneficiary pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider; Or,
- The MHP denies a hospital's continued stay authorization request and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider.

Denial of Authorization

If a MHP denies a hospital's authorization request, the MHP must work with the treating provider to develop a plan of care. Services and payment for services shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health needs of the beneficiary.

If the MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

Outcomes following a denial of authorization:

An MHPs denial of an authorization request and a consultation between the treating provider and the MHP may result in one of the following outcomes:

• The MHP and the hospital treating provider agree that the beneficiary shall continue inpatient treatment at the acute level of care, and the denial is reversed.
• The MHP and the hospital treating provider agree to discharge the beneficiary from the acute level of care and a plan of care is established prior to the beneficiary transitioning services to another level of care.
• The MHP and the hospital treating provider agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down facility bed is not available, and the beneficiary remains in the hospital, on administrative day level of care.
• The MHP and treating hospital provider do not agree on a plan of care and the beneficiary, or the treating provider on behalf of the beneficiary, appeals the decision to the MHP.

DIAGNOSIS USING DSM-5

The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. All Health Insurance Portability and Accountability Act (HIPAA) – covered entities must implement ICD-10-CM on October 1, 2015 (http://www.cms.gov/Medicare/Coding/icd10/).
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 International Classification of Diseases (ICD-10-CM) code should be selected. DSM-5 provides a suggested ICD-10 code 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.

Note: The list of included diagnoses for SMHS medical necessity is provided in terms of ICD-10-CM codes. The shift to DSM-5 does not change the included diagnoses required to meet medical necessity criteria.

Uninsured Patients

Uninsured patients, who are resident in Los Angeles County, may be eligible for services at Psychiatric Health Facilities. They need to meet the same medical necessity criteria as other patients.

SECTION V

Assessment and Treatment Plan

Assessment

Pursuant to the Code of Federal Regulations (CFR), Title 42, Chapter IV, Subchapter C, Part 456, Subpart D; §456.170; and the Contract between the State Department of Health Care Services, the Los Angeles County Department of Mental Health (LACDMH) has established required components of an assessment. LACDMH ICD CAU ~~Unit~~, acting as the Point of Authorization (POA) shall review the beneficiary's medical record for presence of an Initial Psychiatric Evaluation. POA shall apply all rules and regulations pertaining to initial assessment requirements.

CFR, §456.170 specifies that "before admission to a mental hospital, or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or beneficiary's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation".

Assessment means 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. 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.

Initial Assessment Requirements:

1. Assessor Information (name, discipline);
2. Identifying information and special service needs
    a. Beneficiary name
    b. Date of birth
    c. Gender
    d. Ethnicity
    e. Preferred language
    f. Other relevant information
3. For children, biological parents, caregivers and contact information.
    a. Names
    b. Contact information (phone or address)
    c. Other relevant information
4. Presenting problem(s): beneficiary's chief complaint, history of presenting problem(s), including current functioning level, relevant family history and current family information; Precipitating event/reason for admission
    a. Current symptoms/behaviors including intensity, duration, onset and frequency
    b. Impairments in life functioning
5. Beneficiary strengths: documentation of beneficiary's strengths in achieving client plan goals;

6. Mental Health History: previous treatment, including providers, therapeutic modality, (e.g. medications, psychosocial treatments) and response, 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;
    a. Psychiatric hospitalizations including dates, locations and reasons
    b. Outpatient Treatment including dates, locations and reasons
    c. Response to treatment, recommendations, satisfaction with treatment
    d. Past suicidal/homicidal thoughts/attempts
    e. Other relevant information
7. Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;

8. Medications: Information about medications that the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. Documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of informed consent for medications;
    a. Medication
    b. Dosage/frequency
    c. Period taken
    d. Effectiveness, response, side effect, reactions
    e. Other relevant information
9. Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

10. **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: include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
    a. Doctor's name and contact inform
    b. Allergies
    c. Relevant Medical Information
    d. Developmental History (for children)
    e. Developmental Milestones and Environmental Stressors (for children)
11. Relevant conditions and **psychosocial factors** affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history or trauma or exposure to trauma;
    a. Education/school history, status, aspirations
    b. Employment history/vocational information including means of financial support (for adults)
    c. Juvenile court history and current status

d. Abuse/protective service information (for children)
e. Dependent Care Issues (for adults)
f. Current and past relevant living situations including social supports
g. Family History/Relationships
h. Family Strengths (for children)
i. Other relevant information

12. Mental Status Examinations;
    a. Mental Status examination
13. Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data;
14. A diagnostic descriptor consistent with the clinical information
    a. Diagnostic descriptor
15. Most current ICD code set documentation consistent with the diagnostic descriptor; ICD Diagnostic Code Specialty Mental Health Services Medical Necessity Criteria
16. Staff name and signature of the person performing a Psychiatric Diagnostic Assessment (staff person must practice within the scope of licensure).

Certification of Need for Inpatient Care

A physician must certify for each beneficiary that inpatient services in a mental hospital are needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a mental hospital, before the Medicaid agency authorizes payment. Reference: *CFR, Title 42, Chapter IV, Subchapter C, Subpart D, Section 456.160*

Beneficiary Plan of Care (Treatment Plan)

An individual plan of care or treatment plan must be in place: a) before admission to a mental hospital or before authorization for payment. Attending physician or staff physician must establish the treatment plan for each applicant or beneficiary.

Required components of a Plan of Care pursuant to *42 CFR, Chapter IV*, Subchapter C, *Subpart D, Section 456.180; DHCS BHIN No. 22-017*

a. Diagnosis, symptoms, complaints and complications indicating the need for admission;
b. Description of the beneficiary's functional level;
c. Specific, observable and/or specific, quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of a qualifying mental health diagnosis;
d. Descriptions of the types of interventions/modalities with a detailed descriptions of the proposed interventions (consistent with the qualifying diagnosis and includes the frequency and duration of each intervention;

e. Any orders for:
    a. Medication
    b. Treatments
    c. Restorative and rehabilitative services
    d. Activities
    e. Therapies
    f. Social Services
    g. Diet
    h. Special procedures recommended for the health and safety of the beneficiary

1. Plans for continuing care, including review and modification of the treatment plan;
2. Discharge plans:
3. Physician signature and date on the written treatment plan indicates their establishment of the plan.

Aftercare Plan

The Los Angeles County Department of Mental Health (LACDMH) continues to develop quality assurance efforts to ensure comprehensive quality of care services for its beneficiaries. Continuity of care is essential for the successful transition of a beneficiary from inpatient hospitalization to a lower level of care. In conjunction with the discharge of a Medi-Cal beneficiary, the inpatient provider must prepare a written aftercare plan to be submitted to the appropriate LACDMH outpatient provider and a copy given to the beneficiary. A copy of the aftercare plan must also be included with the discharge documents to be submitted to CAU.

Scope of Medical Practice

CCR, Title 9, Chapter 11, Section 1830.230 and CCR, Title 22, Section 51003 only allow for one professional service claim per day for a patient, notwithstanding receiving services from more than one professional provider in a day.

SECTION: VI

CONCURRENT REVIEW PROCESS

The Concurrent Review Process

Pursuant to the Welfare & Institutions Code §14680 through §14726 and under the State Department of Health Care Services (DHCS), Los Angeles County Department of Mental Health (LACDMH) operates the Local Mental Health Plan (LMHP). In accordance with the DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) No. 19-026 & BHIN 22-017, the LACDMH is required to conduct concurrent review and authorization for all psychiatric inpatient hospital services, except for some limited circumstances. If the circumstances are deemed appropriate, the medical record will be reviewed retrospectively. DHCS IN: 19-026 & BHIN 22-017 determines Medical Necessity.

Definitions

Assessment: Assessment means 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.

AVATAR:
LACDMH software application for electronic medical records.

Beneficiary**:** The person receiving services; synonymous with consumer, or patient.

Central Authorization Unit (CAU) LACDMH unit responsible for Concurrent Review of Psychiatric Health Facility.

Chief Information Officer Bureau **(CIOB):** The Los Angeles County Department of Mental Health's bureau responsible for maintaining automated data collection and reporting system, i.e., the LACDMH Data Collection and Reporting System**.**

Client Identification Number (CIN**)**: Medi-Cal beneficiaries are assigned the client identification number by the Department of Public Social Services (DPSS).

Concurrent Review:
Clinical review of treatment authorizations for all inpatient psychiatric services following the first day of admission.

Continued Stay Services:
Psychiatric inpatient hospital services for beneficiaries that occur after admission. (*CCR, Title 9, Chapter 11, §1820.200(b*)).

Fee-For-Service Medi-Cal Hospital:
A hospital providing acute inpatient psychiatric services to the LMHP's Medi-Cal beneficiaries; and submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the fiscal intermediary.

Institutions of Mental Disease (IMD):
Per *Code of Federal Regulations (CFR), §435.1009(b)(2)*, defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Integrated Behavioral Health Information System (IBHIS):
The Electronic Health Record System (EHRS) implemented by Los Angeles County Department of Mental Health (LACDMH).

Local Mental Health Plan (LMHP) Agency designated by the State Department of Health Care Services (DHCS) responsible for implementation and management of the Medi-Cal Consolidation Program, e.g., Los Angeles County Department of Mental Health (LACDMH as the LMHP).

Medi-Cal Eligibility Data System (MEDS): The data system maintained by the State DHCS that contains information on Medi-Cal eligibility including a beneficiary's county of responsibility.

Medical Necessity Criteria for Acute Inpatient Services:
The conditions necessary for receiving inpatient acute psychiatric services following a psychiatric evaluation; and required for Medi-Cal reimbursement.

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.

Microsoft Teams:
Messaging application- a workspace for real-time collaboration and communication, meetings, files, etc. in one place, all in the open, all accessible to LACDMH TAR Unit staff.

Notice of Adverse Benefit Determination (NOABD):
Notice to beneficiaries of the adverse benefit determination that LACDMH has made, and procedures for exercising beneficiary's rights.

***NPI*:** National Provider Identifier

PHF: Psychiatric Health Facility**.**

Point of Authorization (POA):
LACDMH, Clinical Operations, Intensive Care Division, Treatment Authorization Unit is the POA to authorize payment for services.

Provider: Hospital providing acute inpatient psychiatric services

ProviderConnect:
Web interface used to communicate with IBHIS. It is a standard browser-based application and can be launched from any web browsing application such as Internet Explorer, Chrome or Firefox, and has real time communication with IBHIS. Any information submitted via ProviderConnect is directly entered and updated into the IBHIS system immediately.

Psychiatric Health Facility Services:
Services provided by a hospital to beneficiaries for whom the facilities, services and equipment are medically necessary for diagnosis and treatment of mental disorder.

Psychiatric Inpatient Hospital Services means both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.

Retrospective Review:
A review of medical documentation following discharge. Retrospective reviews shall be conducted under the following conditions: Retroactive Medi-Cal Determinations; Inaccuracies in the Medi-Cal Eligibility Data System; Authorization of services for beneficiaries with other healthcare coverage pending evidence of billing, including dual-eligible beneficiaries and/or beneficiary's failure to identify payer (e.g. Inpatient Psychiatric Hospital Services).

Single Point of Contact (SPOC): The person authorized by the provider to discuss or obtain any/all information concerning a specific TAR and/or Medi-Cal beneficiary.

Treatment Authorization Reviewer:
A LACDMH credentialed and State of California licensed mental health employee trained and assigned to review for medical necessity criteria for acute inpatient hospital admissions and continued stays.

Initial Process for the Submission of Medical Record Documentation for Concurrent Review and Authorization

Admission

- Within 24 hours of admission or the next working day, providers are required to enter the episode information and submit the required admission documentation via Provider Connect

- Contents of the provider uploads are limited to the documents listed on the “List of Required Documents for Concurrent Review”.
    - Beneficiary’s admission orders
    - Face Sheet
    - Initial Plan of Care
- Upon receipt of provider’s documentation, the CAU Clinical Reviewers will conduct concurrent review of the documentation and enter review notes in ProviderConnect’s Plan Communication.
- Once the documentation has been reviewed and the Provider has answered any questions, if needed, then the clinical reviewer will move forward with the approval process.
- The Provider can check in the service request status in ProviderConnect to view the service request authorization outcome.

Continuing Days

- The provider submits documents via ProviderConnect requesting a review at least one business day before the weekly authorization period expires. These documents will establish whether the beneficiary meets medical necessity criteria.
- Documents should include:
- Psychological Evaluation
- Progress Notes
- Updates to the treatment plan
- Medications
- History & Physical Examination Report

Once the CAU Clinical Reviewer receives clinical documents, notification of the authorization status will be sent via email from DMH CAU within one business day.

PHYSICIAN CONSULTATION OF DENIAL AFTER CONTINUED STAY REVIEW

- The CAU Clinical Reviewers may elect to authorize multiple days; however, documentation for each day of treatment must meet medical necessity criteria for admission and/or continued stay. The CAU Physician Reviewer may deny previously approved days done by CAU Clinical Reviewers if clinical documentation does not meet medical necessity criteria.

- The CAU Physician Reviewer’s reason for denial is noted in the Plan Communication. The TAS and the Notice of Adverse Benefit Determination (NOABD) are completed, logged and sent to the provider and beneficiary’s treating physician within 24 hours of the decision.

- For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, the MHP must mail the notice to the beneficiary within two business days.

Note: Please ensure that the beneficiary has Medi-Cal eligibility on the month that acute psychiatric inpatient services are provided. If Medi-Cal eligibility is pending, or if Medicare or other funding sources are being utilized, the provider shall request authorization and medical records within 14 days of discharge. The medical records will be reviewed retrospectively.

SECTION: VII

APPEALS, NOABD

Effective July 1, 2017, the Los Angeles County Department of Mental Health, Intensive Care Division, Treatment Authorization Unit, (LACDMH/ICD, CAU Unit), complies and operates with all applicable federal managed care requirements, state regulations and will implement its policies in processing adverse benefit determinations. The Policy and Procedures for the Intensive Care Division NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD), NOTICE OF APPEAL RESOLUTION (NAR) AND THE RIGHT TO A STATE HEARING will be discussed in this chapter.

The Appeal described below will only be followed after the LMHP has denied services following a Concurrent or Retrospective Reviews and after the beneficiary or provider's receipt of an NOABD.

APPEALS

An Appeal is a written request from the beneficiary to appeal a determination from the CAU on denial of acute day(s) for inpatient hospitalization that did not establish medical necessity criteria. Appeal is further defined by DHCS MHSUDS Information Notice No. 18-010E that under new federal regulations, an "Appeal" is a review by the Plan of an Adverse Benefit Determination.

The Los Angeles County Department of Mental Health, Intensive Care Division, (LACDMH ICD) TAR Unit, acting as the Point of Authorization (POA) and handling of standard and expedited appeals shall only have one level of appeal for beneficiaries.

TIMELINE FOR FILLING STANDARD APPEALS

- All Standard Appeal documents must be submitted by the beneficiary, authorized representative or provider within 60 calendar days of the initial denial date and receipt of the Notice of Adverse Benefit Determination (NOABD) letter. This is the date the initial authorization and NOABD were faxed to the provider.

METHOD OF FILING

- In accordance with the Code of Federal Regulations (CFR), Title 42, Section 438.402(c)(3)(iii) and California Code of Regulations (CCR), Title28, Section 1300.68(a)(1), Appeals may be filed by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing.

Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. The provider is expected to obtain this consent and file it in the beneficiary's medical records. An oral appeal (excluding expedited Appeals) shall be followed by a written, signed appeal by the beneficiary.

The date of the oral Appeal establishes the filing date for the Appeal.

The Patient's Rights Office (PRO) of the Los Angeles County Department of Mental Health has staff assigned to area hospitals and PHFs. The PRO staff are responsible in assisting beneficiaries in completing appeal forms and other procedural steps to file an appeal and informing beneficiaries of the location of the forms on the Plan's website or providing the form to the beneficiaries without having to make verbal or written requests to anyone. The PHF facilities have a dedicated space that contains the Beneficiary Rights, Appeal and Grievance Forms and envelops that are readily available to beneficiaries and hospital staff.

The presence of posted forms are also monitored during the triennial Inpatient System Review by the Intensive Care Division, Compliance Unit.

STANDARD APPEAL PROCESS (Note: Appeals may be submitted electronically through ProviderConnect)

1. Submit a written Appeal/Internal Appeal by the provider/beneficiary to the LACDMH CAU Unit on provider letterhead and signed by the treating physician addressing the medical necessity criteria for each day being appealed, and addressing each issue raised by the Provider. A written, signed Appeal by the beneficiary is also required; however, in the event that the CAU Unit does not receive a written, signed Appeal from the beneficiary, the CAU Unit shall neither dismiss nor delay resolution of the Appeal.
   An oral appeal may be submitted by calling the CAU's dedicated line at @ (213)-948-2971. This oral submission of a standard appeal shall be followed by a written request to include the consent and signature of the beneficiary.
2. The provider/beneficiary/authorized representative shall submit the Appeal to the LACDMH ICD CAU Unit within 60 calendar days from the date on the NOABD. All documentation must be submitted at the same time.
3. Retention of envelopes, receipts and emails documenting submission dates are retained on all Appeals that failed to meet the 60-calendar day timeline for an Appeal.
4. The CAU Unit shall Fax a written acknowledgment to provider and beneficiary within five (5) calendar days of receipt of the Appeal. The acknowledgment letter shall include the date of receipt as well as name, telephone number, and address of the CAU Unit representative who the beneficiary may contact about the appeal.
5. Submit the Request for an Appeal in narrative form or a summary that may refer to other documentation in the chart, include: Copy of Initial authorization denial (e.g., nurses' notes, but must definitely support the medical necessity criteria as outlined in the DHCS BHIN No. 22-017 to support the Appeal. Clarification of illegible notes may be submitted but must be printed or typed before resubmission.
6. CAU Unit shall distribute Appeals of adverse benefit determination to the CAU Unit credentialed and licensed personnel not involved in the initial denial, modification or any previous level of decision-making and were not subordinates of any individual who was involved in a previous level of review to determine the appeal decision. Decision makers of the submitted appeal will take into account all comments, documents, records, and other information submitted by the

beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. The Appeal Physician Reviewer makes the final decision on behalf of the Office of the Medical Director, Intensive Care Division.

7. The CAU may extend the timeframe for processing an appeal by up to 14 calendar days, if the beneficiary requests an extension or the CAU determines that there is a need for additional information and that the delay is in the beneficiary's benefit.
8. If the CAU extends the timeframes, the CAU shall, for any extension not requested by the beneficiary, make reasonable efforts to give the beneficiary reasonable efforts to give the beneficiary prompt oral notice of the delay and notify the beneficiary of the extension and reasons for the extension in writing within two (2) calendar days of the decision to extend the timeframe. The CAU's written notice of extension shall inform the beneficiary of the right to file a grievance if he/she disagrees with the CAU's decision. The CAU shall resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires. (42 CFR, Section 438.408(c)(2)(i)-(iii). The written notice of the extension is not a Notice of Adverse Benefit Determination. Allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person or in writing.
9. Provide the beneficiary or his/her representative the beneficiary's case file including medical records, and any other documents and records, and any new and additional evidence considered, relied upon, or generated by the CAU in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the beneficiary. 42 CFR, Section 438.406(b)(5)
10. Provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe. The CAU shall resolve the standard appeal by sending a Notice of Appeal Resolution (NAR) within 30 days from the day of the receipt of the appeal.
11. The CAU shall notify the beneficiary, and/or her representative, of the resolution of the appeal in writing using the attachment to DHCS MHSUDS Information Notice No.:18-010E, Notice of Appeal Resolution.
12. In the event that the CAU fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the mental health plan's appeal process and may initiate a State Hearing.
13. Allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties of the appeal.

EXPEDITED APPEALS

"Expedited Appeal" is an appeal used when the mental health plan determines that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The Expedited Appeal Process:

1. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.
2. The beneficiary may file the request for expedited appeal orally without requiring the beneficiary to submit a subsequent written, signed appeal. It should be noted that there will be no punitive action taken by the mental health plan against a provider who requests an expedited resolution or supports the beneficiary's expedited appeal.
3. The CAU shall acknowledge written receipt of the Expedited Appeal request. The acknowledgment letter shall include the name, address, telephone number of the staff handling the appeal. The letter shall be sent as expeditiously as possible considering the timeframe for resolution.
   The CAU shall log the time and date of the appeal receipt when expedited resolution is requested as this specific time of receipt of the request drives and begins the timeframe for resolution.
4. The CAU shall inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. This information shall be included in the CAUs ~~Unit's~~ acknowledgement letter to the beneficiary
5. The CAU must resolve and provide oral and written notice no longer than 72 hours after receipt of the Expedited Appeal request. The decision shall be communicated in the Notice of Appeal Resolution (NAR), and the NAR shall either be Overturned or Upheld based on the initial decision made in the NOABD. The CAU shall provide prompt oral notice to the beneficiary of the resolution. The CAU shall log the hospital staff's name receiving the oral notice of the resolution.
6. The CAU ~~t~~ may extend the timeframe up to 14 calendar days if the beneficiary requests an extension, or the CAU determines that there is need for additional information and that the delay is in the beneficiary's interest.
7. If the CAU extends the timeline for processing an expedited appeal not at the request of the beneficiary, the CAU shall make reasonable efforts to give the beneficiary prompt oral notice of the delay and notify the beneficiary of the extension and the reason(s) for the extension, in writing, within two (2) calendar days of the determination to extend the timeframe. The written notice of the extension is not an NOABD.
8. The CAU shall resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
9. The CAU shall send the beneficiary *Notice of Appeal Resolution* using the attachment found in *DHCS MHSUDS Information Notice No. 18-010E*. There must be a clear and concise explanation of the reason(s) for the decision. For

determination based on medical necessity criteria, the notice must include the clinical reasons for the decision and a description of the criteria used.

If the CAU denies the request for an expedited appeal resolution, the CAU ~~Unit~~ shall:

a. Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the CAU ~~Unit~~ receives the appeal.
b. Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal. The CAU ~~Uni~~t shall provide written notice of the decision and reason for the decision within two (2) calendar days from the date of the denial and inform the beneficiary of the right to file a grievance if he or she disagrees with the decision. It shall be noted that the written notice of denial of the request for appeal is not an NOABD.

NOTICE OF APPEAL RESOLUTION (NAR)

The NAR is a formal letter informing a beneficiary that the Adverse Benefit Determination (NOABD) has been overturned or upheld.

A. Adverse Benefit Determination Upheld

For appeals not resolved wholly in favor of the beneficiary, the CAU ~~Unit~~ shall utilize the DHCS template included in the MHSUDS Information Notice No. 18-010E, for upheld decisions, which is comprised of two (2) components:

1. Notice of Appeal Resolution; and
2. Your Rights" attachments. These documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR. The NAR shall contain the following:

    a. The results of the resolution and the date it was completed;
    b. The reasons for the determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
    c. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;
    d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and
    e. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the CAU ~~Unit's~~ adverse benefit determination.

NAR “Your Rights” attachment provides beneficiaries with the following required information pertaining to NAR:

a. The beneficiary’s right to request a State hearing no later than 120 calendar days from the date of the CAU written appeal resolution and instructions on how to request a State hearing; and
b. The beneficiary’s right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e. within ten (10) days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420

B. Adverse Benefit Determination Overturned

For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. CAU shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. The CAU shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions.

The CAU must authorize or provide the disputed services promptly and as expeditiously as the beneficiary’s condition requires. If the CAU reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. CAU shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

Should the beneficiary file a grievance related to the denied Expedited Appeal Request then the CAU shall:

- Notify the beneficiary with a written acknowledgment of Receipt of the grievance postmarked within (five) calendar days of the receipt of the grievance. The timeframe for resolving a grievance related to a denied Expedited Appeal Request shall not exceed 30 calendar days.
- The CAU shall send a Notice of Grievance Resolution (NGR) letter to the beneficiary providing a summary of the grievance filed, steps taken to resolve the grievance, a clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the beneficiary, and the reasons for the decision. A copy of the NGR shall be transmitted to the Patient’s Rights Office. If the beneficiary is dissatisfied with the resolution of the grievance, the beneficiary may file another grievance with the Mental Health Plan. In accordance with CFR, Title 42, Section 438.402, a beneficiary may file a grievance with the MHP at any time.

Submit documentation for Appeal/Internal Appeal (formerly known as first level appeal) to:

Los Angeles County Department of Mental Health
Intensive Care Division, CAU /Appeals Section
510 S. Vermont Avenue, 20th Floor
Los Angeles, CA 90020
Telephone number: (213) 739-7300

This phone number is answered by staff during regular office hours of 8:00 AM to 5:00 PM Monday through Friday. Office is closed on Saturday, Sunday, and holidays

GRIEVANCE

Pursuant to *Title 42, Code of Federal Regulations, §438.400(b)*, the term "grievance" has been redefined to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The definition specifies that grievances may include, but not limited to, the quality of care or services provided, 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 rights to dispute an extension of time proposed by the Plan to make an authorization decision. There is no distinction between an informal and formal grievance. 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".

Note: The Local Mental Health Plan's (LMHP) CAU shall not discourage the filing of Grievances. The beneficiary need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry. The complaint shall still be aggregated for tracking and trending purposes as with other Grievances.

Timeframes for Filing Grievances

In accordance with *Title 42, Federal Code of Regulations (CCR), §438.402*, a beneficiary may file a grievance at any time.

Method of Filing

A beneficiary, or a provider and/or authorized representative, may file a grievance either orally or in writing.

Standard Grievances Acknowledgement

The CAU shall provide the beneficiary a written acknowledgment of receipt of the grievance postmarked within five (5) calendar days of receipt of the grievance. The acknowledgement letter shall include the date of receipt, as well as the name, telephone number, and address of the LMHP representative who the beneficiary may contact. The Los Angeles County Department of Mental Health, Intensive Care Division, Central Authorization Unit (CAU) under the Appeals Section is responsible for completing this task when grievances are received from the Psychiatric Health Facility (PHF) when representing a beneficiary or from beneficiaries or their authorized representatives.

Resolution

The CAU shall resolve the standard grievance and notice to affected parties not to exceed 90 calendar days from the day it received the grievance.
The following steps shall be taken into consideration when formulating a resolution for the standard grievance:

a. "Resolved" means that the CAU has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
b. The resolution of the grievance shall be completed within 90 calendar days of the receipt of the grievance. The CAU shall enter on the Grievance Log the following:
    1. Date and time of receipt of the grievance;
    2. The name of the beneficiary filing the grievance;
    3. The name of the representative (TAR Unit staff) recording the grievance;
    4. A description of the complaint or problem;
    5. A description of the action taken by the CAU or provider to investigate and resolve the grievance;
    6. The proposed resolution by the CAU or provider;
    7. The name of the CAU staff responsible for resolving the grievance; and
    8. The date of notification of the resolution.
c. The timeframe for resolving grievances related to disputes of the CAU's decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days.
d. The CAU shall use the *Department of Health Care Services' (DHCS) Information Notice No.:18-010E Enclosure* of written Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the CAU's decision.
e. Pursuant to *Title 42, CFR, §438.408(b)and(c*), the CAU is allowed to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the CAU identify that there is a need for additional information and how the delay is in the beneficiary's interest. In the event that the resolution of a standard grievance is not reached within 90 calendar days as required, the CAU shall provide the beneficiary with the applicable Notice of Adverse Benefit

Determination (NOABD), and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.

If the CAU extends the timeframe, not at the request of the beneficiary, it must complete all of the following:

a. Give the beneficiary prompt oral notice of the delay;
b. Within two calendar days of making the decision, give the beneficiary written notice of the reason of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision; and
c. Resolve the grievance no later than the date the extension expires.

Grievance Process Exemptions

1. Grievances received over the telephone or in-person by the CAU or a network provider of the LMHP, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt of the grievance are exempt from the requirement to send a written acknowledgement and disposition letter.
2. Grievances received via mail by the CAU, or a network provider of the LMHP, are not exempt from the requirement to send an acknowledgement and disposition letter in writing.

   If the CAU or a network provider of the LMHP receives a complaint pertaining to an Adverse Benefit Determination, as defined under *42 CFR §438.400,* the complaint is not considered a grievance and the exemption does not apply.

3. The CAU must transmit issues identified as a result of the grievance to the LACDMH Quality Improvement Committee, the Quality Assurance Division, the LACDMH administration or another appropriate body within Los Angeles County's operations. The CAU currently enters all pertinent information regarding Grievances and Appeals in a Log that is located in the AVATAR System. The information that are entered into the IBHIS are available to the LACDMH Quality Improvement Division for analyses and submission. The LMHP shall ensure exempt grievances are included in its Beneficiary Grievance and Appeal Report that is submitted to DHCS.

STATE HEARING

The *California Code of Regulations, Title 22, Section 50951* refers to State Hearing as the Right of beneficiaries if they are dissatisfied with any action or inaction of the county department, the Department of Health Care Services (DHCS) or any person or organization acting on behalf of the county or the Department relating to Medi-Cal eligibility or benefits.

A beneficiary has the right to request a State Hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness. Beneficiaries must exhaust the Los Angeles County Department of Mental Health, Intensive Care Division, Central Authorization Unit's (LACDMH ICD CAU) appeal process prior to requesting a State Hearing.

The beneficiary's right to file for a State hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary shall be indicated in the NAR. The CAU's communication with the provider shall also include information of the beneficiary's right to request and receive benefits while the State Fair hearing is pending, and how the beneficiary makes this request. Included in the beneficiary and provider communication letters, as appropriate, are updated attachments to DHCS Information Notice No. 18-010E 'Your Rights", Language Assistance taglines, Notice of Adverse Benefit Determination (NOABD) "Denial", Nondiscrimination Notice, NOABD Financial Liability, and NOABD "Upheld".

Timeframe for Filing

Pursuant to the *Federal Code of Regulations, Title 42, §438.408(f)(1) and (2)*, beneficiaries are allowed to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary that the Adverse Benefit Decision has been upheld by the CAU ~~Unit~~.

Note: The parties to State Hearing include the LAC DMH, as well as the beneficiary and his/her authorized representative or the representative of a deceased beneficiary's estate.

State Fair Hearing/State Hearing Decision Timeframes

Standard Hearings

The CAU shall notify beneficiaries that the State must reach its decision within 90 calendar days of the date of the request.

Expedited Hearings

If the beneficiary thinks that waiting for 90 days for the resolution of the hearing will affect his/her health, an **"expedited appeal"** may be filed. The reason for the expedited appeal request shall be stated. An expedited state hearing will be resolved within three (3) working days

.

The CAU shall notify beneficiaries that the State must reach its decision within three (3) working days of the date of the request.

Overturned Decisions

The CAU shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

HOW DO BENEFICIARIES FILE FOR A STATE FAIR HEARING?

A State Fair Hearing must be filed within 120 days from the date of the NAR letter. A beneficiary can ask for a State Fair Hearing by phone, electronically, or in writing:

By phone: Call **1-800-952-5253**. If the beneficiary has a hearing or speech impairment, he/she can call **TTY/TDD 1-800-952-8349.**

Electronically: A beneficiary 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: A beneficiary shall 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

To complete the application, the beneficiary shall ensure that he/she includes the following: name, address, telephone number, date of birth, and the reason why a State Hearing is being pursued. If someone is helping the beneficiary to request for a State Hearing, it is important to add their name, address, and telephone number to the form or letter.

The need for an interpreter and in what language must be requested at the time of filing. Interpreter service will be provided for free.

A beneficiary may also get legal help by calling the local Legal Aid program of Los Angeles County at **1-888-804-3536.**

All of the above information can be found in an attachment sent with the NOABD. This attachment is called, "NOABD Your Rights".

Notices to LMHP on Decisions Regarding State Hearing Appeals

Upheld Decisions to LMHP:

The California Department of Social Services, State Hearings Division will notify the LACDMH ICD CAU on its decision on the Provider's Appeal.

- The LMHP will not communicate any information to the beneficiary regarding Appeal decision. California Department of Social Services, State Hearings Division will notify the beneficiary directly of its decision.
- Enter the Upheld Decision in the State Hearing Appeal Log, and input the decision in the AVATAR system and complete the AVATAR Summary of the findings.

Reverse and Split (Partially Approved and Partially Denied Days) Decisions:

- The LACDMH CAU shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the MHP's adverse benefits determination.

After receipt of the State Hearing Division decision, The CAU Appeal staff will:

- Enter the Reverse and Split Decision in the Appeal Log, and input the decision in the AVATAR System and complete AVATAR Summary of the findings.
- File the State Decision Letter in Provider's Appeal file until the LMHP receives a State Hearing Appeal request from the Provider as indicated in the DSS instructions to the Provider. A provider appeal request written on the provider's letter head must be submitted with admission and discharge dates completed by the Provider and must include the days that are reversed and requested for payment.
- Write "Approved as Requested" Provider appeal request by the CAU staff for both Reverse Decisions and Split Decisions.
- Write "# days approved at State Hearing Appeal" for Reversed Decisions.
- Write "# days approved at State Hearing Appeal," "# days remain denied" for Split Decisions.
- Deliver the above CAU, DSS Decision Letter and Instructions to CAU administrative support staff for further processing.

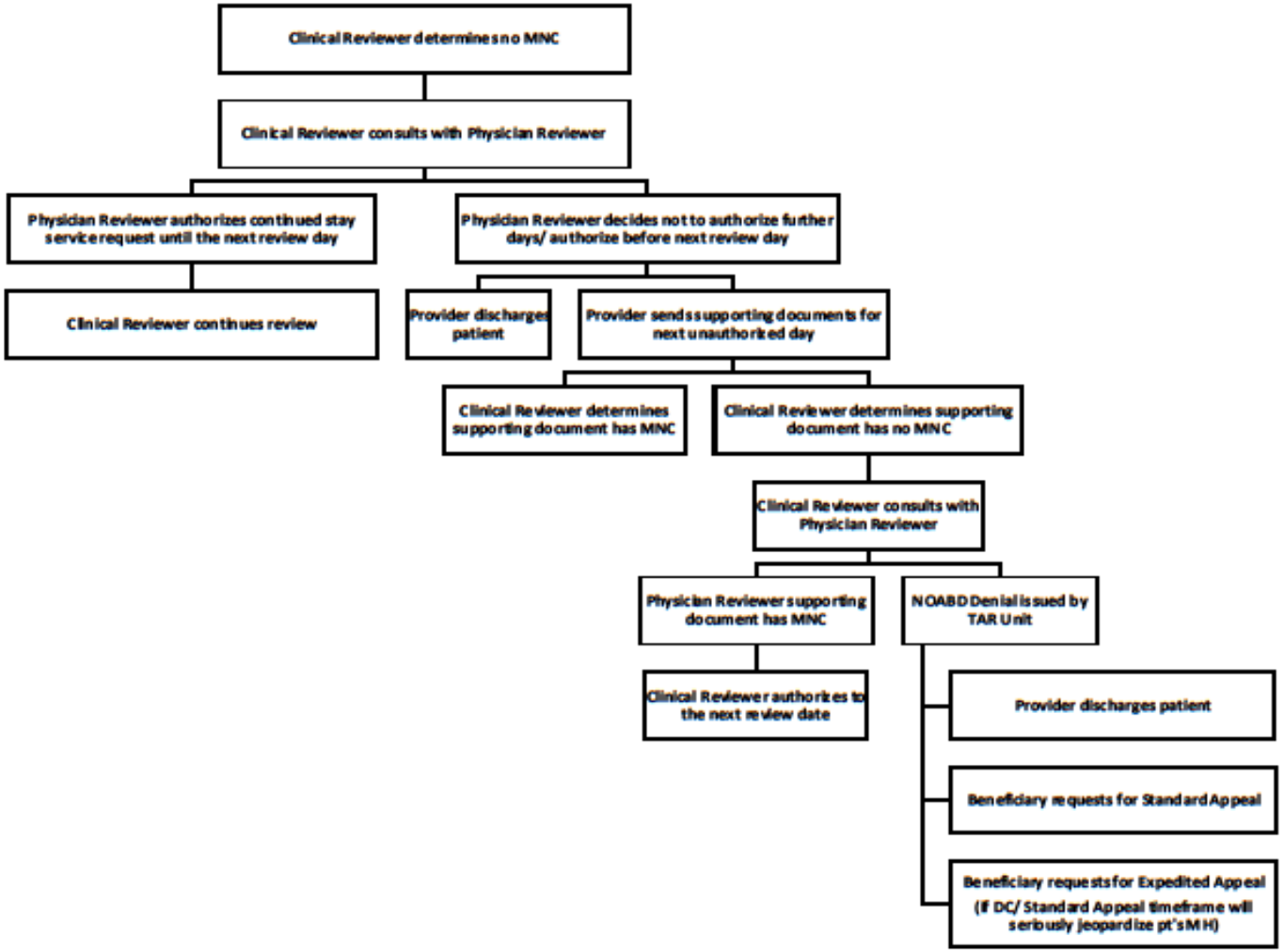
Submit Provider Completed State Hearing Level Reverse/Split Documents

- Fax within 14 calendar days the Completed State Hearing appealed- decision letter w/ cover letter to the Provider.
- FedEx within 14 calendar days the Completed State Hearing appealed
- File original documents with CAU Records staff.

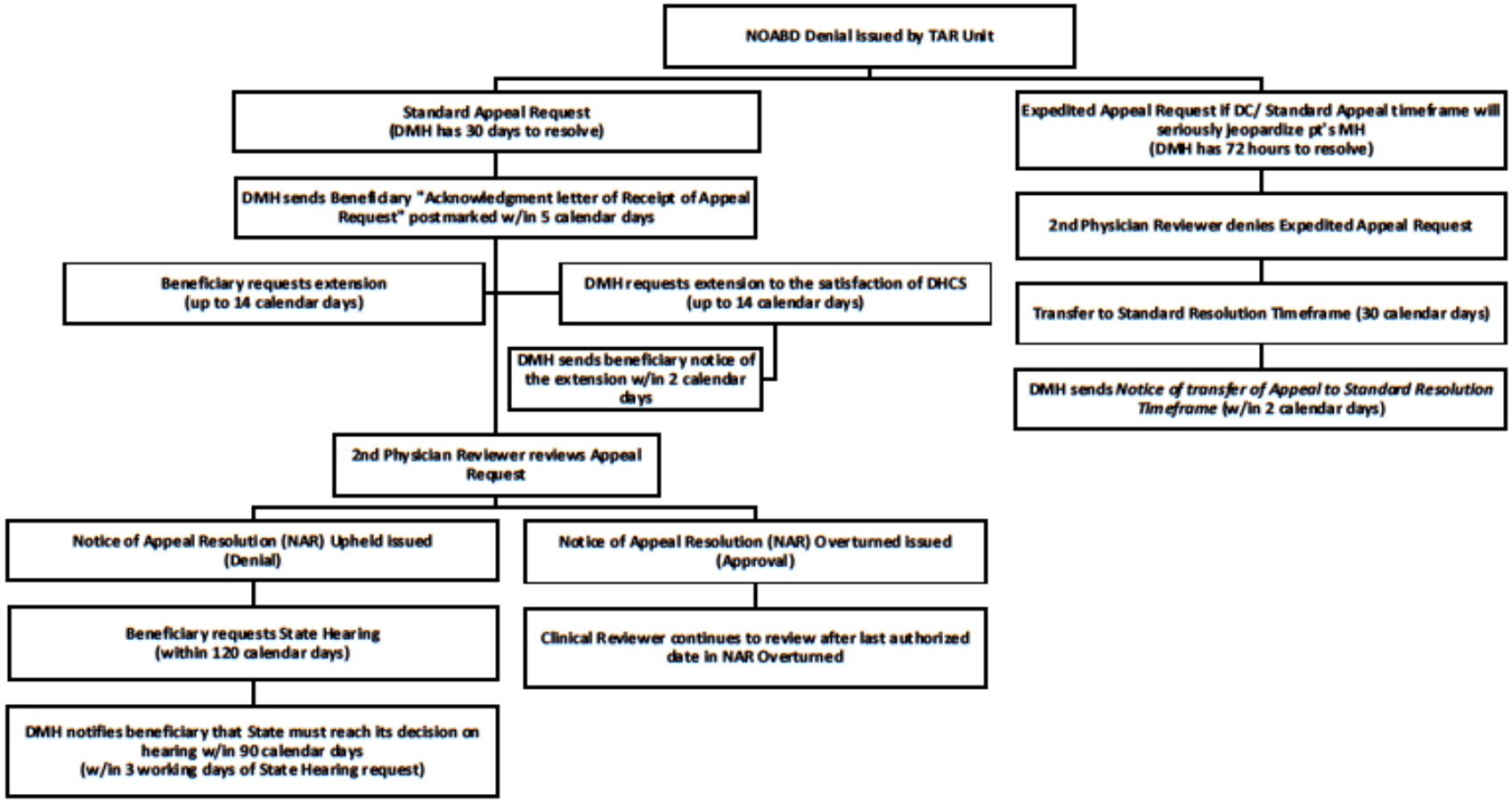
AUTHORITY:

Welfare & Institutions Code Section 14680

Denial Process for Concurrent Review



Standard and Expedited Appeal Process for Concurrent Review



SECTION: VIII

RETROSPECTIVE AUTHORIZATION

SUBMISSION OF DOCUMENTATION FOR RETROSPECTIVE AUTHORIZATION

CIRCUMSTANCES WHEN RETROSPECTIVE Documentation CAN BE SUBMITTED

Retrospective documentation may be submitted for payment authorization request beyond the timelines specified by regulations for the following limited circumstances upon verification of the LMHP:

1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or;
4. Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

Documentation that meets retrospective criteria must be **submitted within 60 calendar days** of the following:

1. Date of discovery of Medi-Cal eligibility.
2. Date Remittance Advice Statement (RA) showing partial payment or Notice of Exhaustion of Benefits (EOB) was received from third party.

Note: Documents are to be submitted via ProviderConnect only after having billed any other insurance carrier including Medicare. LACDMH shall not be responsible for reimbursing PHF facilities that deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi-Cal program.

SECTION: IX

PROVIDER SITE REVIEW

PROVIDER SITE REVIEW

All hospitals shall comply with Federal requirements for utilization control pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D. These requirements include certification of need for care, evaluation and medical review, plans of care and utilization review plan. Each hospital shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care and to identify problems with quality of care. Composition of the committee shall meet the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D, §456.150 through §456.245.

In accordance with oversight authority contained in the Los Angeles County Department of Mental Health Service Agreement Contract Allowable Rate, the Intensive Care Division, Compliance Unit schedules provider reviews once every three years or more often when egregious issues are identified through documentation reviews and outcome of the system review. Findings that are not in compliance with the established rules and regulations will require a Plan of Correction from the provider.

The four major areas of review consist of the following areas:

1. Utilization Review including Utilization Review Plan and Medical Care Evaluation Studies;
2. System review consisting of review of Policies and Procedures and their practical applications;
3. Chart review to ensure that Policies and Procedures and Contract provisions are being followed particularly in the areas of beneficiary consents, treatment planning, discharge planning and service referrals; and
4. Beneficiary interviews to ensure that the providers are complying with applicable laws and regulations relating to patient's rights.

Note: Included in the System Review will be monitoring of the presence of Beneficiary Consent Form to be used when the Beneficiary, PHF or Beneficiary Representative files a grievance or appeal. A Plan of Correction will be issued if the hospital fails to submit the document.

SECTION: X

REPORTING ADVERSE OUTCOMES

REPORTING ADVERSE OUTCOMES

All contracted providers must report adverse outcomes to the LACDMH. Such adverse outcomes include any event which threatens or causes actual damage to the health, welfare and/or safety of beneficiaries, staff or the community, including but not limited to, the following:

- Death (unknown cause, suspected or known medical cause or suspected or known suicide;
- Suicide attempt requiring emergency medical treatment;
- Client sustained intentional injury requiring emergency medical treatment;
- Injury to others caused by a client and requiring emergency medical treatment;
- Homicide by a client;
- Alleged client abuse;
- Adverse medication events including medication errors; and
- Possible malpractice.

- Notification of Death: PHF providers shall immediately notify ICD Medical Director upon becoming aware of the death of any client provided services hereunder. Notice shall be made immediately by telephone and in writing through the UHC Safety Intelligence: Event Reporting Portal.
- Notification of special incidents: PHF providers shall report through Safety Intelligence reporting portal all special incidents within 72 hours. Special incidents shall include, but are not limited to , suicide or attempt, absence without leave (AWOL), death or serious injury of clients, criminal behavior (including arrests with our without conviction), and any other incident which may result in significant harm to the client or staff or in significant public or media attention to the program.

Before the Adverse Outcome Report is faxed, a telephone call shall be made to the Office of the Medical Director notifying the secretary that the material will be transmitted.

Questions regarding mental health inpatient adverse outcome issues should be directed to the LACDMH LPS Designation Coordinator, by telephone at (213) 639-6315.