

**PLACER COUNTY
SYSTEMS OF CARE**

**BEHAVIORAL HEALTH –
NETWORK PROVIDER MANUAL**



**11716 Enterprise Drive
Auburn, CA 95603**

**Main Line: (530) 886-5400
Fax: (530) 886-5499**

**24-Hour Emergency Lines:
Adult Intake Services (888) 886-5401
Family & Children's Services (886) 293-1940**

QUICK REFERENCE PHONE NUMBERS

The list of telephone numbers below is intended to provide a quick reference guide to important contacts.

Sierra County Emergency/Urgent Services and Child/Adult Abuse Reporting

Sierra County Mental Health Services (530) 993-6747

Placer County Emergency/Urgent Services and Child/Adult Abuse Reporting

Placer County Adult Intake Services (916) 787-8860

Adult Intake Services Toll Free (888) 886-5401

Adult Intake Services Intake Fax (916) 787-8915

Placer County Family & Children's Services (916) 872-6549

Family & Children's Services Toll Free (866) 293-1940

Family & Children's Services Intake Fax (916) 787-8915

IHSS Public Authority (530) 886-3680

ASOC Public Guardian/Adult Protective Services (530) 886-2900

Managed Care Unit (530) 886-5400

MCU Fax (530) 886-5499

Network Provider Services

Provider Network Applications (530) 886-5400

Provider Informal Appeals (530) 886-5400

Problem Resolution/Appeals (530) 886-5400

Provider Relations (530) 886-5400

Accounting/Claims Department (530) 745-3111

Quality Management Office

QI Coordinator (530) 886-5440

Office of Consumer Affairs

Patients' Rights Advocacy (530) 886-5419

Placer County Ombudsman (530) 889-6752

State of California Ombudsman (800) 896-4042

National Alliance for the Mentally Ill (**NAMI**) (800) 950-6264

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I. THE PLACER/SIERRA COUNTY MENTAL HEALTH PLAN (MHP)

INTRODUCTION

As a result of the Medi-Cal Specialty Mental Health Services Consolidation Phase II that took effect in Placer County on April 1, 1998, all non-hospital Specialty Mental Health Services are now administered and provided through the Placer/Sierra County Mental Health Plan (MHP). To avoid confusion, note that this is not the same entity as the Placer County Health Plan (PCHP). Medi-Cal beneficiaries previously seen in the Short-Doyle/Medi-Cal system and those previously seen in the Fee-for-Service Medi-Cal system will now be served by this entity. The term “consumer” refers to recipients of Mental Health services and will be used interchangeably throughout this manual.

To avoid confusion, also note that the phrase “non-hospital” refers to costs and services that are not directly attributable to a hospital or facility. The costs for professional services during an inpatient or residential stay are considered “non-hospital services”, and are thus governed by the policies and procedures contained in this provider manual.

This consolidation creates a context in which essentially all mental health services, whether inpatient, outpatient, clinical, or rehabilitative are viewed as components of an array of services designed to care for adults with mental illness, and children and adolescents with emotional disturbances. It also creates a collaborative partnership, between beneficiaries, family members, and all service providers, that works to achieve the beneficiary’s desired outcome in a cost-effective and clinically efficient manner.

PRINCIPLES

MHP is guided by the following principles that affect the implementation of all levels of consumer services:

1. Services are provided to consumers with respect and dignity.
2. Services focus on consumers’ strengths and not weaknesses.
3. Services are provided in a culturally competent manner.
4. There is an organized, collaborative, coordinated, and cost-effective approach to care and treatment.
5. Services are consumer-driven, family-focused and achieve positive mental health outcomes for culturally diverse populations across all age groups.
6. The emphasis when serving adults with serious and persistent mental illnesses and children and adolescents with serious emotional disturbances is through a comprehensive, community-based, coordinated system of care.
7. For less serious and less enduring conditions, the emphasis is on short term solution-focused treatment at all levels of service.
8. The service system is “user-friendly” with easy access for consumers and a “seamless” interface with the physical health services provided to Medi-Cal beneficiaries through the PCHP.
9. The service delivery system is accountable for quality services and has defined outcomes as ways of measuring effectiveness and efficiency.

ELIGIBILITY FOR MHP MEMBERSHIP

All Placer/Sierra County Medi-Cal beneficiaries are eligible for membership in the Placer/Sierra Mental Health Plan (MHP). A Placer or Sierra County Medi-Cal beneficiary is any person certified as eligible

for services under the Medi-Cal Program according to Section 51001, Title 22, Code of California Regulations, whose beneficiary identification information includes Placer County Code Number 31 and Sierra County Code Number 46.

In addition, MHP recognizes the public mental health system's role as a safety net for Placer/Sierra County residents who do not possess insurance coverage or the personal means to adequately cover the cost of mental health care. Placer and Sierra Counties have opted to provide a single Mental Health Plan with comparable services for Medi-Cal beneficiaries and indigent Placer/Sierra County residents.

CATEGORIES OF MHP PARTICIPATING PROVIDERS

- **Hospitals, skilled nursing facilities, institutes for mental disease (IMD) and mental health rehabilitation facilities** licensed by the State Department of Health Services and meeting national accreditation standards for staff qualifications.
- **Organizational providers** certified by MHP and the State to deliver mental health services through Short-Doyle Medi-Cal clinics staffed by licensed mental health professionals and registered interns under licensed supervision. (**Appendix I — Certification**)
- **Network Providers** include Psychiatrists, Psychologists, Clinical Social Workers, and Marriage & Family Therapists licensed for independent practice. These individuals are eligible to credential and participate as Network Providers. Interns are also eligible to be credentialed under the supervision of a credentialed provider but are not reimbursable by Medi-Cal.

SERVICES COVERED BY MHP

MHP Members have access to a comprehensive array of community-based services including, but not limited to the following, as resources allow:

- Information and referral service
- Prevention services
- A full range of voluntary mental health services for children, adults, and older adults including assessment, outpatient therapy, case management, medication support, social rehabilitation, vocational rehabilitation, day treatment, dual diagnosis treatment, supported housing, residential care, transitional residential treatment, sub-acute residential treatment, and crisis residential treatment upon establishment of medical necessity for services, and to the extent resources are available.
- Mental health services for children who need them to meet education goals (Special Education)
- 24-hour Psychiatric Emergency Services and a Crisis Hotline
- Involuntary assessment, inpatient, and long-term care services for individuals who are a danger to themselves or others, or gravely disabled due to a psychiatric condition.

Services covered by MHP do not include all mental health services that have been reimbursed through the State's Fee-for-Service Medi-Cal program. Services that the State excluded from MHP will continue to be provided and billed through the State's Fee-for-Service Medi-Cal program. These services include: substance abuse services, private psychologist and psychiatrist services for individuals who have both Medi-Cal and Medi-Care, and services for individuals with cognitive and organic brain disorders. Mental health services delivered by primary care providers will not be covered by MHP.

The State Medical Necessity Criteria listed in **Appendix III** identifies included and excluded diagnoses. Individual providers, organizational providers, group practices, skilled nursing facilities and hospitals should refer to their individual contracts to determine their included procedures and rates.

II. HOW TO OBTAIN AUTHORIZATION FOR MENTAL HEALTH SERVICES

Specialty mental health services offered by the Placer/Sierra Mental Health Plan (MHP) fall into three broad categories: *Planned Services* which require prior-authorization by MHP; *Urgent Care Services* which sometimes require prior-authorization; and *Emergency Services* which do not require prior authorization. This section of the Provider Manual describes the processes related to each of these service categories.

AUTHORIZATION FOR PLANNED SERVICES

All planned (non-emergency) mental health services must be prior-authorized by the Placer/Sierra Mental Health Plan. The MHP has contracted with some providers for specific services that are not subject to this requirement. These provisions are defined clearly in the providers' contracts.

For all planned Outpatient Mental Health Services the Mental Health Adult Intake Services and Family & Children's Services Telephone Lines are responsible for taking preliminary information for referral to the Adult System of Care (ASOC), Children's System of Care (CSOC), or the Managed Care Behavioral Health Unit (MCU) depending on the intensity of services needed. Referrals are distributed to case managers who provide authorization to individual Network Providers and some Organizational Providers.

Authorization for Services: To obtain authorization for Outpatient Mental Health Service, members call the Mental Health Adult Intake Services Line at (888) 886-5401 or the Family & Children's Services Line at (866) 293-1940. Office hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday. The Mental Health Adult Intake Services and Family & Children's Services staff responds to requests for specialty mental health services from MHP members 24 hours a day, seven days a week. After confirming member eligibility and screening for medical necessity, the member is referred to ASOC, CSOC or MCU where a case manager will be assigned to provide a Service Authorization and referral to a credentialed Network Provider, or refer the member to the most appropriate community service. Referrals will take into account language, cultural variables, age, geographic location, and modalities of treatment. A copy of the authorization will be mailed. The authorization will specify services by codes, which are authorized for a given time period.

After completing the initial assessment sessions, the Network Provider will forward the assessment to the referring case manager to review for medical necessity and authorize continuing therapeutic treatment. Authorization for additional outpatient treatment may occur when additional services beyond the initial authorization are medically necessary. It is the Network Providers responsibility to seek prior approval through the case manager for additional services before continuing services. Network Providers are not to provide services without a current service authorization.

The case manager will either authorize further treatment or inform the provider of recommendations for other appropriate services. Authorizations will be issued specifying the date of expiration of the services, a total amount of time to be billed during the authorization timeline, and a recommended number of sessions for which this time is to be used under the service function codes being authorized. The appropriate code number(s) must be used when the service is billed to the Mental Health Plan (MHP).

Reauthorization for Services: The Network Provider will send the Placer County case manager a Request for Authorization/Treatment Plan three weeks prior to the end date on the Service Authorization. The provider's documentation on the Request for Reauthorization will be reviewed by the case manager to determine continuing medical necessity, and treatment progress. If the member continues to meet the criteria for medical necessity and the treatment recommendation is clearly delineated, the case manager will write a new Service Authorization and mail (and/or fax) the provider a written confirmation of the reauthorization. This reauthorization will be for a specific number of

sessions conducted within a specified period. Organizational Providers conduct a secondary eligibility determination and conduct utilization review, but receive authorization from the MHP. Initial authorization for services will be limited to a total of 12 sessions after medical necessity has been established. Additional sessions may be granted due to extreme clinical need, as resources allow.

Denial of Request for Authorization: If services are denied, the beneficiary and the provider will be informed of the denial, the reasons for the denial, and the process by which they may appeal this decision or file a State Fair Hearing for Medi-Cal beneficiaries. This advisement, in the form of a Notice of Action (NOA) must be issued by the MHP, within three (3) days of the denial. If a member contacts a Network/Organizational Provider about a denial, the provider should direct the member to call the referring case manager.

Adult Intake Services (AIS) and Family & Children's Services (FCS) intake staff also provides additional services to members such as information and referral to appropriate agencies, social services, entitlements, housing, physical health, and substance abuse resources. Adult Intake Services (AIS) and Family & Children's Services (FCS) Intake staff will have information about how members can use the Mental Health Plan Problem Resolution Process, which includes Grievances, Appeals, and Provider Changes. AIS and FCS Intake staff will give information regarding 24-Hour Mental Health Services. Referrals to non-acute 24-hour Mental Health Services including long-term care, residential treatment, transitional residential treatment, and residential care facilities must be pre-authorized by the Placer County Mental Health Plan. An inter-agency committee reviews all referrals for admission of children and youth to sub-acute or residential services. Contact the Program Manager of FCS at (916)889-6785.

URGENT CARE

The State defines an urgent condition as: a situation experienced by a member that without timely intervention is certain to result in an immediate, emergency, psychiatric condition that requires psychiatric hospitalization. The State distinguishes urgent conditions from emergencies. Emergencies require voluntary or involuntary hospitalization and meet the criteria for medical necessity for psychiatric inpatient hospital services. Emergency Services are described in a subsequent section.

Providers are expected to offer urgent care services to beneficiaries during regular hours of operations and to arrange for after-hour coverage. If a beneficiary with which you are working is experiencing an urgent psychiatric condition, their safety and welfare is of paramount concern. To receive authorization for payment for treating urgent conditions, you must call the referring case manager before offering the service unless you are designated through your contract or agreement with MHP to provide the service, or you have already been authorized for a service that could be used to provide urgent care. The AIS or FCS Lines will assist members who call to locate Urgent Care services even when they are outside Placer County.

Members who are in crisis and cannot reach their provider can receive assistance through the AIS Line that operates 24-hours/day, 7 days/week at (888) 886-5401 or the FCS Line which also operates 24-hours/day, 7 days/week at (886) 293-1940.

EMERGENCY (UNPLANNED) SERVICES

An emergency psychiatric condition is defined by State regulations as one that requires voluntary or involuntary hospitalization and meets the criteria for medical necessity for psychiatric inpatient hospital services by meeting one of the following conditions as a result of a mental disorder:

- a) danger to self,
- b) danger to others, or
- c) currently unable to provide for or utilize food, shelter or clothing.

No prior authorization for payment from the Mental Health Plan will be required for emergency services delivered by either in-plan or out-of-plan providers for MHP members.

EMERGENCY PSYCHIATRIC HOSPITAL ADMISSIONS

AIS or FCS Lines provides 24-hours/day, 7 days/week emergency evaluation which may lead to psychiatric hospitalization for children, adolescents or adults. In case of an emergency psychiatric admission, hospitals shall notify MHP as soon as possible and no later than 24 hours after the time of the admission of the beneficiary. Emergency admissions must meet the medical necessity criteria. Notification of inpatient admission to the MCU may be made by facsimile or voice mail within 24 hours of admission. MHP inpatient authorizations will incorporate both the facility and professional (psychiatrist/psychologist) services.

Managed Care Unit
11716 Enterprise Drive
Auburn, CA 95603
(530) 886-5400
Fax: (530) 886-5499

Failure to provide the completed Treatment Authorization Request (TAR) to the MHP within 14 days of discharge may result in a payment denial for all, or a portion of, the inpatient psychiatric services delivered.

PLANNED HOSPITAL ADMISSIONS

For psychiatric conditions or crises that do not meet emergency criteria, all planned hospital admissions must be prior-authorized by MHP. Documentation showing that the member meets medical necessity criteria must be faxed prior to admission. MHP inpatient authorizations will incorporate both the facility and professional services. Contact the Managed Care Program Manager at (530) 886-5440.

EXCEPTIONS TO THE GENERAL AUTHORIZATION PROCESS

- Exception 1:** Professional services provided by psychiatrists and licensed psychologists to a beneficiary in a psychiatric hospital, defined ONLY as the daily visit of the attending professional do not need to be preauthorized. In instances where the payment for the bed day is retroactively denied, payment for the professional services delivered on the denied dates also will be denied, unless prohibited by a contract with the hospital.
- Exception 2:** Professional services provided by psychiatrists and licensed psychologists to adult beneficiaries placed in a long-term care facility (e.g., IMD, SNF) by Adult Systems of Care case managers will be authorized by those same case managers.

PHARMACY AND LAB SERVICES

Medi-Cal members may obtain their pharmacy benefits through the Fee-for-Service Medi-Cal program or their health plan if enrolled in a health plan. Members enrolled in health plans continue to obtain certain medications through the Fee-for-Service Medi-Cal program. Pharmaceutical Services for indigent members of the MHP can use their pharmacy benefits at private community pharmacies contracted with Placer County Health Services. This benefit is available only to financially eligible registered MHP members receiving authorized services from MHP providers. Medi-Cal members may obtain their laboratory benefits through the Fee-for-Service Medi-Cal program or their health plan if enrolled in a health plan.

III. MEMBER SERVICES / MEMBERS' RIGHTS

The MHP Guide to Medi-Cal Mental Health Services reminds members that they have the legal right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Receive information on available treatment options and alternatives, and have them presented in a manner that is understood.
- Participate in decisions regarding mental health care, including the right to refuse treatment.
- 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.
- Request and receive a copy of their medical records, and request that they be amended or corrected.
- Receive information about the services covered by the MHP, other obligations of the MHP, and consumer rights.
- Receive specialty mental health services from a MHP that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- Services are provided in a safe environment.
- The right to have an advance directive.

NON-DISCRIMINATION

A provider shall not discriminate against a member on the basis of the fact or perception of the member's race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, disability, AIDS/HIV status, and medical or mental health condition, unless such condition cannot be appropriately treated by provider.

ELIGIBILITY CATEGORIES

Placer and Sierra Counties have opted to provide a single Mental Health Plan (MHP) with comparable medically necessary services for Medi-Cal beneficiaries and indigent Placer and Sierra County residents, as resources allow. Eligibility for services is determined by the staff of the Adult Intake Services Line at (888) 886-5401 or Family & Children's Services Line at (866) 293-1940 before referral using the following guidelines.

- All Placer/Sierra County Medi-Cal beneficiaries are eligible for membership in the Placer/Sierra Mental Health Plan. A Placer/Sierra Medi-Cal beneficiary is any person certified as eligible for services under the Medi-Cal Program according to Section 51001, Title 22, Code of California Regulations whose beneficiary identification information includes Placer County code number 31 or Sierra County code number 46.
- In addition, the MHP is a safety net for Placer and Sierra County residents who do not possess insurance coverage or the personal means adequate to cover the cost of medically necessary mental health care. These individuals may receive necessary mental health services at MHP operated clinics, as resources are available.
 - Individuals who have no insurance will be charged under the State Uniform Method of Determining Ability to Pay (UMDAP) guidelines if their income is over poverty level.
 - Individuals who are under-insured (their insurance does not provide needed specialty mental health services) will be charged under the UMDAP guidelines if they receive medically necessary services through the MHP and their health payor will not pre-authorize the treatment.

- A child in special education whose Individual Education Plan (IEP) recommends mental health services are eligible for services.

MEMBER PROBLEM RESOLUTION PROCESSES

The Mental Health Plan (MHP) has established two policies and procedures for its members regarding grievances and appeals. Grievances are to express dissatisfaction while appeals are to contest a decision to reduce or terminate services. These are described in more detail in other sections of this manual.

It is essential that Network Providers read the policies and understand their role in informing their consumers about these processes. The primary goal is to ensure that members are provided with information and assistance in resolving grievances or appeals in a timely manner and at the earliest possible point of intervention. Network Providers are expected to ensure that they inform their consumers about the grievance and appeal procedures, including posting information as described in the policies.

Members may be assisted by the Patients' Rights Advocate at (530) 886-5419. The Patients' Rights Advocate will: 1) respond to questions and inquiries about the problem resolution processes for grievances and appeals, and 2) assist members and their family members with their specific grievances or appeals. Other persons may serve as representatives, such as family members or friends at the request of the consumer.

MEMBER GRIEVANCE PROCEDURE

Consumers shall be informed of their option to file a grievance if they are dissatisfied with the result of their informal attempts to resolve an issue. Consumers are not required to pursue any informal process for resolving issues before filing a grievance.

The person filing a grievance may obtain assistance from the Patients' Rights Advocate. Appeal/Grievance forms and self-addressed, postage-paid envelopes are available at the Network Providers' office or may also be obtained through the Patients' Rights Advocate.

Systems of Care/Patients' Rights Advocate
11716 Enterprise Drive
Auburn, CA 95603
(530) 886-5419

GRIEVANCE RESOLUTION PROCEDURES AND TIMEFRAMES

Grievances should be sent to the Office of Quality Improvement at the above address. The Patients' Rights Advocate will provide for a resolution of a beneficiary's grievance as quickly and as simply as possible. The Patients' Rights Advocate will ensure that the individuals making the decision on the grievance were not involved in any previous level of review or decision-making. If the grievance is regarding clinical issues, the MHP will ensure that the decision-maker has the appropriate clinical expertise, as determined by the MHP and scope of practice considerations, in treating the consumer's condition.

Within sixty (60) working days of receipt of a grievance, the Patients' Rights Advocate will review the grievance and provide a decision on the grievance. This timeframe may be extended by up to 14 days if the consumer requests an extension, or if the Mental Health Plan determines that there is a need for additional information and that the delay is in the consumer's interest.

A letter summarizing the decision on the grievance will be mailed to the consumer or the consumer's representative by the end of the timeframe in the above section. If unable to contact the consumer or his/her representative, documentation of the efforts to contact the consumer will be maintained.

APPEAL RESOLUTION PROCEDURES AND TIMEFRAMES

An appeal is any of the following:

- A request for review of an “Action”, which occurs when MHP does at least one of the following:
 - Denies or modifies payment authorization for a requested service, including the type or level of service,
 - Reduces, suspends, or terminates a previously authorized service,
 - Denies, in whole or in part, payment for a service prior to the delivery of the service based on the determination that the service was not medically necessary or not a covered service,
 - A request for review of a provider’s determination to deny, in whole or part, a Beneficiary’s request for a covered mental health service,
 - A request for review of a determination by the MHP or its providers that medical necessity, as defined in Title 9, CCR, does not exist.

The MHP will ensure that the individuals making the decision on the appeal were not involved in any previous level of review or decision-making and, if the appeal is regarding a denial based on lack of medical necessity, or is about clinical issues, ensure that the decision-maker has the appropriate clinical expertise, as determined by the MHP and scope of practice considerations, in treating the Beneficiary’s condition.

Within 45 working days of receipt of an appeal or 3 days for an expedited appeal, the MHP will review and provide a decision on the appeal. This timeframe may be extended by up to 14 days if the Beneficiary requests an extension, or if the Mental Health Plan determines that there is a need for additional information and that the delay is in the Beneficiary’s interest. (see Appendix V for additional details).

A letter summarizing the decision on the appeal will be mailed to the Beneficiary, the Beneficiary’s representative, and all other parties involved including the provider by the end of the timeframe in the above section. If unable to contact the Beneficiary or his/her representative, documentation of the efforts to contact the Beneficiary will be maintained.

NOTICE OF ACTION

Medi-Cal Beneficiaries may receive a Notice of Action. A Notice of Action (NOA) is a form given to a Beneficiary and provider when the Mental Health Plan (MHP) determines the Medi-Cal Beneficiary does not meet medical necessity; when the MHP denies or modifies payment authorization of a requested service; when the MHP denies payment for a service post-service delivery; when the MHP fails to act within the required timeframes for disposition of grievances, appeals, and expedited appeals; and when the MHP fails to provide services in a timely manner, as determined by the MHP. The purpose of the NOA is to advise the Medi-Cal Beneficiary of the action and to provide information on the Beneficiary’s right to appeal the decision via a State Fair Hearing. Members who are Medi-Cal Beneficiaries who receive a Notice of Action showing their services have been denied, reduced, or terminated may request a State Fair Hearing. This does not prevent Beneficiaries from using the MHP grievance and appeal procedures.

IV. PROVIDER NETWORK REQUIREMENTS

Placer/Sierra Mental Health Plan credentials or obtains the credentialing of three provider types:

- Hospitals and Skilled Nursing Facilities or Institutes for Mental Disease
- Organizational Providers
- Network Providers

PROVIDER STANDARDS

The MHP has set the following standards for providers:

- Completed appropriate education and experience in the theory and practice of psychotherapy
- Possess the necessary license (and DEA certificate for MD's) to practice psychotherapy independently in the State of California
- Maintain a safe facility and professional office setting:
 - Clearly visible signs identifying the space as a professional office
 - Clearly marked waiting area
 - Overall professional environment guaranteeing confidentiality
- Store, label, and dispense medications in compliance with all applicable state and federal laws and regulations
- Maintain consumer records in a manner that meet state and federal standards
- Have a good reputation among their professional colleagues
- Respond within a reasonable time to beneficiaries referred by MHP. Return non-urgent phone calls within one business day and offer an appointment within five business days of initial contact
- Assure that consumers in crisis can receive clinical support 24-hours a day, 7 days a week
- Have no unacceptable malpractice history
- Are in good standing in the Medicaid/Medi-Cal program
- Participate in MHP quality assurance activities as requested
- Participate in at least one Billing and Documentation training session per year
- Promptly disclose to the Provider Liaison any change in the status of their credentials
- Ability to demonstrate positive outcomes and cost-effectiveness as defined by MHP
- Maintain professional liability insurance of no less that \$1,000,000 per incident and \$3,000,000 aggregate
- Possess a valid CC Business Tax certificate if doing business in Placer/Sierra County
- Sign a Network Provider agreement with the County of Placer
- Shall not refuse a referral solely on the basis of age, sex, sexual orientation, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider

HOSPITALS AND SKILLED NURSING FACILITIES/INSTITUTES FOR MENTAL DISEASE (IMDs)

Hospitals and Skilled Nursing Facilities/IMDs must be licensed by the State Department of Health Services and meet national accreditation standards for staff qualifications. To participate in the MHP provider network, you must meet the state requirements.

ORGANIZATIONAL PROVIDERS

Organizational providers are certified by MHP and the State to deliver mental health services through Short-Doyle Medi-Cal clinics staffed by licensed mental health professionals and interns under licensed supervision. Organizational providers contracting with MHP must be certified for participation in the

Medi-Cal program by MHP. The MCU provides technical assistance in the process for Medi-Cal program certification and re-certification for MHP operated organizational providers and conducts the actual review and certification for contract organizational providers. If your program is new, moving, or otherwise changing significantly, recertification may be required. More information about this can be obtained by contacting the Provider Liaison at (530) 886-5463.

Commensurate with scope of practice and organizational MHP contracts, Mental Health Services may be provided by any of the following staff:

- Physician
- Licensed/registered Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Registered Nurse or Licensed Vocational Nurse
- Licensed Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Designated Mental Health Worker
- A registered ASW or MFT-I under the direct supervision of a licensed professional. For Network Providers, the Intern's supervisor must also be a Placer County MHP credentialed provider.

Commensurate with scope of practice, Medication Support Services may be provided by any of the following staff:

- Physician
- Registered nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Pharmacists

INDIVIDUAL NETWORK PROVIDERS

Psychiatrists, Psychologists, Licensed Clinical Social Workers, and Marriage and Family Therapists licensed for independent practice are eligible to participate as Network Providers. Network Providers must have valid California clinical licenses or be registered or license eligible with the Board of Behavioral Sciences. Registered/license eligible Interns will not be able to provide services for Medi-Cal beneficiaries, due to reimbursement rules.

The credentials of Network Providers must be verified before they can become members of the MHP Provider Network. Initial program requirements for Network Providers are that the practitioner must have a credentialing application and tax forms on file in the MCU to receive reimbursement for services provided to MHP beneficiaries. If the Provider is a registered/license eligible Intern, the Intern's supervisor must be willing to complete the credentialing process as well. The Intern's supervisor would then be issued a Provider Number and remittance for the Intern would be paid to their supervisor directly. The supervisor would then be responsible for payment to the Intern. Upon becoming licensed, an Intern must contact Placer County MCU to update their provider file. This would include updating service location address and contact information, new tax ID number, new insurance (if applicable), new billing address, copy of license, etc. The newly licensed individual will be issued a new provider number so payment may be made directly to the provider, and not their former supervisor. It is the responsibility of the Intern to contact Placer County to start this process. Any current authorizations written while the provider was an Intern will remain in force unless that provider contacts their case manager to amend the existing authorization to reflect an end date when the provider has become licensed, and a new authorization written for the same client to cover the remaining part of the original

authorization when the provider was an Intern, not licensed. If this does not occur, the provider's original authorization will remain in place and reimbursement granted at those previously agreed upon rates. Additionally, all Network Providers must submit a copy of their malpractice insurance policy indicating minimum coverage of \$1,000,000 per incident and \$3,000,000 aggregate. Credentialing is awarded after credentials are verified and have been reviewed and approved by the Provider Liaison and the MCU Program Manager. This process may take up to 3 days. If the application packet is incomplete or deficient, the Provider Liaison will contact the applicant to request the deficient documentation or information. This could delay the processing of the application.

The Placer/Sierra County MHP is responsible for selecting practitioners and defining policies and procedures that define the qualifications necessary to participate in its Provider Network. Membership in the Provider Network will be granted based on the results of a credentials verification process and a review of the practitioner's credentials against the MHP quality standards and the needs of its beneficiaries. You will receive a response to your application within 30 days of submitting a complete application to:

Provider Liaison/Managed Care Unit
11716 Enterprise Drive
Auburn, CA 95603
Voice: (530) 886-5463
Fax: (530) 886-5499

NETWORK PROVIDER STATUS

To maintain your status as a Network Provider it is your responsibility to inform the Provider Liaison whenever there is a change in your status and/or qualifications.

The Provider Liaison will review your credentials whenever your license expires to assure that you continue to meet the standards for membership in the Provider Network and whenever they receive a report that brings your credentials into question.

Prior to expiration of your professional license and or evidence of liability insurance coverage, you will receive an email requesting an updated copy of your license. This should be remitted to the MCU as soon as possible. This process will require that you update the credentials information you have on file with the Provider Relations Office. Criteria used for credentials review are designed to assess a practitioner's ability to deliver care that meets MHP standards. At the time of this credentials review, data derived from practice experience within the MHP may be used as part of the process of determining whether you will retain your membership in the Provider Network. This data may also include, but is not limited to, quality improvement findings, utilization review data, and client satisfaction survey results.

If there is no evidence on file with the Provider Relations Office that the Network Provider has a current license or current malpractice insurance, this could result in the loss of status as a Network Provider and payment for services by providers may be suspended by MHP. In addition, providers may lose MHP Network Provider status if the Provider Credentialing Committee finds that their credentials are compromised in a way that indicates they may not be qualified to provide services that meet MHP standards. A Network Provider's status may not be renewed if needs of MHP members have changed or the standards of the organization have changed and the practitioner is no longer able to meet these standards. Standards of documentation and record-keeping, in accordance with Medi-Cal regulations, will also be taken into consideration.

V. CLAIMS ISSUES FOR SERVICES PROVIDED

The Provider Liaison will work with the Network Providers with any suggestions, concerns, or problems to resolve these issues as quickly as possible.

Staff within the MCU will also attempt to identify and resolve provider concerns and problems quickly and easily. If the suggestion, problem or concern involves a claim, providers may submit an “informal appeal” of the denied claim to the MCU. A written response will be sent to the provider.

The MCU will keep a log of provider concerns or problems related to claims. The log will be part of the Network Provider Relations Committee process. The MHP will make every effort to resolve the issue within 14 days of receipt of all required materials.

Anytime before, during, or after calling the Provider Liaison or the MCU regarding the problem, a provider may use the appeal process described below.

PROVIDER COMPLAINT PROCESS FOR DENIED SERVICES

1. When treatment authorization is reduced or denied and the Network Provider disputes this determination, the MCU will review the complaint and respond within fourteen (14) days.

PROVIDER COMPLAINT PROCESS FOR CLAIMS PAYMENT

1. Providers who receive payment directly from EDS may file a written appeal concerning the denial or delay of claims payment for specialty mental health services directly to EDS. EDS will have thirty (30) days from the postmark or fax date of receipt of the appeal to respond in writing to the Network Provider.
2. Providers who receive payment directly from MHP may file a written complaint concerning the denial or delay of claims payment directly to the MCU.
3. The written complaint shall be submitted to the MCU within fourteen (14) days of the date of receipt of the denial or delay of the claims payment.
4. The complaint will be reviewed by the Provider Relations Office and respond to the provider in writing of the result within fourteen (14) days from the post mark or FAX date of receipt of the complaint.
5. If the complaint is upheld or partial payment is approved, MHP will process the claim for payment.
6. MHP may file a complaint regarding the processing or payments of its claim for services paid through the Short-Doyle/Medi-Cal system to the State Department of Mental Health.
7. This complaint process can be used by any residential treatment program provider.

Contact Person For All Provider Claims Issues:

Quality Improvement Coordinator/Systems of Care
11716 Enterprise Drive
Auburn, CA 95603
(530) 886-5440

GENERAL ASPECTS OF THE APPEAL/COMPLAINT PROCESS

Senior clinical staff from MHP, excluding the person who made the decision under dispute, will review appeals/complaints regarding treatment authorization. The written response from the MHP regarding the appeal/complaint shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision. A copy of the decision will be forwarded to the appropriate MHP case manager for appropriate action to be taken.

Appeals related to inpatient services will be reviewed by senior clinical, licensed staff. Appeals regarding inpatient claim decisions will be reviewed by the Mental Health Division’s Medical Director.

Denials upheld in the appeal process will be submitted to the Mental Health Division Director's designee(s) before a written response is made to the appellant. Hospital providers may appeal the MHP's denial of an appeal for payment Authorization of Emergency Services to the State Department of Mental Health. State regulations define an emergency psychiatric condition as one that requires voluntary or involuntary hospitalization and meets the criteria for medical necessity for psychiatric inpatient hospital services. Within thirty (30) days after receiving denial of an appeal for payment authorization of emergency services, a provider may file an appeal with the State Department of Mental Health. This process is described in Chapter 11, Title 9, Division 1, California Code of Regulations, Section 1850.305 Provider Problem Resolution and Appeal Processes and in the MHP Inpatient Psychiatric Utilization Review/Payment Authorization Plan.

VI. CLAIMS PROCESSING AND PAYMENT

This section describes the process for submitting a claim, including procedures and requirements for processing and payment of mental health service claims.

The MHP processes claims for authorized specialty mental health services provided to MHP members. Claims will come from Individual Licensed/Registered Network Providers, Organizational Providers, and Skilled Nursing Facilities/IMDs. Private hospitals will continue submitting their claims to Electronic Data Systems (EDS).

SUBMITTING A CLAIM TO MHP

Network Providers and Organizational Providers submit claims to the (MHP) Placer County HHS Centralized Accounts Payable and Payroll (CAPP) Unit for authorized mental health services rendered to plan members within sixty (60) calendar days after the date the authorized service was rendered. Network Providers and Organizational Providers must use the CMS 1500 Claim Form or the MHP Claim Form (**Appendix VII**) when submitting services for payment under the MHP.

Providers must use Current Procedural Terminology (CPT) and Common Procedure Coding System (HCPCS) service codes on their claims. Any claim submitted with a procedure code(s) other than the authorized service(s) may result in the claim being denied or in delay of payment.

Only specialty mental health services covered under the MHP and are prior-authorized will be paid. Emergency services do not require prior authorization. The MCU will adjudicate these according to State regulations and MHP rules. Claims for non-emergency services submitted to the MHP require an authorization number. The MHP will make its best efforts to process claims in a timely manner. Incomplete claims will be returned to the Provider for correction and resubmission.

The MHP does not generally authorize services or pay for individuals who are covered under both Medi-Care and Medi-Cal.

Network Providers and Organizational Providers should send claims and attachments, related forms, and documentation for authorized specialty mental health services to the following address:

HHS Fiscal Services (MSO)
CDRA Building
3091 County Center Dr Ste 290
Auburn, CA 95603

Please call the HHS CAPP Unit Provider Liaison at (530) 745-3111 to inquire about a claim submission. You will then receive a response about the status or disposition of the claim. When submitting paper claims, staple all claims for the same client together. Please enter all information within the designated field. Do not print, write, or stamp extraneous data on the form. Use only dark blue ink. If you are using a printer, please make sure the print is dark. Replace worn printer ribbons or toner. Review your claim form for completeness and readability before sending. Make sure the form is signed (by the Network Provider). This certifies the information contained on the claim is true and

accurate. Claims submitted to the CAPP Unit by Network Providers and Organizational Providers will be processed in as timely a manner as possible upon receipt of an accurately completed claim.

ATTESTATION

Individual providers and executive directors of contracted provider agencies participating in the Medi-Cal program are required to attest to their compliance with statutes (Title 9, California Code of Regulations Section 1840.112, "MHP Certifications of Claims and Program Integrity"), regulations, and contractual obligations by signing a form that correlates with one signed by the County. (Appendix VII)

There are options for Network Providers submitting claims to MHP:

1. Providers using the CMS 1500 Claim Form, by their signature in box 31 on each and every claim are certifying that the statements on the reverse side of the form are true and accurate. This is in addition to the Attestation signed as part of the provider credentialing process.

OR

2. *Providers not utilizing the CMS1500 claim form must have a statement attesting to the truthfulness and accuracy of the claim being submitted.*

Claims not submitted in one of these manners will be returned for resubmission.

UNPROCESSABLE CLAIMS

The following conditions may result in the rejection of the claim for processing or payment and the claim returned to the Network Provider:

- Prior authorization or timely notification (for urgent care services) requirement was not met
- Diagnosis listed is not covered under the Mental Health Plan
- Place of Service is not authorized or not covered under the MHP
- Service provided or the procedure code listed is not covered
- Provider of Service has not met MHP credentialing and contracting requirements
- Claim was submitted late. Claims must be submitted within sixty (60) days after the authorized service was rendered or they will be denied.
- Claim is for a Medi-Care covered beneficiary and should be submitted to EDS
- Claim is for a Medi-Cal beneficiary who was a resident of another county at the time services were rendered, unless pursuant to SB 785.
- Full scope Medi-Cal was not active for the date of service
- Share of Cost was not met for the month of service.

CLAIMS IN PENDING STATUS

Any claim items that require additional information are placed in "Pending" status. The Claim Examiner may attempt to get the missing information by contacting the provider directly if it is possible and reasonable to do so. Otherwise, the claim will be returned for correction and resubmission.

The provider should check the questionable data items identified on the returned claim form and make any necessary corrections or additions then return the corrected claim form to the HHS Fiscal Services (MSO), CDRA Building, 3091 County Center Dr Ste 290, Auburn, CA 95603. The corrected information will be processed. Providers have ten (10) calendar days from the date of the returned claim form to submit the missing or corrected information. Claims that are incomplete, illegible or otherwise cannot

be processed because of errors in completing the form will be returned to the provider with a letter citing the deficiency.

MEDICATION AND LAB SERVICES

As described in the Pharmacy section of this manual, the MHP will not pay for any prescription charges or laboratory tests for beneficiaries who are covered by Medi-Cal, whether through Fee-for-Service or those enrolled in a health plan. For MHP members who are not covered by Medi-Cal, the MHP will only pay for prescriptions and laboratory tests that are prescribed and dispensed according to the MHP Pharmacy Services guidelines and that are listed on the MHP Formulary. Some members who are referred to Network Providers may be required under State law to contribute to the cost of their services. A member's financial obligation is also known as either an "UMDAP" (Uniform Method of Determining Ability to Pay) liability or a Medi-Cal Share of Cost amount. Providers will be informed of the member's co-payment or UMDAP amount when the treatment authorization is issued. The MHP shall bill the patient or their responsible party for this amount.

VII. COORDINATION WITH HEALTH PLAN AND PRIMARY CARE PROVIDERS

Within the guidelines of MHP policies regarding confidentiality and release of information, MHP providers are expected to coordinate with other providers serving their consumers.

COORDINATION WITH PRIMARY CARE PROVIDER

MHP members who have Medi-Cal may be enrolled in either the Placer County Health Plan or Healthy Families for their health services and their pharmacy benefit. MHP provides the mental health benefit for these members, as resources allow.

ROLE AND RESPONSIBILITY OF PRIMARY CARE PHYSICIAN

The primary care physician is responsible for assessing patients for the possible occurrence of a mental disorder. The primary care physician is responsible for providing mental health treatment to his/her patients when the patients have uncomplicated mental health disorders. Patients who appear to require more intensive mental health services such as residential care, intensive case management, day treatment, etc., may be referred for more intensive services from the MHP and should contact their referring case manager. The primary care provider, in conjunction with the Network Provider, should contact the referring case manager for consultation in the following situations:

- The patient presents with a level of potential danger to self or others, or with an impairment of functioning which is beyond the clinical skill or experience of the referring primary care provider,
- OR**
- the mental health treatment provided by the referring primary care provider for the disorder has not produced adequate symptomatic improvement,
- OR**
- the existence, nature or proper treatment of the mental disorder is unclear to the referring primary care provider.

VIII. LEGAL REQUIREMENTS

PATIENTS' RIGHTS

As required by State law, the Placer/Sierra MHP investigates and resolves consumer complaints and infractions of mandated rights and trains staff in compliance with these rights. All providers are required to cooperate with patients' rights activities. The Placer/Sierra Guide to Medi-Cal Mental Health Services includes information regarding the MHP member's rights and responsibilities. The MHP requires that providers uphold these rights and responsibilities..

CONFIDENTIALITY/RELEASE OF INFORMATION

MHP Network Providers are expected to maintain consumer confidentiality under applicable state and federal law as it applies to beneficiary-psychotherapist privilege, mandated child/elder abuse reporting requirements, and disclosure of drug and alcohol program records.

LIABILITY INSURANCE

Network Providers will be required upon credentialing and re-credentialing to provide proof of professional liability and general liability insurance with limits of coverage \$1,000,000 per incident and \$3,000,000 aggregate. In rare instances, a provider may be preauthorized to conduct mobile therapy which involves travel to a client's home or another location, most often due to an exceptional clinical need. In these instances, that provider must also submit proof of automobile insurance.

CONSENT

Individuals receiving mental health services have the right to decide whether to participate in mental health services. The individual's consent must be freely given and can be expressed (oral or written) or implied (e.g., existence of a medical emergency). The MHP Consent for Mental Health Services form along with MHP consent policies should be used to document an individual's, or legal guardian's consent to participate in mental health services. Network Providers should utilize their own consent to treat forms.

SCOPE OF PRACTICE

MHP providers use treatment approaches based on accepted national standards of professional practice. Psychotherapeutic modalities must be generally accepted by national mental health and professional associations and recognized in professional journals and standard psychological/psychiatric references. Placer County embraces a wellness/recovery, strengths-based, short term model of therapy. Brief therapeutic modalities and evidence-based or promising practice methods are the preferred methodology. Long-term, insight oriented psychodynamic practices are discouraged in part due to ineffectiveness in providing short term stabilization and restoration of functioning

IX. MHP QUALITY MANAGEMENT PROGRAM

Below is a list of those functions that a Network Provider must perform as a requirement for participation in the MHP. Copies of all policies may be obtained by calling the Provider Liaison at (530) 886-5463.

INTRODUCTION

The MHP is committed to the provision of quality mental health services to all of its members. The Quality Management program (QM) is designed to assure the quality of clinical care as well as its availability, accessibility, and coordination. The Quality Management program is founded on the principles of continuous quality improvement. The structure and processes of the Quality Management program are described in detail in the MHP's Quality Management Plan. The structure of the Quality Management program is designed to satisfy regulatory and organizational requirements and to establish processes that will result in improved consumer care. The work of the QM is organized into quality improvement activities which are overseen by a quality improvement committee structure which reports directly to the local mental health director. These Quality Improvement processes are designed to obtain input from all stakeholders in the MHP. Consumers and family members participate at the highest level of quality management policy advisement in the Quality Improvement Committee (QIC). The following processes and indicators are used by the QM to review, evaluate, and plan improvements in care. Each of these indicators is regularly reviewed in the QM structure.

QUALITY OF CARE REPORTING SYSTEM

A critical function of Quality Management is to analyze risk data through various measures. All providers of mental health services are required to report certain quality of care concerns using prescribed procedures. Certain types of occurrences must be reported to the MHP immediately or as soon as practically possible. These include but are not limited to: violent behavior/assaults, physical sexual assault/misconduct, suicide attempts, medication issues resulting in severe adverse drug reactions, violation of professional code of ethics, client death, occurrences that require reports to licensing agencies, physical damage to facility caused by a client, accidents on-site resulting in serious injury and other occurrences which in your judgment threaten the welfare, safety, or health of a resident, visitor, volunteer, student, or employee. Such occurrences must be reported to the refereeing case manager who then reports to the Quality Improvement Committee. For questions about reporting requirements, contact the Quality Improvement Coordinator at (530) 886-5440.

DOCUMENTATION/PEER REVIEW

The appropriate QI committees shall have access to relevant clinical records to the extent permitted by state and federal laws. This function provides the QM with a process to review routine care at individual and system-wide levels. QI reviews are conducted on a sample of consumer cases using a standardized protocol to evaluate compliance with clinical standards and compliance with documentation requirements. The basis for the protocol is the state-mandated documentation requirement.

DOCUMENTATION AND SERVICE DELIVERY STANDARDS

The MHP expects Network Provider clinical files to contain a complete assessment, treatment plan, and progress notes which detail contact with consumers which are secured in a locked storage area that ensures safety and confidentiality. The MHP requires that all consumers will receive a comprehensive biopsychosocial assessment that includes at minimum the following areas:

ASSESSMENTS shall include:

- Identifying information
- Relevant physical health conditions reported by the consumer and updated as appropriate
- Presenting problems and relevant conditions affecting the consumer's physical/mental health status
- Consumer strengths in achieving consumer plan goals

- Special status situations that present a risk to the consumer or others and updated as appropriate
- Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Consumer self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities
- A mental health history including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports
- For children and adolescents, pre-natal and peri-natal events and complete developmental history shall be documented.
- Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs
- A relevant mental status examination
- A five-axis diagnosis from the most current DSM consistent with the presenting problems, history, mental status evaluation, and/or other assessment data
- An updated assessment is required every three years.

Whenever the assessment indicates a coexisting substance abuse or medical disorder, it is the responsibility of the provider to assure that appropriate collateral referrals are made. When concurrent medical problems are identified, providers should refer the consumer to, and coordinate ongoing treatment with, the primary care physician.

TREATMENT PLANS shall include:

- Specific, observable and/or specific quantifiable/measurable goals. Goals should be focused on successful completion within a 3-6 month timeframe.
- Proposed type(s) of intervention to meet these specified goals.
- Proposed duration of intervention(s) to meet these specified goals.
- Plans shall be consistent with the diagnosis, and the focus of intervention shall be consistent with the consumer plan goals, and there shall be documentation of the consumer's participation in an agreement with the plan..
 - The consumer signature on the plan as documentation of participation.
 - If consumer refuses or is unavailable for signature, the treatment plan shall include a written explanation of the refusal or unavailability.
 - A copy of the plan must be offered to the consumer. Be signed (or electronic equivalent) by:
 - The person providing the service(s)
 - The plan must be updated at least annually.

PROGRESS NOTES:

Items contained in the consumer record related to the consumer's progress in treatment include:

- Names of persons present for each service
- The number of minutes of service and the number of minutes of documentation time
- The date the service was provided

- The location of service
- Documentation relating to progress made toward the specified goals, and interventions utilized in achieving those same goals.
- Document consumer encounters including relevant clinical decisions and interventions
- Document referrals to community resources and other agencies, when appropriate
- The signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure
- The record shall be legible.
- Follow-up care, or as appropriate, a discharge summary

Treatment Approach

Placer/Sierra County MHP uses a short-term, solution focused, recovery oriented method of resolving acute psychiatric symptoms and ameliorating other problems identified by the consumer, as resources allow. Within this framework, the following provider requirements apply:

- Provides comprehensive assessment
- Identifies acute target symptoms
- Sets realistic, short term treatment goals
- Actively involves consumer in the formation of goals
- Sets goals within time frames, generally 3-6 months towards successful completion or stabilization
- Conveys appropriate expectations for assessment and treatment
- Provides treatment services of sufficient intensity and type to meet acute clinical needs
- Coordinates with other healthcare and social service providers as necessary
- Makes appropriate termination plans to include integration into their community with natural supports

CHART AUDITING

Client records are subject to MHP Audit. All Network Providers both active and inactive that have provided behavioral health services to Placer County beneficiaries will be subject to auditing. Medi-Cal regulations govern these auditing practices. Each fiscal year, a minimum of 5% percent of the total Medi-Cal beneficiaries' medical records are required to be audited. Network Providers will be randomly selected for audit. Following the audit, the provider will receive a letter either stating successful completion of the audit or a request for corrections. Requested corrections will be required within 30 days of notice of corrections. Copies of missing progress notes will be required prior to approval of corrections. Failure to provide corrections or copies of deficient progress notes may result in termination from the provider network. Treatment records must be maintained for seven (7) years or the minimum period required by applicable state and federal law.

Client records are also subject to a state EPSDT audit. If the Placer County MCU is notified by the State of an upcoming audit, the MCU will immediately request the delivery of specified files to our offices. These specified files must be delivered as soon as possible, not to exceed two (2) business days to our offices. Provider files are expected to be in compliance with Medi-Cal regulations at all times. Failure to provide files in a timely manner or to be out of compliance with Medi-Cal regulations may result in termination from the provider network, as well as repayment for disallowed claims.

Professional Office Standards

MHP providers deliver services in a professional office setting with the following minimum requirements:

- Clearly visible signs identifying the space as a professional office
- A clearly marked waiting area
- Overall professional environment guaranteeing confidentiality
- The visible and accessible posting of all required informing materials, including envelopes

Consumer Satisfaction

At county run clinics and contract programs, adult consumers are given Consumer Satisfaction Measures twice a year during a two-week administrative period. This data is submitted to the State Department of Mental Health (DMH) under DMH mandate. Network and Organizational Providers have the opportunity to complete satisfaction measures annually as part of the overall QI activity.

Performance Review

Contracts with all Organizational Providers clearly outline quality improvement expectations and functions. Assurance and compliance with these same such functions is also the responsibility of the Network Provider. A periodic program or site review includes an evaluation of the Organizational/Network Provider's quality improvement work.

PLACER/SIERRA MENTAL HEALTH PLAN REQUIREMENTS

All MHP Providers must:

- Be in good standing with the Medicaid program
- Have ability and willingness to serve beneficiaries with severe and persistent mental illness and/or children with serious emotional disturbances
- Have ability and work with beneficiaries and their families in a collaborative and supportive manner
- Provide a voice mail greeting which should refer consumers to 24/7 emergency telephone numbers
- Assure consumer callback within three (3) business days for routine matters
- Offer an appointment within ten (10) business days
- Participate in at least one Placer County sponsored training meeting a year
- Ensure they are up to date with current Federal and State statutes and regulations including Medi-Cal requirements, and applicable Placer County policies and procedures
- Disclose circumstances and outcomes of any current or previous litigation of a clinical nature
- Have ability to demonstrate positive outcomes and cost-effectiveness as defined by the MHP
- Invoice Placer/Sierra County for services rendered using the published rate of pay, unless performing pre-approved other services that have a rare exception rate.
- Ensure Placer/Sierra County beneficiaries will receive the same level of services as provided to all other clients.
- Ensure that beneficiaries will not be discriminated against in any manner.

APPENDIX I — PROVIDER CERTIFICATION

As a part of the Network or Organizational Provider certification requirements the Placer/Sierra Mental Health Plan will verify through an on-site review the following:

- The Network or Organizational provider possesses the necessary clinical license/registration, business license or tax ID number, and MHP required certification.
- The spaced owned, leased or operated by the provider and used for services or staff meets local fire codes.
- The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary and in good repair.
- The provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well being of beneficiaries and staff.
- The provider maintains client records in a manner that meets all applicable state Medi-Cal regulations and federal standards.
- If applicable, the provider has staffing adequate to allow claiming federal financial participation for the services delivered to beneficiaries as described in Title 9.
- The provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
- The provider has, as a head of service, a licensed mental health professional or other appropriate individual as described in Title 9.
- All Patients' Rights posters, brochures, and Appeal/Grievance forms, including envelopes, are available on the provider site, easily visible and accessible to clients, and in all Placer/Sierra threshold languages (currently English and Spanish).
- For Organizational providers that provide or store medication, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
 - All drugs obtained by prescription are labeled in compliance with federal and state laws. Only persons legally authorized to do so shall alter prescription labels.
 - Drugs intended for external use only or foodstuffs are stored separately from drugs for internal use.
 - All drugs are stored at proper temperatures, room temperature drugs at 59-86 degrees F and refrigerated drugs at 36-48 degrees F.
 - Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense, or administer medication.
 - Drugs are not retained after the expiration date. IM multi-dose vials are dated and initiated when opened.
 - A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated, and abandoned drugs in a manner consistent with state and federal laws.
 - Policies and procedures are in place for dispensing, administering, and storing medications.
- For Organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that is in compliance with State requirements for Day Treatment Intensive and Day Rehabilitation Programs.

- When on-site review of an Organizational Provider is required, the MHP will conduct an on-site review at least once every three years. Additional certification review of an Organizational Provider may be conducted if:
 - The provider makes major staffing changes
 - The provider makes organization and/or corporate structure changes
 - The provider adds day treatment or medication support services when medications shall be administered or dispensed from the provider site
 - There are significant changes in the physical plan of the provider site
 - There is a change of ownership or location
 - There are complaints regarding the provider
 - There are unusual events, accidents, or injuries requiring medical treatment for consumers, staff, or members of the community.

Network Providers are also subject to on-site review. This occurs during the Network Provider chart auditing process; additional reviews may occur due to unusual occurrences or complaints lodged against the provider.

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APPENDIX II — CREDENTIALING INDIVIDUAL AND GROUP PROVIDERS

INITIAL APPLICATION PROCESS

Individual providers must submit the following information regarding their credentials to the MHP Office of Provider Services:

Credentialing Application and California Participating Physician Application, if applicable. This includes attestation that the application is complete and correct and provides for disclosure of any of the following:

- illegal drug use
- alcohol or other dependency problems ,
- physical or mental health problems, which impair ability to practice within the scope of privileges,
- censured, restricted, suspended or revoked hospital privileges,
- denial of a medical license or certification by a specialty board,
- convicted of a crime other than a minor traffic moving violation,
- convicted of a felony or pled guilty to any crime relating to profession,
- documented charges by Medicare/Medicaid,
- professional liability been denied, canceled or not renewed,
- judgments, settlements, or cases pending,
- business interest or an investment as an owner or general partner in any clinic, laboratory, diagnostic testing center, hospital, or other business dealing with the provision of ancillary health services, equipment or supplies.

Other required documentation for the application packet includes:

- Photocopies of California License,
- Certificate of graduation from accredited program,
- National provider Index (NPI) number and taxonomy code,
- Malpractice Face Sheet,
- DEA Certification,
- Board Certification,
- Curriculum Vitae with Work History and Education History,
- Placer County Payee Data Record and 590 Tax Withholding Form,
- Professional references from two licensed practitioners,
- Declaration & Release of Credentialing Information.
- Also required is certification of training curriculum for specialty area(s) if provider declares specialties on provider application.

MAINTENANCE OF CREDENTIALS

Providers will be asked to submit proof of current insurance every time their professional liability and general liability insurance expires. Psychiatrists will be asked for a copy of their new DEA certificate when their certificate expires.

Providers are required to notify the Provider Services Office whenever the status of their license changes

DELEGATION OF CREDENTIALING AND RE-CREDENTIALING VERIFICATION

The Placer/Sierra Mental Health Plan maintains responsibility for the verification of provider's credentials. The Provider Credentialing committee is responsible for recommendation of credentialing and re-credentialing, and with the assistance of an Information Technology Technician, maintenance of current credentialing information. Applicants that are former employees of Placer County may apply for credentialing and must indicate this former status on the provider application. These individuals are eligible for provider status only if they have separated from Placer County voluntarily. In such instances in which there was a voluntary separation, but Placer County personnel believes there is a substantial risk to clients or the county by credentialing as a provider after consultation with the Personnel Department and county counsel, the applicant may be denied.

Credentialing may also be accepted from another county mental health plan for providers who reside outside of Placer and Sierra Counties. This credentialing acceptance occurs only after a review of the organization's credential verification policy to ensure that it is sufficient and meets Placer/Sierra Mental Health Plan standards.

A Provider may also be recommended for de-credentialing. De-credentialing may be recommended in instances when the provider does not provide up-to-date license and insurance information; when they do not respond to requests for documentation review and/or improvement; when guidelines for clinical care are not followed, when reauthorizations are consistently requested late or when there is a consistent inability to provide appropriate documentation per regulation. A final decision regarding de-certification will be made by the Provider Credentialing Committee after the provider has been notified in writing and given an opportunity to ameliorate the situation.

APPENDIX III — MEDICAL NECESSITY CRITERIA FOR THE PLACER/SIERRA MENTAL HEALTH PLAN

Covered Services must meet criteria listed in each section below:

A. Diagnosis

Must have one of the following DSM-IV-TR/ICD-9 diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

1. Pervasive Developmental Disorders, except Autistic Disorder
2. Attention Deficit and Disruptive Behavior Disorders
3. Feeding & Eating Disorders of Infancy or Early Childhood
4. Elimination Disorders
5. Other Disorders of Infancy, Childhood, or Adolescence
6. Schizophrenia & Other Psychotic Disorders
7. Mood Disorders
8. Anxiety Disorders
9. Somatoform Disorders
10. Factitious Disorders
11. Dissociative Disorders
12. Paraphilias
13. Gender Identity Disorders
14. Eating Disorders
15. Impulse-Control Disorders Not Elsewhere Classified
16. Adjustment Disorders
17. Personality Disorders, excluding Antisocial Personality Disorder
18. Medication-Induced Movement Disorders related to other included diagnoses

Excluded Diagnoses:

1. Mental Retardation
2. Dementia
3. Organic Brain Syndrome
4. Learning Disorders
5. Motor Skills Disorder
6. Communication Disorders
7. Autistic Disorder Other Pervasive Developmental Disorders are included.
8. Tic Disorders
9. Delirium, Dementia, and Amnestic and Other Cognitive Disorders

10. Mental Disorders Due to a General Medical Condition
11. Substance-Related Disorders
12. Sexual & Gender Identity Disorders, except Paraphilias and Gender Identity Disorders in Children which are included
13. Sleep Disorders
14. Antisocial Personality Disorder
15. Other Conditions That May Be a Focus of Clinical Attention, except Medication Induced Movement Disorders which are included.

B. Impairment Criteria

Must have at least one of the following impairments as a result of the mental disorder(s) identified in the diagnostic criteria above:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

C. Intervention Related Criteria

Must meet all conditions listed below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, and
 2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate, and
 3. The condition would not be responsive to physical healthcare-based treatment.
2. In addition, clients who will receive services in the Adult System of Care must meet Priority Population criteria. This criteria was developed to target intensive services to the most severe and chronic adult population of consumers. Clients who do not meet these criteria may still be served in the Managed Care Behavioral Health Unit if they meet medical necessity criteria, and may be authorized to a Network Provider for short-term treatment.

APPENDIX IV — MENTAL HEALTH CONSUMER GRIEVANCE PROCEDURES

I. PURPOSE:

The purpose of this Consumer Grievance Policy is to:

- A. Promote consumer access to medically necessary, high quality, consumer-centered mental health services by responding to consumers' concerns in a sensitive and timely manner.
- B. Provide consumers with an easily accessible, problem resolution process for resolving issues whenever possible.
- C. Provide consumers with an easily accessible, grievance resolution process.
- D. Protect the rights of consumers during the grievance process.
- E. Monitor, track, and analyze consumer grievances.

II. REFERENCES:

Title 42, CFR, Chapter P/, Subchapter C, Part 438, subpart F. Refer to Placer/Sierra Mental Health Plan—GUIDE TO MEDI-CAL MENTAL HEALTH SERVICES.

III. POLICY:

- A. The Mental Health Plan shall maintain written procedures for tracking, addressing and resolving consumers' grievances.
- B. All consumers receiving or seeking mental health services shall be informed of the procedures involving grievance resolution.
- C. All consumers receiving mental health services shall be informed of their rights to access the Patients' Rights Advocate assistance during the grievance process.

IV. AUTHORITY/RESPONSIBILITY:

Mental Health Quality Improvement Coordinator
Program Directors
Program Managers
Program Supervisors
Credentialed Network Providers
Patients' Rights Advocates

V. PROCEDURE:

- A. Informing the Consumer of the Grievance Processes
 - 1. A consumer of mental health services shall be informed, via the Guide to Medi-Cal Mental Health Services and posted notices of the process for the reporting and resolution of grievances.
 - a) Every effort shall be made to provide the written procedures for reporting and resolving grievances to each consumer during the initial assessment.

- b) Consumers shall receive grievance procedure information, through written or verbal means, upon request during the provision of services.
- c) Each county direct service provider facility (inclusive of contracted organizational providers) shall exhibit all of the following in a visible, public area:
 - (1) Signs describing consumer grievance procedures;
 - (2) Signs referring to the Guide to Medi-Cal Mental Health Services;
 - (3) Grievance Request and Change of Provider forms. These forms must be made available without the client having to ask anyone for them;
 - (4) Self-addressed postage-free envelopes for consumers to use for submitting grievances.
- d) The following Informing Materials are mailed to the consumer by the Managed Care Behavioral Health Unit;
 - (1) Guide to Medi-Cal Mental Health Services;
- e) Consumers are encouraged to pursue an informal process for resolving issues; they shall be informed of their option to file a grievance at any time they are dissatisfied about any matter other than those covered by an appeal, as defined below. Consumers are not required to pursue any informal process for resolving issues before filing a grievance.

An appeal is defined as a request for review of an action which denies, reduces, suspends or terminates a previously authorized service.
- f) Consumers shall be informed of their right to request and receive, at no charge, assistance from a Patients' Rights Advocate at each step in the grievance process: Contact the Patients' Rights Advocate at (530) 886-1859 (collect calls accepted).
- g) Twenty-four (24) hour a day telephone access to grievance information and assistance shall be provided to consumers by calling the Patients' Rights Advocate (530) 886-5419 or the Adult Intake Services line which is (888) 886-5401.
- h) In addition to English, consumer grievance information shall be posted and made available to consumers in Spanish. The AT&T Language Line and other contracted translation services shall be made available and utilized for additional language and translation needs.

B. Filing Grievances (*Consumer Role*)

- 1. Consumers or their representatives may either report a verbal or file a written grievance.
 - a) Consumers may report a verbal grievance to the Patients' Rights Advocate or any mental health services staff.
 - b) Consumers or their representatives may file a written grievance at any time. Consumers file a written grievance by completing the Appeal/Grievance form. Assistance in writing the grievance is available through the Patients' Rights Advocate. Requests for grievance reviews may be deposited at any county location. Postage-paid envelopes are provided at all county facilities and provider locations. The may be sent to:

Placer County Systems of Care
 Attn: Quality Improvement Coordinator
 11716 Enterprise Drive
 Auburn, CA 95603

C. Submission of Grievances (*Staff Role*)

1. The Patients' Rights Advocate, any mental health staff, or Network Provider shall offer the consumer aid in filing a grievance. Consumers will be assisted and responded to in their primary language, either through written or verbal communication, as appropriate.
2. Grievances received by providers or program staff shall be submitted to the QI Coordinator at:

Placer County Systems of Care
Attn: Quality Improvement Coordinator
11716 Enterprise Drive
Auburn, CA 95603

D. Processing of Grievances

1. A centralized log will be maintained for all grievances. This log shall contain at least the following:
 - a) Name of consumer,
 - b) Date of receipt of the grievance,
 - c) Date acknowledgment of receipt sent,
 - d) Nature of the problem,
 - e) Final disposition of a formal grievance,
 - f) Date written decision sent to consumer, or
 - g) Documentation of the reason(s) that there has not been final disposition of the grievance.

Grievances will be recorded in the log within one working day of the date of receipt of the grievance.

2. The Quality Improvement Coordinator shall be the primary person responsible for tracking, reporting and monitoring consumer grievances. Responsibilities include:
 - a) Ensuring that procedures are implemented to inform consumers of how to initiate a grievance
 - b) Reviewing grievances for resolution in a timely manner
 - c) Reporting grievances to the Quality Improvement Committee
 - d) Monitoring actions taken to resolve grievances

VI. GRIEVANCE RESOLUTION PROCEDURES AND TIMEFRAMES

- A. The Quality Improvement Coordinator will provide for a resolution of a consumer's grievance as quickly and as simply as possible.
- B. The Quality Improvement Coordinator will insure that the individuals making the decision about the grievance were not involved in any previous level of review or decision-making. If the grievance is regarding clinical issues, the Quality Improvement Coordinator will ensure that the decision-maker has the appropriate clinical expertise, as determined by the MHP and scope of practice considerations, in treating the consumer's condition.
- C. Within sixty (60) working days of receipt of a grievance, the Quality Improvement Coordinator will review the grievance and provide a decision on the grievance. This timeframe may be extended by up to 14 days if the consumer requests an extension, or if the Mental Health Plan determines that there is a need for additional information and that the delay is in the consumer's interest.

- D. A letter summarizing the decision on the grievance will be mailed to the consumer or the consumer's representative by the end of the timeframe in the above section. If unable to contact the consumer or his/her representative, documentation of the efforts to contact the consumer will be maintained.

VII. OTHER OPERATING PRINCIPLES

All grievance procedures shall ensure the confidentiality of consumer records as defined by State and Federal law. Consumers shall not be subject to any discrimination, penalty, sanction, or restriction for filing a grievance. Rights of a Network Provider who is the subject of a grievance: When a concern regarding a Network Provider's practices or performance is identified as a result of a complaint or grievance, the concern shall be addressed in accordance with Placer County Personnel Policies and Program or Administrative Procedures.

DRAFT

APPENDIX V — OUTPATIENT MENTAL HEALTH CONSUMER APPEAL AND EXPEDITED APPEAL PROCEDURES

I. PURPOSE:

The purpose of this Consumer Appeal and Expedited Appeal Policy is to:

- Define the process by which Beneficiaries can request a review of a decision by the MHP which denies, reduces, modifies, or terminates covered specialty mental health services,
- Ensure that Beneficiaries are informed of the appeal process,
- Describe the roles and processes in the resolution of appeals,
- Protect the rights of Beneficiaries during the appeal or expedited appeal processes.

II. REFERENCES:

Title 42, CFR, Chapter IV, Subchapter C Part 438, Subpart F
Title 9, CCR Section 1830 205(b) 1, (b)2, (b)3C,
DMH Letter 05-03 Placer/Sierra Mental Health Plan

III. POLICY:

- The MHP shall maintain procedures for tracking and processing appeals in a timely manner.
- All Beneficiaries receiving or seeking mental health services shall be informed of the procedures for filing an appeal.
- The MHP will ensure that the individuals making the decision about the appeal were not involved in any previous level of review or decision-making and, if the appeal is regarding a denial based on lack of medical necessity, or is about clinical issues, ensure that the decision-maker has the appropriate clinical expertise, as determined by the MHP and scope of practice considerations, in treating the beneficiary's condition.
- All Beneficiaries receiving mental health services shall be informed of their rights to access Patients' Rights Advocate assistance during the appeal process.

IV. DEFINITIONS

A. Appeal - An appeal is any of the following:

1. A request for review of an Action, as defined in "B" below,
2. A request for review of a provider's determination to deny, in whole or part, a Beneficiary's request for a covered mental health service,
3. A request for review of a determination by the MHP or its provider that medical necessity has not been identified, as defined in Title 9, CCR.

B. Action - An Action occurs when at least one of the following is done:

1. Denies or modifies payment authorization for a requested service, including the type or level of service,
2. Reduces, suspends, or terminates a previously authorized service,
3. Denies, in whole or in part, payment for a service post-service delivery based on the determination that the service was not medically necessary or not a covered service,
4. Fails to provide services in a timely manner, as determined by the MHP,

5. Fails to act within the timeframes for the resolution of standard grievances or appeals, or expedited appeals.

V. AUTHORITY/RESPONSIBILITY:

Mental Health Quality Improvement Coordinator

Utilization Review Coordinator

MHP Authorizers

Program Directors

Program Managers

Program Supervisors

Patients' Rights Advocate

Network Providers

V. PROCEDURE:

- A. General: To ensure that Beneficiaries have adequate information about the MHP's appeal processes, the following will occur:
 1. Consumers of mental health services shall be informed, via the Guide to Medi-Cal Mental Health Services, of the appeal and expedited appeal processes.
 2. Notices shall be posted explaining the appeal process in all County and Network Provider sites. This will be sufficient to ensure that the information is available to both Beneficiaries and provider staff. Appeal information may be included with posted information regarding other Beneficiary problem resolution processes such as grievances and provider change requests.
 3. Self-addressed postage-free envelopes for consumers to use for submitting grievances.
 4. Whenever possible, programs will make available Navigators, Friend and Family Coordinators, Youth Advocates, and/or Family Advocates to assist in the filing of appeals.
 5. Beneficiaries shall be informed of their right to request and receive, at no charge, assistance from a Patients' Rights Advocate at each step in the appeal process. Consumers may contact the Patients' Rights Advocate at (530) 886-5419. (Collect calls accepted)
 6. In addition to English, beneficiary appeal information shall be posted and made available to beneficiaries in Spanish.
 7. The Language Line and other contracted translation services shall be made available and utilized for additional language and translation needs.
- B. Filing Appeals (Beneficiary Role)
 1. Beneficiaries or their representatives may file an appeal orally or in writing. Standard oral appeals must be followed-up with written, signed appeals. The MHP will use the time that the oral appeal was filed to establish the earliest possible filing date.
 2. The written appeal should be sent as soon as possible after the oral appeal, but must be sent within 45 days or no decision will be made by the QI Coordinator regarding the action. The Patients' Rights Advocate is available to assist consumers with appeals. The Patients' Rights Advocate is familiar with the Problem Resolution Process and can assist Beneficiaries by answering general questions about the process and assisting in the completion and/or submission of related forms. Beneficiaries may file a verbal or written appeal to the Patients' Rights Advocate, or any mental health services staff, verbal appeals

may also be made by calling the MCU at (530) 886-5400. Written appeals should be sent to:

Placer County Systems of Care
Attn: Patients' Rights Advocate
11716 Enterprise Drive
Auburn, CA 95603

3. Beneficiaries may request a State Fair Hearing but must exhaust the local appeal process prior to filing for a hearing.
4. Beneficiaries may present evidence and allegations of fact or law, in person or in writing.
5. The Beneficiary and/or his or her representative may examine the Beneficiary's case file, including medical records, and any other documents or records considered during the appeal process before and during the appeal process.
6. The Beneficiary and/or his or her representative, or the legal representative of a deceased Beneficiary's estate may be included as parties to the appeal.
7. An expedited review process for appeals may be requested when the Beneficiary and/or the provider determines that taking the time for a standard resolution could seriously jeopardize the Beneficiary's life, health or ability to attain, maintain, or regain maximum function.

C. Processing of Appeals (*Staff Role*)

1. The Patients' Rights Advocate, or any mental health staff, shall offer the Beneficiary aid in filing an appeal or writing a request for an appeal. The Patients' Rights Advocate can assist Beneficiaries by answering general questions about the process and assisting in the completion and/or submission of related forms.
2. Beneficiaries will be assisted and responded to in their primary language, either through written or verbal communication, as appropriate
3. The Patients' Rights Advocate, any county staff, or Network Provider receiving a verbal or written request for appeal shall be responsible for communicating the appeal request to the QI Coordinator.
4. Verbal appeals may be made by calling the MCU at (530) 886-5400. Written appeals should be sent to:

Placer County Systems of Care
Attn: Patients' Rights Advocate
11716 Enterprise Drive
Auburn, CA 95603

5. The QI Coordinator shall maintain a secure, confidential appeal log. Appeals shall be recorded within one working day of the date of receipt of the appeal. An acknowledgement of receipt letter shall be sent to the beneficiary.
6. The log entry shall include but not be limited to:
 - a) The name of the Beneficiary,
 - b) The date of receipt of the appeal,
 - c) The date that the acknowledgement was sent,
 - d) The nature of the problem,
 - e) The date of the final disposition,
 - f) The final disposition,
 - g) The date the notice of the final disposition was sent to the Beneficiary,

h) The date the notice of the final disposition was sent to the involved provider.

D. Notification and Timelines

1. Standard Appeal - The QI Coordinator will provide for a decision on a standard appeal and provide written notification to the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days if the Beneficiary requests an extension, or the QI Coordinator determines that there is a need for additional information and that the delay is in the Beneficiary's interest.
 - a) If the MHP fails to notify the affected parties of the appeal decision within the above timeframes, a Notice of Action will be provided to the Beneficiary advising the Beneficiary of the right to request a fair hearing. The MHP shall provide the notice of action on the date that the timeframe expires.
2. Expedited Appeal - In the event of an expedited appeal, the resolution decision and notification of the affected parties in writing of that decision will occur within three working days after the MHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the Beneficiary requests an extension, or the MHP determines that there is need for additional information and that the delay is in the Beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the enrollee, give the Beneficiary written notice of the reason for the delay. If the MHP denies a request for expedited resolution of an appeal, the MHP shall:
 - a) Transfer the appeal to the timeframe for standard appeal resolution; and
 - b) Make reasonable efforts to give the Beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process, and follow up within two calendar days with a written notice.
3. If the appeal decision rendered by the MHP is not wholly in favor of the Beneficiary, the written notification of the decision shall include the following:
 - a) notice to the Beneficiary that he/she has the right to file a State Fair Hearing (SFH),
 - b) instructions on how to file a request for a SFH,
 - c) his/her right to request Aid Paid Pending while the SFH is pending and how to make that request.
4. To the extent required by State and Federal regulations, no actions shall be taken to change, reduce, or terminate a service during the State Fair Hearing process unless continuing the disputed treatment or service may be injurious to the consumer or to others.

E. State Fair Hearing

1. Upon intake and as appropriate, Medi-Cal Beneficiaries of any Placer or Sierra County Mental Health Service shall be informed of their right to request a State Fair Hearing. An individual may request a State Fair Hearing when there has been a denial of service, reduction of service (frequency, level of care, etc), or termination of service. However, Beneficiaries are required to exhaust the MHP appeal process prior to filing for a State Fair Hearing.
2. Beneficiaries requesting a State Fair Hearing shall be informed of their right to assistance from a Patients' Rights Advocate.
3. Confidentiality - Appeal procedures shall ensure the confidentiality of Beneficiary records as defined by State and Federal laws.
4. Discrimination - Beneficiaries shall not be subject to any discrimination, penalty, sanction, or restriction for filing an appeal or from requesting an expedited appeal.

APPENDIX VI — CREDENTIALING PROCESS

The credentialing application can be found on the Placer County Managed Care website at the following URL:

<http://www.placer.ca.gov/Departments/hhs/Managed%20Care/ManagedCareForms.aspx>

Complete the Application and return it with all required documentation as soon as possible. If a question is not applicable, enter NA. Please attach a copy of the following documents with your application:

- Photocopy of your current California license to practice and DEA Certificate (if applicable, with an expiration date clearly visible on the copy)
- Proof of professional liability insurance coverage indicating limits of coverage and expiration date (photocopy of Certificate of Insurance with \$1,000,000 per incident and \$3,000,000 aggregate) and general liability insurance with the same limits of coverage.
- Completed Placer County Payee Data Record and CA 590 Tax Withholding Form (attached to application)
- A list of continuing education programs attended over the last 24 months and credits received, including Annual Professional Society certification when possible
- Your National Provider Identifier number. You may apply for this number at the following URL:

www.npienumerator.com

If there is more information you wish to communicate, you may submit a curriculum resume, which includes education, post-graduate training, professional experience, credentials and professional memberships.

Mail your application and all attachments to the following address:

Systems of Care – Managed Care Behavioral Health Unit
Attn: Network Provider Liaison
11716 Enterprise Drive
Auburn, CA 95603

Network Providers who wish to be inactivated on the Provider List are required to submit a written request to the Provider Liaison asking to be placed inactive as a provider:

Placer County Systems of Care
Attn: Network Provider Liaison
Managed Care Behavioral Health Unit
11716 Enterprise Drive
Auburn, CA 95603

This request may be faxed to the following number: (530) 886-5499. Questions regarding the Credentialing Process should be addressed to Provider Liaison — Phone: (530) 886-5463.

APPENDIX VII — CLAIMS AND PAYMENT

CLAIMS AND PAYMENTS

All claims are to be submitted on the CMS 1500 billing form. Mail claims monthly to:

HHS Fiscal Services (MSO)
CDRA Building
3091 County Center Dr Ste 290
Auburn, CA 95603

OUTPATIENT CLAIM FORM — CMS 1500

ALL CLAIMS MUST BE SUBMITTED WITHIN 60 DAYS OF SERVICE.

- The required boxes to complete on the CMS 1500 are as follows:
 - 1a. Patient's identification #
 - Patient's name
 - Patient's DOB
 - 17b. NPI# (National Provider Identifier)
 - 21. Diagnosis (ICD-9)
 - 23. Current authorization number
 - 24a. Dates of service
 - 24d. State CPT code
 - 24f. Charges
 - 24g. Units in minutes
 - 25. Federal tax I.D. number
 - 28. Total charges
 - 31. Network Provider Signature (**blue ink only**)
 - 32. Location where services were provided
 - 33. Network Provider's billing name, address, Zip Code, and phone number

ALL OTHER BOXES ARE **NOT** REQUIRED FIELDS.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP <input type="checkbox"/> (SSN or ID) HEALTH PLAN FECA <input type="checkbox"/> (SSN) BLK LUNG OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					7. INSURED'S ADDRESS (No., Street)				
ZIP CODE					TELEPHONE (Include Area Code) ()					CITY					STATE				
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
23. PRIOR AUTHORIZATION NUMBER _____										23. PRIOR AUTHORIZATION NUMBER _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ _____									
29. AMOUNT PAID \$ _____										30. BALANCE DUE \$ _____									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____									
33. BILLING PROVIDER INFO & PH # ()										33. BILLING PROVIDER INFO & PH # ()									

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bill.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1996, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0099. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. **DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.**

Schedule of Contracted Rates Using Standardized CPT/HCPCS Codes

Effective July 1, 2012

CPT CODE	DESCRIPTION	UNIT OF SERVICE	RATE PER UNIT
90801	Assessment	Minute	Licensed - \$1.00/minute Intern - .80¢/minute
90806	Individual Therapy	Minute	Licensed - \$1.00/minute Intern - .80¢/minute
90812	Interactive Individual Therapy	Minute	Licensed - \$1.00/minute Intern - .80¢/minute
90846	Family Therapy (without client present)	Minute	Licensed - \$1.00/minute Intern - .80¢/minute
90847	Family Therapy (with client present)	Minute	Licensed - \$1.00/minute Intern - .80¢/minute
90887	Collateral	Minute	Licensed - \$1.00/minute Intern - .80¢/minute
90853	Group Psychotherapy	Group	Licensed - \$36.00 per session/per client For the purposes of billing \$36.00 per session includes Setup, Cleanup and Documentation time.
90862	Medication Support (M.D. Only)	Minute	\$1.17/minute

APPENDIX VIII — PLACER/SIERRA MHP MEDI-CAL ATTESTATION FORM

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services for the provider named below; that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606 and 438.608; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. I agree and shall certify under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the provider listed below. The services were, to the best of my knowledge, provided in accordance with the clients' written treatment plans. I also certify that all information submitted to the Department is accurate and complete. I understand that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. I agree to keep for a minimum period of seven years from the date of service (for minors seven years after reaching the age of 18) a printed representation of all records, which are necessary to disclose fully the extent of services furnished to the clients. I agree to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit: California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; Managed Risk Medical Insurance Board; Placer County Health Services Department; or their duly authorized representatives. I also agree that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiaries was conducted in compliance with the requirements established in the Mental Health Plan (MHP) contract with the California Department of Mental Health (DMH). The beneficiaries were recorded in the State Medi-Cal Eligibility database as eligible to receive Medi-Cal services at the time the services were provided to them. The services included in the claim were actually provided to the beneficiaries. Medical necessity was established for the beneficiaries as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided. A client plan was developed and maintained for each beneficiary that met all client plan requirements established in the MHP contract with DMH. For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the DMH.

NETWORK PROVIDER NAME (please print): _____

NETWORK PROVIDER SIGNATURE: _____

DATE: _____