1.4.4, 2.2.2

INYO COUNTY HEALTH AND HUMAN SERVICES – BEHAVIORAL HEALTH

Provider Manual

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QUICK REFERENCE

Contact Information

Inyo County Mental Health Plan
162 J Grove Street
Bishop, CA 93514

24-Hour Screening and Referral	**1-800-841-5011**
Administrative	(760) 873-6533
FAX	(760) 873-3277

Mental Health Plan Contract Support/Administrative Secretary (760) 872-2590

Regular Clinic Hours: Monday through Friday, 8:00 am-12:00 and 1:00 to 5:00 pm

PATIENT'S RIGHTS ADVOCATE

(760) 873-6533

Definitions

Beneficiary: This is a Medi-Cal-eligible individual who is an Inyo County resident requesting behavioral health treatment services. Parents or legal guardians also may call to request services on behalf of a minor beneficiary (under the age of 18).

Contract Provider: This is a licensed mental health professional, organization, or hospital that has contracted with the Inyo County Health and Human Services - Behavioral Health Plan to provide evaluation and treatment to Medi-Cal beneficiaries.

Emergency Condition: The criterion for emergency status is that the individual is a danger to self or others, or is gravely disabled.

ICHHS-BH: Inyo County Health and Human Services - Behavioral Health is referred to as ICHHS-BH throughout this document. ICHHS-BH is the Mental Health Plan (MHP) for Medi-Cal specialty mental health services in Inyo County.

Intake Process: Support staff with basic intake skills training will receive calls from beneficiaries and providers. Support staff will ask questions regarding the general nature of the call. Support staff are required to obtain basic information to complete a state-mandated Access Log.

Medi-Cal: This is California's version of the Federal Medicaid program. This is a State and Federal-funded health insurance program for low-income individuals and families.

Medical Necessity: Medical necessity is required to justify payment for specialty mental health services. See the later section titled "Medical Necessity."

Behavioral Health Plan Contract Support/Administrative Secretary: A staff member with Administrative Assistance/Managed Care training and experience who will take calls from beneficiaries and providers regarding grievances, authorizations, billing procedures and payments, hospital and provider contracts, etc. When the caller has a complaint or requests information only, the Behavioral Health Plan Contract Support/Administrative Secretary may answer the question, or transfer the caller to the Behavioral Health Director or designate.

Preauthorization: Once medical necessity has been determined outpatient mental health Services and case management do not require preauthorization. Day treatment Intensive and Day Treatment rehabilitation services do require pre authorization.

Screening and Referral Line: This is the ICHHS-BH primary line, which is available to help Medi-Cal beneficiaries obtain mental health treatment. Callers may ask questions about eligibility for mental health services, and can obtain referrals and/or authorization for mental health services. They also may express a concern or complaint, or get immediate help for a crisis. A provider may also call this number to obtain information on claims. (Note: The hearing impaired may call the TDD number: 1-800-735-2929.)

Specialty Behavioral Health Services: Client, family, and group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. Behavioral Health Services are interventions consistent with the requirements for learning, development, independent living, and enhanced self-sufficiency. Service activities may include, but are not limited to: assessment, evaluation, collateral, individual and group therapy, rehabilitation, and plan development.

Urgent Condition: This is a situation experienced by the individual that, without timely intervention and treatment, is certain to result in an immediate emergency psychiatric condition.

MISSION STATEMENT AND VALUES

Mission Statement

The mission of the Inyo County Health and Human Services - Behavioral Health Plan (ICHHS-BH) is to provide each eligible beneficiary with access to a high quality, effective, cost-efficient system of mental health care which is community based, culturally competent, and consumer guided.

Values

ICHHS-BH holds respect for each beneficiary as its central value, including beneficiary choice, satisfaction, and confidentiality. ICHHS-BH is committed to developing and maintaining a system of care for children, adults and older adults which is culturally competent and consumer guided. The following principles are the basis for the process of improving cultural competency and age-appropriate services:

- ✓ Planning and design of services will be delivered with respect for the culture and diversity of each beneficiary.
- ✓ ICHHS-BH recognizes that the family, as defined by each culture, is a primary system of support, and therefore, should be incorporated into the service planning whenever possible.
- ✓ ICHHS-BH will provide language accessibility and cultural competence within the service system to the extent possible within our resources.
- ✓ ICHHS-BH is committed to hiring staff that are proficient and skilled in serving diverse populations.
- ✓ ICHHS-BH is committed to providing timely and appropriate access to care.
- ✓ ICHHS-BH values prevention and early intervention as strategies to promote wellness, avert crises, and maintain each beneficiary within his/her community to the extent possible.
- ✓ ICHHS-BH staff will recognize and work with each beneficiary's strengths and own desired outcome(s) in the provision of care.
- ✓ Positive outcomes will be achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.
- ✓ ICHHS-BH values prevention and early intervention as strategies to promote wellness avert crises and maintain each beneficiary within his/her community if possible. Staff will recognize and work with each beneficiary's own desired

outcome(s) in the provision of care. Positive outcomes will be achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.

- ✓ ICHHS-BH will strive through treatment and discharge planning to allow each beneficiary to maintain the least restrictive setting and most appropriate level of care, enhancing community linkages and natural supports, whenever possible.

MEDICAL NECESSITY CRITERIA

After a period of assessment and engagement justification of medical necessity must be documented. The ICHHS-BH Medical Necessity Checklist is the tool used to assure consistency and maximum objectivity in their decision-making process. Medical necessity criteria are defined in the California Code of Regulations (CCR), Title 9, Sections 1810.2015 and 1810.210.

OUTPATIENT SERVICES

Process

The following assumes that the provider is located in Inyo County and that the client is an Inyo County Medi-Cal-eligible beneficiary.

Admission for Non-Urgent Care

The ability to ensure timely access and appropriate utilization of services is a responsibility that ICHHS-BH is committed to fulfill. It is the goal of ICHHS-BH to manage resources in a manner that allows all individuals requesting planned services to receive an initial intake assessment appointment as soon as possible, but no later than seven (7) working days from the initial request for services.

ICHHS-BH staff shall complete initial assessments for those clients who request services through ICHHS-BH. After an initial screening and medical necessity determination clients shall be referred to an appropriate county or contract provider for services.

- If a client meets medical necessity for special mental health services and is requesting to receive medication support services, he/she shall be notified by the front desk staff or the clinician to schedule the next available MD appointment.
- If the Medi-Cal beneficiary is denied services due to medical necessity or other allowable reasons for denials, the Authorization Team shall notify the client in writing, using the Notice of Adverse Benefit Determination (NOABD) process. Non-Medi-Cal eligibles are notified of the denial in writing and are referred to the managed care plan (Anthem or California Health and Wellness) through the use of the Bidirectional Care Referral Form. .

A. If pre-authorization is required the following time frames will be used unless medical necessity warrants a different period of time or further assessment is needed:
    - Therapeutic Behavioral Health Services: Individual – 6 Months to 1 Year
    - Intensive Day Treatment – 3 Months
    - Day Rehabilitation Services – 6 Months

B. Upon notification of a client's referral, assigned providers shall:

1. Review the client's intake packet and other documentation
2. Contact the client to schedule the first service delivery appointment Offer at least 3 appointment times).
    - If unable to contact the client after twenty (20) working days, providers will document attempts to contact the client and complete a discharge summary
3. Meet with the client to discuss goals of services and complete a Client Care Plan. Clinicians, case managers, and social worker staff must submit the Initial Service Plan for review within sixty (60) calendar days from the clinical assessment date. All initial and revised Client Care Plans must have client and provider signatures (as well as other required staff, family member, and/or guardian/conservator), or documentation explaining the reason(s) that the client did not sign.
    - Clients are given copies of the Client Care Plan upon request.

4. Document the Medication Support Service Plan on the Medication Support Progress Note form (psychiatric staff).

5. Discharge the client when treatment is completed or the client drops out of treatment by forwarding a completed Discharge Summary to ICHHS-BH.

Reassessment for Continued Services, or Add-on Services

If clients require more than one (1) year of outpatient services, a request for reassessment of services must be submitted prior to the last day of the Service Plan period. Add-on services must be added to the client care plan with mode specific goals or objectives.

Discharge Summary

Providers are required to submit a discharge summary to ICHHS-BH within thirty (30) days of the completion or cessation of treatment of all ICHHS-BH clients who received mental health services.

Prescription Medications

Beneficiaries and providers utilize the Managed Care Plan (MCP) process for authorization and/or reimbursement for prescription medications. Medications are not a part of ICHHS-BH.

OTHER OUTPATIENT
AUTHORIZATION SCENARIOS

Inyo County Clinic Provider; Client from another County
Unless an urgent service is needed, authorization of services to be provided to any beneficiary from another county must be obtained from the authorization unit of the client's county of origin. Service authorization approval must be obtained to assure that the beneficiary's county of origin will reimburse ICHHS-BH for services delivered.

Inyo County Client; Professional Provider from another County
The Clinical Supervisor or designee Team is responsible for authorization of all contract and other Provider requests, including those for beneficiaries that cross county lines. Cases that cross county lines are those in which ICHHS-BH clients are treated by providers in other counties. Often these clients are in residential placements.

The provider seeking to treat that beneficiary shall be required to meet the same authorization requirements as other ICHHS-BH providers. ICHHS-BH will coordinate with the provider to ensure that the cost to the beneficiary is no greater than it would be if the services were provided by an ICHHS-BH staff member.

INPATIENT SERVICES
AUTHORIZATION PROCESS

Initial Authorization

Emergency Admissions: Emergency hospital admissions do not require pre-authorization. We request that the hospital social worker call ICHHS-BH intake staff at 760-873-6533 to coordinate with ICHHS-BH staff around coordination of treatment and discharge planning.

Planned Admissions: All planned inpatient admissions must be pre-authorized by members of the ICHHS-BH Authorization Team or the On-Call Worker. Providers should contact the intake staff for authorization.

Hospital Admissions directly from an Institution for Mental Disability (IMD): Such transfers must be coordinated through the LPS Deputy Conservator. Providers should contact the intake staff at 760-873-6533.

Urgent Care: Any beneficiary who needs urgent care during regular business hours (Monday through Friday 8a.m.-5p.m.) should be referred immediately to an ICHHS-BH Clinic for a face-to-face assessment with a mental health clinician and/or physician, as needed. Authorizations for subsequent care will be determined within one (1) hour. After hours, beneficiaries should be referred to the 24 hour line at 800-841-5011 for both emergency and urgent care.

Confidentiality

Whenever referrals for other agencies and providers are necessary, strict confidentiality guidelines will be followed to assure the beneficiary's privacy. Information regarding the beneficiary will not be provided without written permission of the beneficiary except as allowed for coordination of care.

Concurrent Authorization

Authorization for inpatient stays beyond the initially authorized stay for planned admissions must be authorized by a member of the Authorization Team. ICHHS-BH staff will facilitate the hospital's communications with the designated staff member.

Case Management and Discharge Planning

The hospital discharge planner will assure that all clients admitted to acute inpatient facilities have an assigned ICHHS-BH staff member to monitor the inpatient stay and assure appropriate discharge planning.

Inpatient staff must complete an assessment of the beneficiary's available support system including community agencies and orders for all appropriate interventions.

- The hospital discharge planner will be responsible for making appropriate pre- and post-discharge referrals including contacting the ICHHS-BHICHHS-BH staff responsible to assure continuity of care and coordination with community services.

- The ICHHS-BHICHHS-BHstaff assigned will keep in close contact with inpatient staff to check on beneficiary progress and assist with the aftercare plan.

Documentation and Final Review of TAR

TAR/Request for Mental Health Stay in Hospital: Within fourteen (14) days of discharge, the hospital shall provide ICHHS-BH with a properly completed TAR form and a copy of the client's medical record. ICHHS-BH licensed/waivered mental health staff will evaluate the case per current state specifications. After reviewing the TAR, the licensed/waivered mental health staff will 1) approve the TAR as written, or 2) request more information from the provider, or 3) deny the TAR.

ICHHS-BH licensed/waivered mental health staff review will be completed within fourteen (14) calendar days of receipt of the request. All adverse decisions by the licensed/waivered mental health staff regarding inpatient TARs (payment denial) are subject to final review by an ICHHS-BH psychiatrist MD.

ICHHS-BH will process approved payments through EDS and provide the hospital billing office with a copy of the approved TAR.

Any inpatient provider appeal of a denied or modified payment ruled in favor of the provider will be processed for payment within fourteen (14) calendar days of receipt of a revised TAR.

Inpatient Professional Services

Since contracting acute care hospitals have negotiated rates, inpatient professional visits do not need a separate ICHHS-BH authorization. Reimbursement for professional visits will be dependent upon the authorization of each corresponding bed day. **Limit: One (1) assessment per hospitalization; One (1) hospital visit per day.**

OTHER INPATIENT AUTHORIZATION SCENARIOS

Emergency Services – Inyo County Client; Out-of-County Provider
If a beneficiary is out-of-county and requires emergency inpatient services, the beneficiary, staff, and/or family can call 1-800-841-5011 to talk with the ICHHS-BHICHHS-BH staff on a 24 hour per day, seven days a week basis.

Urgent Services – Inyo County Client; Out-of-County Provider
Any provider who desires to provide BH urgent services to an ICHHS-BHICHHS-BH beneficiary who is out of Inyo County must contact the ICHHS-BH by calling 760-873-6533 or 1-800-841-5011. Request for payment for urgent care will be authorized by the daytime and after hours mental health on-call staff member who answers the statewide toll free number (1-800-841-5011), or call 760-873-6533. All authorizations for urgent

care will be approved/supervised by a licensed mental health professional within one hour of the authorization request.

QUALITY MANAGEMENT
Assurance and Improvement

Quality Assurance

The ICHHS-BH Director has the responsibility of assuring that high quality services are provided to the client in an effective and efficient manner. The Director reviews services and programs of providers in order to ensure:

1. Accessibility;
2. Services that are meaningful and beneficial to the client;
3. Services that are culturally and linguistically competent; and
4. Services that produce highly desirable results through the efficient use of resources.

Quality Improvement

ICHHS-BH establishes policies, structure, and processes to ensure continuous quality improvement through its Community Quality Improvement Committee. The ICHHS-BH Director oversees the QIC and coordinates with other performance monitoring activities.

The QIC will monitor clients' satisfaction with services that they are receiving from staff and providers. ICHHS-BH staff will evaluate contract performance based on mutually identified measurable objectives. The QI Program, on a periodic basis, reviews collected information, data, and trends relevant to standards of cultural competence and linguistic capabilities.

If the QIC finds that a provider may be deficient in rendering or managing care, or if other problem areas are discovered, procedures outlined in the Provider Problem Resolution Process will be initiated. If these deficiencies or problem areas are verified, corrective sanctions may be applied. These sanctions may include mandatory reviews of all claims, periodic review of medical records, or termination of the provider's contract with ICHHS-BH.

Provider may be asked to participate in Satisfaction Surveys and Outcome Studies

Training and Consultation

Upon request, ICHHS-BH designated staff (and additional clinical staff, as needed) shall provide training and consultation to providers in the following areas:

- Medical necessity criteria,
- Clients' rights issues,
- Cultural competence and ethnic diversity;
- Medications and medication management,
- Outcomes, and
- Other quality components referenced in this manual.

PROVIDER SELECTION AND RETENTION

Individual Providers

Licensed psychiatrists (MD), licensed clinical psychologists (Ph.D.), licensed clinical social workers (LCSW), licensed marriage and family therapists (MFT), and licensed registered nurses (RN) (within their scope of practice), are eligible to be credentialed as individual providers with ICHHS-BH. Providers serving Inyo County Medi-Cal clients may become part of the ICHHS-BH provider network by submitting for review:

1. A confidential provider application;
2. Work history
3. A copy of the current license;

The provider application packet shall be reviewed by the ICHHS-BH Director or designee. Decisions regarding provider applications, including denials, will be given to the applicant in writing. If approved, a provider contract will be developed and submitted to the provider for signature. As part of this contract, the provider will also submit:

1. A Certificate of Insurance verifying that the provider has a minimum of $1,000,000 aggregate annually Professional Liability Insurance;
2. Current Inyo County Business Tax Certificate or a W9 form.
3. HIPAA Business Agreement

PROVIDER SELECTION AND RETENTION

Organizational Providers

Organizational providers that offer mental health services through the ICHHS-BH are required to:

- Possess the necessary license to operate;
- Provide for appropriate supervision of staff;
- Have as Head of Service a licensed mental health professional or other appropriate individual as described in state regulations;
- Possess appropriate liability insurance;
- Maintain a safe facility with required fire clearances;
- Store and dispense medications in compliance with all applicable state and federal laws and regulations;
- Maintain client records in a manner that meets state and federal standards;
- Meet the standards and requirements of the ICHHS-BH Quality Management Program;
- Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to California Code; and
- Meet any additional requirements that are established by ICHHS-BH as part of a credentialing or evaluation process.

Certification of Organizational Providers

- ICHHS-BH shall certify organizational providers in accordance with the requirements of the MHP contract between ICHHS-BH and the California Department of Health Care Services (DHCS); and applicable state and federal standards.

- Organizational provider certification shall include an on-site review, pursuant to California Department of Health Care's Provider Site Certification Protocol (DMH Notice 04-09) in addition to a review of relevant documentation.

- Organizational providers must ensure that a) licensed providers are in good standing with his/her licensing board, ordering/rendering providers have a current National Provider Identification (NPI) number and that any individual (licensed or otherwise) is not on an exclusion list. The following lists shall be checked for exclusions:

    - The OIG *List of Excluded Individuals and Entities* (LEIE) is checked prior to hiring or contracting with entities and no less frequently than monthly. http://www.oig.hhs.gov/fraud/exclusions.html
    - The Medi-Cal List of Suspended or Ineligible Providers. https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
    - The Social Security Death Master File is checked upon hiring.

- The Excluded Parties List System/System Award Management (EPLS/SAM) database is checked prior to hiring and no less frequently than monthly. https://www.sam.gov/portal/SAM/#1#1
- The accuracy of new and current providers in the National Plan and Provider Enumeration System (NPPES) is checked upon hiring.

Service Delivery Prior to Certification

- ICHHS-BH may allow an organizational provider to begin delivering services to beneficiaries prior to the date of the on-site review, provided that the provider's site is operational and has required fire clearances.

- ICHHS-BH shall complete any required on-site review of a provider's sites within six (6) months of the date that the provider begins delivering covered services to beneficiaries at the site in question.

PROVIDER SITE CERTIFICATION

Organizational Providers

All organizational providers who contract with ICHHS-BH must be site certified by Inyo County Health and Human Services - Behavioral Health or by the Host County. The Site Certification verifies that:

1. The organizational provider possesses the necessary license to operate, if applicable, and any required certification.

2. The space owned, leased or operated by the provider and used for services or staff meets local fire codes.

3. 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.

4. The organizational 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.

5. The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required state or federal notices (DRA), and procedures for reporting unusual occurrences relating to health and safety issues.

6. The organizational provider maintains client records in a manner that meets the requirements of the Contractor, the requirements of the MHP contract between ICHHS-BH and DHCS; and applicable state and federal standards.

7. The organizational provider has sufficient staff to allow the Contractor to claim federal financial participation (FFP) for the services that the organizational provider delivers to beneficiaries, as described in CCR, Title 9, Sections 1840.344 through 1840.358, as appropriate and applicable.

8. The organizational provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

9. The organizational provider's head of service, as defined in CCR, Title 9, Sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.

10. For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:

    a. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.
    b. Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.
    c. All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
    d. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.
    e. Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.
    f. 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.
    g. Policies and procedures are in place for dispensing, administering and storing medications.

Site Certifications will be required every three (3) years, or when a provider relocates, changes their type of services, changes staffing, changes in ownership, or makes modifications to its physical plant/facility. ICHHS-BH will require a written program description from the facility prior to a Site Certification. Site Certification must be completed or verified prior to the start of contracted reimbursable services.

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DOCUMENTATION STANDARDS

Assessments

Inyo County Health and Human Services - Behavioral Health utilizes a multi-cultural clinical assessment, which meets the current DHCS requirements. The following areas are described by DHCS as a part of a comprehensive client record:

Presenting Problem. The beneficiary's chief complaint, history of presenting problems, including current level of functioning; relevant family history and current family information.

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

Mental Health History. Previous treatment including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response. Inpatient admissions. If possible, include information from other sources such as previous mental health records, relevant psychological testing or consultation reports and site the reference.

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

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

Substance exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (Complementary and alternative medications), over-the-counter, and illicit drugs.

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

Risks: Situations that present a risk to the beneficiary and/or others. Examples of risks include:
☐ History of Danger to Self (DTS) or Danger to Others (DTO);
☐ Previous inpatient hospitalizations for DTS or DTO;

☐ Prior suicide attempts;
☐ Lack of family or other support systems;
☐ Arrest history, if any;
☐ Probation status;
☐ History of alcohol/drug abuse;
☐ History of trauma or victimization;
☐ History of self-harm behaviors (e.g., cutting);
☐ History of assaultive behavior;
☐ Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and,
☐ Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

Mental status examination.

Diagnosist formulation: From the most current DSM, or a diagnosis form the most current ICD-Code shall be documented. Consistent with the presenting problems history, mental status examination and/or clinical data.

Additional clarifying information as needed.

Timeliness and Frequency Standards for Assessments

ICHHS-BH standards for timeliness and frequency for assessments are as follows:

- At admit
- Annually, or when there are significant changes in a client's level of functioning or symptomatology

Client Care Plans

Per ICHHS-BH and DHCS standards, Client Care Plans shall:

- Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
- Identify the proposed type(s) of intervention/modality (which will be consistent with the client plan goals) including a detailed description of the intervention to be provided.
- Have a proposed frequency/duration of intervention(s)
- Be consistent with the client's qualifying diagnoses
- Interventions that focus and address the identified functional impairments as a result of a mental disorder.
- Interventions are consistent with the client plan goals and treatment objectives.
- Be signed (or electronic equivalent) and dated by:

- The individual providing the service(s) or
- An individual representing a team or program providing services, and
- A person representing the Contractor providing services, if applicable
- By one of the following providers, if the client plan indicates that some services will be provided by a staff member under the direction of one of the categories of staff listed below and/or the person signing the client plan is not one of the categories of staff listed below:
  - A physician
  - A licensed/waivered psychologist
  - A licensed/registered/waivered social worker
  - A licensed/registered/waivered marriage & family therapist
  - A licensed/registered/waivered professional clinical counselor
  - A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists.
- The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan or documentation as to why the unable to get signature.

In addition, ICHHS-BH and its providers shall ensure that:

- The Client Care Plan is used to establish that services are provided under the direction of an approved category of staff
- A Client Care Plan is written for all outpatient mental health services
- Clients who receive Medication Support Services Only receive a separate Medication Plan.
- The client receives a copy of the Client Plan upon request.

Timeliness and Frequency Standards for Client Plans

Providers shall ensure that the client plan is written within the first 60 days Client plans are required to be reviewed prior to reauthorization requests and updated as needed (maximum authorization period: one year).

Provision of Services Prior to a Client Plan Being in Place

Prior to the client plan being approved, the following SMHS and service activities are reimbursable:

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization
- Medication Support Services (for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented)
- Targeted Case Management and Intensive Care Coordination (ICC) (for assessment plan development, and referral/linkage to help a beneficiary obtain

needed services including medical, alcohol and drug treatment, social, and educational services)

Progress Notes

ICHHS-BH requires that Progress Note documentation will be entered within 72 hours of service delivery, preferably on the same day of service.. Progress Note documentation shall contain the following information:

- Date of Service
- Client identification number
- Client Name
- Service procedure code (identify type of service delivered)
- Duration of service
- Location of service
- A description of what was attempted and/or accomplished by the client, family (when applicable), and staff toward the goal
- Documentation of progress towards each Client Plan goal
- Description of changes in the client's medical necessity
- Mental health staff/practitioners' documentation of client encounters, including relevant clinical decisions when decisions are made, alternative approaches for future interventions
- Interventions applied, beneficiary's response to the interventions and the location of the interventions
- Documentation of referrals to community resources and other agencies
- Documentation for follow-up care or, as appropriate, a discharge summary
- Signatures of the person providing the service, professional degree or licensure or, job title
- Legible signatures:. If the signature is not legible, the writer's name is printed legibly in proximity to the signature.
- Co-signatures by an approved category of staff for Progress Notes written by unlicensed staff who do not meet minimum educational and experiential standards

Frequency Standards for Progress Notes

Progress Notes shall be written for on the following schedule of frequency for specific service types:

Every Service Contact	Mental Health Services Collateral Services Medication Support Services Crisis Intervention Case Management/Brokerage
Each Shift	Crisis Residential Crisis Stabilization Day Treatment Intensive

Weekly Summary	Day Rehabilitation Adult Residential

Timeliness Standards for Progress Notes
ICHHS-BH promotes, as a standard of practice, that **all progress note documentation shall be completed within 72 hour and preferably on the day of service delivery**.

Medication Documentation

ICHHS-BH requires the following documentation procedures regarding medication management and monitoring:

1. A signed *Medication Information and Consent form* must be reviewed with the client by the prescribing physician. This review includes information on side effects and must be signed by the client and filed in the client's chart except with as allowed during the COVID 19 waiver period per Executive Order N-55-20 that suspends WIC 14043.341 This review must be provided each time the client's prescription is initiated to a different class of medications.

2. Providers must obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the beneficiary.

3. Additional requirements for informed consent for antipsychotic medications include:

   A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications. In order to make an informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible) which shall include the following:

   a. The nature of the patient's mental condition;
   b. The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;

c. The reasonable alternative treatments available, if any;
d. The type, range of frequency, and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications;
e. The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient;
f. The possible additional side effects which may occur to patients taking such medications beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

4. All identifying information, including allergies, must be documented. Known drugs prescribed by other medical physicians will also be noted.

5. All medication orders must be signed with first and last name and title of physician (no initials).

6. All medication prescribed and/or dispensed by the physician, or given by the nurse with a physician's order, must be noted and recorded in the Progress Note of the client's chart.

7. Clients will be re-evaluated by the psychiatrist at least every three – six months for dose/frequency of injectable and oral medication. Medication must be re-ordered at least every six months.

8. Physicians may dispense oral medication in amounts greater than a daily dose on an emergency basis only.

9. Laboratory tests for patients on medications requiring laboratory tests will be ordered according to minimum protocol.

Medication monitoring for all programs is completed through the Medication Monitoring process. Monitoring activities include a review of clinical records and consultation, as requested.

Contract Monitoring for Substance Use Disorder providers

Inyo County Health and Human Services - Behavioral Health ICHHS-BH will monitor the activities of all Subcontractors to ensure that federal awards are used for authorized purposes in compliance with the laws, regulations, and the provisions of the contracts or grant agreements and that performance goals are achieved.
In the event a contract is terminated or not renewed the following must occur; the Administrative Secretary or designee of Inyo County Behavioral Health must notify their assigned DHCS' County Monitoring Unit analyst through e-mail of the termination of any contract with a certified subcontracted provider, and the basis for termination of the contract, within two business days.

1. Subcontractors will adhere to the terms and conditions set forth in the signed Inyo County Standard Contract to include those terms and conditions found in the referenced Inyo County Health and Human Services - Behavioral Health Provider Manual.

2. Monitoring will be conducted and documented site verification to assure that the Subcontractor is compliant with DHCS regulations and the contract. This will occur via the phone at least monthly when a resident is placed in the facility. A site visit will occur at least annually for Substance Use Disorder Program placements.

3. When found out of compliance, any deficits will be documented and a plan of correction will be required of the Subcontractor. This plan will also require documentation of correction from the Subcontractor.

4. The Subcontractor will also demonstrate compliance with the specific requirements set forth in the Net Negotiated (NNA) Contract between the County of Inyo County Health and State ADP for providers receiving the SAPT Block Grant funding. The specific areas are as follows:

A. Religious Objection

Providers receiving funds from the SAPT Block Grant will address religious objection. The subcontractor will show proof of compliance with Exhibit B, Paragraph KK of the NNA contract regarding religious organizations that provide alcohol and drug treatment services per the provisions of Title 42, United States Code (USC), Section 300x-65 and Title 42, Code of Federal Regulations (42 CFR), Part 54.
No funds provided directly from SAMHSA or the relevant state or local government to organizations participating in applicable programs may expend for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.
The subcontractor must comply with 42 CFR, Part 54a.8 *Right to services from an alternate provider.*
Inyo County Health and Human Services – Behavioral Health will monitor this requirement through the collection of data on re referrals due to religious objection at the end of the fiscal year for inclusion in the SAPT Block Grant application.

B. Tuberculosis services

The subcontractor operating a program of treatment for substance abuse will routinely make available tuberculosis services and show documentation as defined in Title 45, CFR, Part 96, Section 96.127.
(a)...any entity receiving amounts from the grant for operating a program of treatment for substance abuse to follow procedures developed by the principal agency of a State for substance abuse, in consultation with the State Medical Director for Substance Abuse

Services, and in cooperation with the State Department of Health/Tuberculosis Control Officer, which addresses how the program-

(1) Will, directly or through arrangements with other public or non-profit private entities, routinely make available tuberculosis services as defined in 96.121 to each individual receiving treatment for such abuse;

(2) In the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services: and

(3) Will implement infection control procedures established by the principal agency of a State for substance abuse, in cooperation with the State Department of Health/Tuberculosis Control Officer, which are designated to prevent the transmission of tuberculosis, including the following; (i) Screening of patients; (ii) Identification of those who are at high risk of becoming infected; and (iii) Meeting all State reporting requirements while adhering to Federal and state confidentiality requirements; including 42 CFR part 2; and (4) will conduct case management activities to ensure that individuals receive such services.

Title 45, Code of Federal Regulations, Part 96, Section 96.121 defines tuberculosis services as:

(1) Counseling the individual with respect to tuberculosis:

(2) Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual; and

(3) Providing for or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

Further, the subcontractor will test and show proof of compliance with ADP Certification Standards section 19015. which states;

(b)All staff and volunteers whose functions require or necessitate contact with participants or food preparation shall be tested for tuberculosis.

C. <u>Youth Treatment Guidelines</u>

The subcontractor providing youth treatment services will comply with NNA contract; exhibit C, Article I., Formation and Purpose, Paragraph B. Control Requirements, Item 9. which states;

shall follow the "Youth Treatment Guidelines", Revised August 2002 in developing and implementing youth treatment programs.

D. <u>HIPAA</u>

The subcontractor will abide by and demonstrate compliance with HIPAA regulations providing appropriate administrative, technical and physical safeguards to reasonably safeguard protected health information from intentional or unintentional unauthorized use. The Subcontractor will also demonstrate that confidentiality of client records is maintained per Title 45, Code of Federal Regulations, Part 2. and will have a policy in place for disciplinary action. Further, the subcontractor will allow Inyo County Health and Human Services – Behavioral Health to review these policies and documented violations.

E. Continuing Education for Staff

The subcontractor will show proof of continuing education for employees per Title 45 Code of Federal Regulations, Part 96, Section 96.132(b) which states:
With respect to any facility for treatment services or prevention activities that is receiving amount from a Block Grant, continuing education in such services or activities (or both, as the case may be) shall be made available to employees of the facility who provide the service or activities.

F. Payment of last resort

The subcontractor will show compliance with the SAPT Block Grant requirements regarding expenditure of Perinatal set aside funds as payment of last resort for services for Pregnant and Parenting Women, Tuberculosis, and HIV per Title 45, CFR, Section 96.137. The subcontractor will show proof of reasonable effort to establish systems of eligibility, billing and collection.

G. Inpatient Hospital Substance Abuse services

Inyo County Health and Human Services - Behavioral Health ICHHS-BH Drug and Alcohol Services assures that specific restrictions on the expenditure of Substance Abuse Prevention and Treatment (SAPT) Block Grants funds will be complied with and assure funds are used in accordance to 45 CFR 96.135. All services are reviewed for appropriate level of SAPT Block Grant Funds are not to be used for. Provision of inpatient hospital substance abuse services, except in cases when each of the following conditions are met:

a. The individual cannot be effectively treated in a community-based, non-hospital residential treatment program based on review of appropriate level of care criteria.
b. The daily rate of payment to the hospital for providing the services does not exceed the comparable daily rate provided by a community based, non-hospital, and residential treatment program.
c. A physician makes a determination that the following conditions have been met: The primary diagnosis of the individual is substance abuse, and the physician certifies that fact. The individual cannot be safely treated in a community based, non-hospital, and residential treatment program. The service can reasonably be expected to improve the person's condition or level of functioning. The hospital based substance abuse program follows national standards of substance abuse professional practice.
d. The service is provided only to the extent that it is medically necessary based on concurrent review.

Overview

Inyo County Health and Human Services - Behavioral Health (ICHHS-BH) contracts with organizational providers for delivery of Day Rehabilitation (DR) services. The ICHHS-BH Director or designee maintains a current list of providers.

Although ICHHS-BH does not deliver DR, ICHHS-BH is responsible for:

- Determining a client's need for Day Rehabilitation services,
- Ensuring that the client has access to these services,
- Authorizing payment for these services, and
- Supervising the quality of these services.

Service Requirements – Day Rehabilitation

In order to be certified as a Day Rehabilitation program, organizational providers must offer, at a minimum, the following components of service:

A. Community meetings – Meetings that occur at least once a day which:
   - Address issues pertinent to the continuity and effectiveness of the therapeutic milieu;
   - Actively involve staff and clients;
   - Include the following staff members:
     - A physician
     - A licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist
     - a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist
   - Address relevant items including, but not limited to, the schedule for the day; current events; individual issues that clients or staff wish to discuss to elicit support of the group; conflict resolution; planning for the day, the week, or for special events; old business from previous meetings or from previous day treatment experiences; and debriefing or wrap-up.

B. A Therapeutic Milieu – A structured therapeutic program with specific activities performed by identified staff and maintained continuously for the scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program). The therapeutic milieu also includes the following:
   - Staff and activities that teach, model, and reinforce constructive interactions;
   - Peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;

- Involves clients in the overall program, for example, by providing opportunities to lead community meetings; and
- Behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

C. Therapeutic Milieu Components – As noted above, the therapeutic milieu requires structured activities. These activities shall be available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day DR programs and an average of two hours per day for half-day DR programs. The required activities are as follows:

- Process groups, which are facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. DR may include psychotherapy instead of process groups and/or process groups.

- Skill building groups, in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

- Adjunctive therapies, a therapeutic intervention in which both staff and clients participate to utilize self-expression (art, recreation, dance, music, etc. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

D. An established protocol for responding to clients experiencing a mental health crisis – The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the DR program, the DR staff will have the capacity to handle the crisis until the client is linked to the outside crisis services.

E. A detailed, written weekly schedule that is available to clients and, as appropriate, to their families, caregivers, or significant support persons. The schedule identifies when and where the service components of program will be provided and by whom. The written weekly schedule shall specify the program staff, their qualifications, and the scope of their responsibilities.

F. Staffing ratios that are consistent with the DR requirements outlined in CCR, Title 9, Section 1840.352. Program staff may be required to spend time on DR activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts. ICHHS-BH requires that at least one staff person is present and available to the group in the therapeutic milieu for all scheduled hours of operation.

   ICHHS-BH requires that if day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. ICHHS-BH requires that there be documentation of the scope of responsibilities for these staff and the specific times in which day rehabilitation activities are being performed exclusive of other activities.

G. An expectation of client participation – ICHHS-BH expects that the client will be present for all scheduled hours of operation for each day. When a client is unavoidably absent for some part of the hours of operation, ICHHS-BH will ensure that the provider receives Medi-Cal reimbursement for DR for an individual beneficiary only if the beneficiary is present for at least 50% of the scheduled hours of operation for that day.

H. Documentation standards that meet standards outlined in Section III under Procedures.

I. At least one contact per month with a family member, caregiver, or significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Contact can occur face-to-face or by an alternative method (e.g., email, telephone, etc.). Adult clients may choose whether or not this service component is completed for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. ICHHS-BH expects that this contact will occur outside hours of operation and the therapeutic milieu.

J. A written program description for Day Rehabilitation that describes the specific activities of the service and reflects each of the required components of DR. ICHHS-BH will review the written program description for compliance before the provider delivers DR services for ICHHS-BH clients.

Payment Authorization – Day Rehabilitation

A. ICHHS-BH requires that DR providers request an initial ICHHS-BH payment authorization for DR services.
   - Payment authorization shall follow the ICHHS-BH authorization process, in regard to medical necessity, involvement of licensed mental health professionals in the decision process, and consistent application of review criteria integral to the Utilization Management Program (Authorization Team activities).

- In regard to timelines for DR payment authorizations, ICHHS-BH shall adhere to the following:
  - Standard authorizations: ICHHS-BH will provide notice of approval or denial of payment authorization within fourteen (14) calendar days following the receipt of the request for payment authorization.
  - Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, ICHHS-BH will provide notice of approval or denial of payment authorization within three (3) working days after receipt of the request for payment authorization.

B. ICHHS-BH will authorize DR for an initial period of six months.

C. Notification to the client regarding denials or modified authorizations shall follow the procedure outline in the Notices of Adverse Benefit Determination policy.

D. ICHHS-BH will notify the provider if a request for ICHHS-BH payment authorization is denied or if ICHHS-BH authorized services in an amount, duration, or scope that is less than requested by the provider. This notice does not have to be in writing.

Payment Authorization – Same Day Services

A. If an organizational provider will be providing routine mental health services (excluding Therapeutic Behavioral Services [TBS]) on the same day as DR, the provider must follow the payment authorization timelines as described above.

B. Providers shall request payment authorization for continuation of these services on the same cycle required for continuation of the concurrent DR services (six months).

Required Documentation

Day rehabilitation requires, at a minimum, the following documentation:

- Assessments
- Client Plans
- Progress notes on activities

Supervision and Quality Management

Although Inyo County currently contracts day rehabilitation services to organizational providers, it will continue to maintain responsibility for determining the need for, providing access to, and managing these Medi-Cal specialty mental health services.

DAY TREATMENT INTENSIVE SERVICES (DT)
Payment Authorization and Service Requirements

Overview

Inyo County Behavioral Health (ICHHS-BH) contracts with organizational providers for delivery of Day Treatment Intensive (DT) services. The ICHHS-BH Director or designee maintains a current list of providers.

Although ICHHS-BH does not deliver DT, ICHHS-BH is responsible for:

- Determining a client's need for Day Treatment Intensive services,
- Ensuring that the client has access to these services,
- Authorizing payment for these services, and
- Supervising the quality of these services.

Service Requirements – Day Treatment Intensive

In order to be certified as a Day Treatment Intensive program, organizational providers must offer, at a minimum, the following components of service:

A. Community meetings – Meetings that occur at least once a day which:
   - Address issues pertinent to the continuity and effectiveness of the therapeutic milieu;
   - Actively involve staff and clients;
   - Include the following staff members:
     - A physician
     - A licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist
     - A registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist
   - Address relevant items including, but not limited to, the schedule for the day; current events; individual issues that clients or staff wish to discuss to elicit support of the group; conflict resolution; planning for the day, the week, or for special events; old business from previous meetings or from previous day treatment experiences; and debriefing or wrap-up.

B. A Therapeutic Milieu – A structured therapeutic program with specific activities performed by identified staff and maintained continuously for the scheduled hours of operation for the program (more than four hours for a full-day program and a

minimum of three hours for a half-day program). The therapeutic milieu also includes the following:

- Staff and activities that teach, model, and reinforce constructive interactions;
- Peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
- Involves clients in the overall program; and
- Behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

C. Therapeutic Milieu Components – As noted above, the therapeutic milieu requires structured activities. These activities shall be available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day DT programs and an average of two hours per day for half-day DT programs. The required activities are as follows:

- Skill building groups, in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

- Psychotherapy, provided by licensed, registered, or waivered staff practicing within their scope of practice.

D. An established protocol for responding to clients experiencing a mental health crisis – The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the DT program, the DT staff will have the capacity to handle the crisis until the client is linked to the outside crisis services.

E. A detailed, written weekly schedule that is available to clients and, as appropriate, to their families, caregivers, or significant support persons. The schedule identifies when and where the service components of program will be provided and by whom. The written weekly schedule shall specify the program staff, their qualifications, and the scope of their responsibilities.

F. Staffing ratios that are consistent with the DT requirements outlined in Title 9, CCR, Section 1840.352, including at least one staff person whose scope of practice includes DT. Program staff may be required to spend time on DT activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts. ICHHS-BH requires that at least one staff person is present and available to the group in the therapeutic milieu for all scheduled hours of operation.

ICHHS-BH requires that if day treatment staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. ICHHS-BH requires that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment activities are being performed exclusive of other activities.

G. An expectation of client participation – ICHHS-BH expects that the client will be present for all scheduled hours of operation for each day. When a client is unavoidably absent for some part of the hours of operation, ICHHS-BH will ensure that the provider receives Medi-Cal reimbursement for DR for an individual beneficiary only if the beneficiary is present for at least 50% of the scheduled hours of operation for that day.

H. Documentation standards that meet standards outlined in Section III under Procedures.

I. At least one contact per month with a family member, caregiver, or significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Contact can occur face-to-face or by an alternative method (e.g., email, telephone, etc.). Adult clients may choose whether or not this service component is completed for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. ICHHS-BH expects that this contact will occur outside hours of operation and the therapeutic milieu.

J. A written program description for Day Treatment Intensive that describes the specific activities of the service and reflects each of the required components of DT. ICHHS-BH will review the written program description for compliance before the provider delivers DT services for ICHHS-BH clients.

Payment Authorization – Day Treatment Intensive

A. ICHHS-BH requires that DT providers request an initial ICHHS-BH payment authorization for DT services.

- Payment authorization shall follow the authorization process outlined in the policy *Authorization Process for Outpatient Services*, in regard to medical necessity, involvement of licensed mental health professionals in the decision process, and consistent application of review criteria integral to the Utilization Management Program (Authorization Team activities).

- In regard to timelines for DT payment authorizations, ICHHS-BH shall adhere to the following:
    - Standard authorizations: ICHHS-BH will provide notice of approval or denial of payment authorization within fourteen (14) calendar days

following the receipt of the request for payment authorization.
  - Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, ICHHS-BH will provide notice of approval or denial of payment authorization within three (3) working days after receipt of the request for payment authorization.

B. ICHHS-BH will authorize DT for an initial period, beginning retroactively to the first of the month that the intake occurred, plus thirty days from the day after the Authorization Team reviewed the documentation.

C. Upon request for continuation of ICHHS-BH payment authorization for services, ICHHS-BH will authorize Day Treatment Intensive for a standard period of six months.

D. Notification to the client regarding denials or modified authorizations shall follow the procedure outline in the Notices of Adverse Benefit Determination policy.

E. ICHHS-BH will notify the provider if a request for ICHHS-BH payment authorization is denied or if ICHHS-BH authorized services in an amount, duration, or scope that is less than requested by the provider. This notice does not have to be in writing.

Payment Authorization – Same Day Services

A. If an organizational provider will be providing routine mental health services (excluding TBS) on the same day as DT, the provider must follow the payment authorization timelines as described above.

B. Providers shall request payment authorization for continuation of these services on the same cycle required for continuation of the concurrent DT services (six months).

Required Documentation

Day treatment intensive requires, at a minimum, the following documentation:

- Assessments
- Client Plans
- Daily Progress Notes on activities
- Weekly clinical summary reviewed and signed by one of the following:
  - Physician
  - Licensed/waivered/registered psychologist
  - Licensed/waivered/registered clinical social worker
  - Licensed/waivered/registered marriage and family therapist
  - Registered nurse, who is either staff to DT or the person directing the service

Supervision and Quality Management

Although Inyo County currently contracts day treatment intensive services to organizational providers, it will continue to maintain responsibility for determining the need for, providing access to, and managing these Medi-Cal specialty mental health services.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Payment Authorization and Service Requirements

Overview

Therapeutic Behavioral Services (TBS) are an Early Periodic Screening, Diagnosis and Treatment (EPSDT)-supplemental service for full-scope Medi-Cal beneficiaries under the age of 21 years who meet medical necessity, as well as criteria specific to TBS.

Therapeutic Behavioral Services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) jeopardizing the client's current living situation or planned transition to a lower level of placement. The purpose of providing Therapeutic Behavioral Services is to further the client's overall treatment goals by providing additional therapeutic services during a short period of time.

Inyo County Health and Human Services - Behavioral HealthICHHS-BHICHHS-BH generally provides TBS through designated staff in the positions of Therapeutic Behavioral Aide (TBA) or Case Manager. TBS is provided as part of a team of clinical staff operating under ICHHS-BH Child and Family Services. When Inyo County eligible youth are placed out of county, then ICHHS-BH contracts with outside providers for delivery of Therapeutic Behavioral Services.

In both circumstances, whether the youth is in county or out of county, ICHHS-BH is responsible for:

- Determining a client's need for Therapeutic Behavioral Services,
- Ensuring that the client has access to these services, and
- Supervising the delivery and quality of these services.

Therapeutic Behavioral Services:

- Provide critical, short-term supplemental support services for full-scope Medi-Cal clients for whom other intensive specialty mental health Medi-Cal reimbursable interventions have not been, or are not expected to be, effective without additional supportive services;
- Are targeted towards clients who, without this service, would require a more restrictive level of residential care, and are designed to:
    - Prevent placement of the client in a more restrictive residential level of care; or
    - Enable placement of the client in a less restrictive residential level, such as enabling a discharge from acute care, a step down from a group home to a foster home, return to natural home, etc.

- Are consistent with the System of Care principles and the Wraparound process; and
- Meet Medi-Cal standards, EPSDT regulations, and the court-mandated requirements of Emily Q. et al v. Belshe and Emily Q. v. Bonta.

Service Description

- The clinician providing Therapeutic Behavioral Services is available to provide individualized one-to-one behavioral assistance and one-to-one interventions in order to accomplish the outcomes specified in the written Service Plan.

- TBS will be provided for a specified short-term period that may vary in length and may last up to 24 hours a day, depending upon the needs of the client.

- TBS may be continued even after the client has met his/her behavioral goals outlined in the TBS Service Plan when TBS is still medically necessary to stabilize the client's behavior and reduce the risk of jeopardizing the client's current or potential living situation.

Service Delivery Requirements

A. Therapeutic Behavioral Services activities focus on:
   - Resolution of target behaviors or symptoms which jeopardize existing placements or which are a barrier to transitioning to a lower level of residential placement, and
   - Completion of specific treatment goals. Therapeutic Behavioral Services must be expected in the clinical judgment of ICHHS-BH to be effective in addressing the above focus to meet the goals of the Service Plan.

B. Therapeutic Behavioral Services are to be decreased when indicated. TBS shall be discontinued when the identified behavioral benchmarks have been reached, or when reasonable progress towards the behavioral benchmarks are not being achieved and are not reasonably expected to be achieved in the clinical judgment of ICHHS-BH.
   - The provision of TBS is intended to be a short-term, time-limited provision and is not appropriate for maintaining a client at a specified level for the long-term.

C. TBS providers shall meet statewide provider selection criteria specified in state regulations. TBS must be provided by licensed practitioners of the healing arts (LPHA) or trained staff members (TBS Aide) who are under the direction of an LPHA.

Notifying Clients of Therapeutic Behavioral Services

A. ICHHS-BH shall notify at-risk, eligible Medi-Cal clients under the age of 21 years (and their representatives) of their right to Therapeutic Behavioral Services through written informing materials in the following circumstances:

- At the time of admission with an emergency psychiatric condition to an ICHHS-BH contract hospital
- At the time of admission to a skilled nursing facility with a special treatment program for the mentally disordered (SNF/STP) or a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMD).
- At the time of placement in a Rate Classification Level (RCL) 13-14 foster care group home.
- At the time of placement in an RCL 12 foster care group home if ICHHS-BH is involved in the placement.

B. These informing materials are available in English and in Spanish. Additional types of language assistance shall be provided as necessary and at no charge to the client.

Determining TBS Eligibility

To qualify for Therapeutic Behavioral Services, a client must meet the criteria in Sections A, B, and C.

A. Eligibility for Therapeutic Behavioral Services: client must meet criteria #1 and #2, below:
   1. Full-scope Medi-Cal client under age 21 years of age.
   2. Meets ICHHS-BH medical necessity criteria.

B. Member of the Certified Class – must meet criteria 1, 2, 3, or 4.
   1. Client is placed in a group home facility of RCL 12 or above and/or a locked treatment facility for the treatment of mental health needs (this facility must not be an Institution for Mental Disease as placement in this facility disqualifies clients from receiving federally-reimbursed Medi-Cal services); **or**
   2. Client is being considered by County for placement into a foster care group home RCL 12 through 14, or Metropolitan or Napa State Hospitals, or a skilled nursing facility, or an Institution for Mental Disease; or
   3. Client has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; **or**
   4. Client previously received Therapeutic Behavioral Services while a member of the certified class.

C. Need for Therapeutic Behavioral Services—**must meet criteria 1 and 2.**
   1. The client is receiving other specialty mental health services.
   2. It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of Therapeutic Behavioral Services:
      a. The client will need to be placed in a higher level of residential care, including **acute care** (including acute psychiatric hospital inpatient services and psychiatric health facility services) because

of a change in the client's behaviors or symptoms which jeopardize continued placement in the current facility; **or**

b. The client needs this additional support to transition to a lower level of residential placement. Although the client may be stable in the current placement, a change in behavior or symptoms is expected and Therapeutic Behavioral Services are needed to stabilize the child in the new environment. (ICHHS-BH or its provider must document the basis for the expectation that the behavior or symptoms will change.)

Clients at Risk of More Restrictive Placements

If ICHHS-BH is considering placement of an EPSDT-eligible beneficiary into a foster care group home RCL 12 through 14, or Metropolitan or Napa State Hospitals, or a skilled nursing facility, or an Institution for Mental Disease, ICHHS-BH must:

A. Consider whether the provision of TBS will allow the child or youth to remain in his/her current living situation; and
B. Ensure that the client receives services, if ICHHS-BH determines that placement to the higher level of care can be prevented; or
C. Follow certification procedures required by the state, if ICHHS-BH determines that the placement cannot be avoided.

TBS Authorization Process

Service Authorization

- Requests for Therapeutic Behavioral Services shall be directed to the Child and Family Program Chief (ICHHS-BH Clinical Supervisor) or designee for assessment consideration. The ICHHS-BH TBS Coordinator shall consult with the Authorization Team regarding appropriateness of the TBS referral and verify that eligibility requirements (above) are met.

- If youth is in placement, the ICHHS-BH Clinical Supervisor will contact the contracting agency to determine agreement with the referral.

- The ICHHS-BH Clinical Supervisor will initiate a team meeting to complete a TBS Service Plan and submit the information to the Authorization Team.

All requests for TBS services made by Medi-Cal clients to ICHHS-BH staff must be referred to ICHHS-BH TBS Coordinator regardless of outcome.

Authorization Timelines

A. <u>Standard Authorization Decisions</u>: ICHHS-BH shall provide authorization notice as quickly as the client's health condition requires, but not more than fourteen (14) <u>calendar</u> days from the receipt of the request for service.
   1. The client may request an extension of up to fourteen (14) additional calendar days.

2. ICHHS-BH may request an extension of up to fourteen (14) additional calendar days if more information is required and the extension is in the client's best interest (as determined by ICHHS-BH).

B. Expedited Authorization Decisions: for cases in which ICHHS-BH or its provider indicates that the standard authorization timeframe could seriously jeopardize the client's life or health, or his/her ability to attain, maintain, or regain maximum function, ICHHS-BH must provide authorization notice as quickly as the client's health condition requires, but not more than 3 working days after receipt of the request for service.
   1. The client or provider may request an extension of up to fourteen (14) calendar days.
   2. ICHHS-BH may request an extension of up to fourteen (14) calendar days if more information is required and the extension is in the client's best interest (as determined by ICHHS-BH).
   3. To utilize this expedited process, the provider shall complete an Expedited Authorization Request form. ICHHS-BH may not deny a provider's request to use this expedited process.

C. Denials or Modifications of Requests for Service
   1. In the event that ICHHS-BH denies or modifies the request for services, a Notice of Adverse Benefit Determination (NOABD-A or NOABD-B) will be sent to the client. The provider requesting the service must be notified as well, but may be given notice verbally.
   2. If ICHHS-BH is not able to make a TBS authorization decision within the specified timeframe, ICHHS-BH shall deny the request and submit a Notice of Adverse Benefit Determination to the client.
   3. All client protections under Title 9, Chapter 11 are applicable to TBS services. Clients have the right to receive a Notice of Adverse Benefit Determination, access the ICHHS-BH appeals process, and access the State Fair Hearing process after completing the ICHHS-BH appeals process.
   4. Refer to the Notices of Adverse Benefit Determination (NOABD) section in this Manual for more information.

Service Plan and Documentation

A. A written Treatment Plan for Therapeutic Behavioral Services must be completed by a clinician as a component of an overall Service Plan for specialty mental health services. ICBHICHHS-BH requests that all TBS Treatment Plans correspond to the following template:

   1. Specific target behaviors or symptoms jeopardizing the current placement or presenting a barrier to transitions, e.g. tantrums, property destruction, assaultive behavior in school.
   2. Specific interventions to resolve the behaviors or symptoms, such as anger management techniques.
   3. Specific outcome measures that can be used to demonstrate the frequency

of targeted behaviors has declined, and replaced with adaptive behaviors.

4. Transition Plan: as a short-term service, each TBS Service Plan must include a TBS Transition Plan. This plan will outline the process for decreasing and/or discontinuing Therapeutic Behavioral Services when they are no longer needed, or appear to have reached a plateau in benefit effectiveness. When applicable, the plan shall also include a process for the client's transition to adult services when the client turns 21 years old and is no longer eligible for TBS. This plan should assist parents and/or caregivers to gain the skills and strategies to provide continuity of care once this service has been discontinued.
5. The TBS Treatment Plan must be reviewed by ICHHS-BH licensed staff to ensure that Therapeutic Behavioral Services continue to be effective and that the client is making progress towards the specified, measurable outcomes. If necessary, the TBS Treatment Plan should be:
    a. Adjusted to identify new target behaviors, interventions, and outcomes as necessary and appropriate; and
    b. Reviewed and updated whenever there is a change in the client's residence.

B. A Progress Note is required for each time period that a Therapeutic Behavioral Services Aide spends with the client. The TBS Progress Note is completed by the TBS Aide.

    1. The Progress Note should include significant interventions that address the goals of the Treatment Plan. The Progress Notes do not have to justify staff intervention or activities for all billed minutes, just each time period spent with the client.
    2. TBS staff shall complete documentation on a daily basis when services are rendered on that day.
    3. Time spent traveling and documenting progress notes is Medi-Cal billable. On-call time for the staff person providing TBS is not Medi-Cal billable.

Supervision and Quality Management

ICHHS-BH maintains responsibility for determining the need for, providing access to, and managing Medi-Cal specialty mental health services.

A. The ICHHS-BH Child and Family Program Chief will provide the appropriate oversight and responsibility for the following:
    1. Reviewing and maintaining the policy and procedures for the TBS program;
    2. Maintain compliance with state regulations;
    3. Maintain compliance with claiming and reporting requirements; and
    4. Ensure distribution of Notices of Adverse Benefit Determination to Medi-Cal clients and DHCS.

B. The ICHHS-BH Child and Family Program Chief and, when appropriate, the TBS contract provider will provide the following:
   1. Recruit and screen Therapeutic Behavioral Services Aides;
   2. Train TBS Aides;
   3. Provide support to TBS Aides;
   4. Coordinate TBS on a day-to-day basis;
   5. Maintain written documentation of all services provided in a standard that meets ICHHS-BH requirements; and
   6. Perform other duties as assigned by ICHHS-BH.

C. Clinical Supervision
   1. As noted, Therapeutic Behavioral Services must be provided by a licensed practitioner of the healing arts or trained staff members who are under the direction of a licensed practitioner of the healing arts, as defined in the contract between DHCS and the ICHHS-BH.
   2. ICHHS-BH will direct a licensed designee to oversee Therapeutic Behavioral Services. All decisions regarding clinical treatment of a client who receives TBS must meet ICHHS-BH approval prior to authorization. All decisions regarding TBS eligibility, assessment, Service Planning, hiring, retention, training, support, will be subject to the final approval of ICHHS-BH.
   3. A licensed clinical supervisor or designee of ICHHS-BH will be available for consultation on a 24-hour a day, 7 day a week basis to assist TBS Aides in any difficulties that they may encounter related to their contractual obligations. When providing services on a day-to-day basis, TBS Aides will contact the ICHHS-BH TBS Coordinator for clarification.

Out-of-County Placements

A. If an ICHHS-BH Medi-Cal client is placed in an out-of-county facility and a request for TBS services is made, ICHHS-BH is responsible for determining eligibility and coordinating service with the out-of-county MHP or contractor.
   1. A list of TBS contacts in each county is available on the Department of Health Care Services (DHCS) website at www.dhcs.ca.gov. This list includes each county mental health plan's TBS contact information, including the Mental Health Director, the Children's Coordinator, the TBS Coordinator, the out-of-county Placement Coordinator, the county contact for TBS authorization, and the county contact for county interagency agreements.

B. ICHHS-BH is responsible for the oversight of its out-of-county placements requesting or receiving TBS, including:
   1. Participating in the interagency placement committee for placement of any child/youth with serious emotional disturbances in an STRTPas required under Section 4096 of the W&I Code and completing a TBS certification form documenting that TBS was considered as an alternate to placement and the reason TBS will not prevent the placement;

2. Completing a TBS certification form documenting that TBS was considered as an alternate to placement and the reason TBS will not prevent the placement if ICHHS-BH is involved in the placement for a group home at RCL 12;
3. Participating in regularly scheduled placement review or discharge planning meetings for any EPSDT eligible child/youth who is a patient at Metropolitan or Napa State Hospitals and completing a TBS certification form if it is determined that TBS in combination with other EPSDT services would not allow the child/youth to return to a lower level of care;
4. Notifying DHCS as soon as there is a change in county services or providers that affects 25 % or more of ICHHS-BH beneficiaries who are receiving services from the MHP;
5. Ensuring that TBS may be used when the child/youth needs additional support to transition to a lower level of residential placement; and
6. Continuing TBS even after a child/youth has met the behavioral goals in his or her TBS plan when TBS is still medically necessary to stabilize their behavior and reduce the risk of regression.

C. Annually, ICHHS-BH is required to report changes in staff who are responsible for coordinating provision of TBS for out-of-county placements. ICHHS-BH is also required to report changes, additions, and reductions in contracts with other county mental health plans and agencies that affect provision of TBS services for out-of-county placements.

Providing TBS in Group Homes

A. It is the responsibility of ICHHS-BH to ensure that Medi-Cal funding for Therapeutic Behavioral Services does not duplicate other funding for the same service. Some STRTPs are required to provide one-to-one assistance as part of mental health certification. If Therapeutic Behavioral Services are provided in a group home with such a requirement, ICHHS-BH clearly specifies that this service is in addition to and different from the services provided through the group home's one-to-one staffing.

B. In addition, if a group home or other provider is using their staff to provide Therapeutic Behavioral Services, there must be a clear audit trail to ensure that there is not duplicate funding.

Notices of Adverse Benefit Determination

ICHHS-BH shall issue Notices of Adverse Benefit Determination regarding denials or modifications of Therapeutic Behavioral Services consistent with state law and requirements. Within one month of being issued, copies of these Notices of Adverse Benefit Determination shall be submitted to DHCS at the following address:

TBS Coordinator

Department of Health Care Services
1501 Capitol Ave. P.O. Box 997413
Sacramento, CA 95899-7413
Fax (916) 440-7404

Reporting Requirements to DHCS

A. Within 30 days of inception of Therapeutic Behavioral Services to a client, ICHHS-BH submits the information specified in the format required by the State. If the client receives Therapeutic Behavioral Services for more than three (3) months, an update is submitted quarterly.
B. A review of paid claims data for this service will be made to ensure information is submitted for every client receiving Therapeutic Behavioral Services. If the required data is not submitted for a client for whom Therapeutic Behavioral Services are claimed, ICHHS-BH will follow up with the provider to ensure the data is submitted. If the provider still does not submit the information, or provides services that have not been pre-authorized, then the claim may be disallowed.

Non-Reimbursable Therapeutic Behavioral Services

Therapeutic Behavioral Services are **not** reimbursable under the following conditions:

A. When the needs for Therapeutic Behavioral Services are solely:
    1. For the convenience of the family or other caregivers, physician, or teacher;
    2. To provide supervision or to assure compliance with terms and conditions of probation;
    3. To ensure the client's physical safety or the safety of others, e.g., suicide watch, or
    4. To address conditions which are not part of the client's mental health condition.

B. For clients who can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day may not need this level of service.

C. For clients who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.

D. When the client is an inpatient of a hospital mental health unit, psychiatric health facility, skilled nursing facility (SNF), crisis residential program, Institution for Mental Diseases (IMD), or locked juvenile justice setting (such as Juvenile Hall).

CONFIRMATION LETTERS and NOTICES OF ADVERSE BENEFIT DETERMINATION

Approvals

When the ICHHS-BH Authorization Team authorizes services on behalf of a beneficiary, a written authorization will be sent to the requesting provider.

Denials or Modified Approvals

If ICHHS-BH denies a request for planned services as not meeting medical necessary criteria, gives approval to services different than those requested (in type, frequency, or duration), or fails to provide services or problem resolutions within specified timelines, ICHHS-BH shall complete a Notice of Adverse Benefit Determination (NOABD) specific to the event and distribute it to both the beneficiary and the service provider within a regulated timeframe.

There are five types of adverse benefit determinations and an appropriate NOABD form for each action:

Type of Notice of Adverse Benefit Determination	Description of Notice of Adverse Benefit Determination
NOABD (Delivery System)	ICHHS-BH determines that the client does not meet medical necessity criteria and no specialty mental health services will be provided.
NOABD (Payment Denial)	ICHHS-BH denies or modifies a request for payment for a service that has not yet been provided.
NOABD (Modification)	ICHHS-BH is unable to approve a requested service, but has approved an alternative treatment.
NOABD (Termination)	ICHHS-BH will no longer be approving a treatment that was previously provided.
NOABD (Timely Access)	ICHHS-BH fails to provide services in a timely manner, as determined by ICHHS-BH.
NOABD (Financial Liability)	ICHHS-BH denies a client's dispute of financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other financial liabilities.

The NOABD forms include information about the ICHHS-BH appeal process. All NOABD forms are issued with a "NOABD Your Rights" attachment that explains the Appeal, Expedited Appeal and State Fair Hearing processes.

Overview

Whether beneficiaries are treated by ICHHS-BH staff or by contract provider staff, they are entitled to utilize the Beneficiary Problem Resolution Process. This process involves procedures for filing *grievances, standard appeals,* and *expedited appeals.* In certain situations, beneficiaries also have access to the State Fair Hearing Process. Providers are required to advise all beneficiaries of their right to use these procedures.

Definitions

- *Adverse Benefit Determination : Occurs when ICHHS-BH or its providers do one of the following*:
    - Denies or limits a requested service through the authorization process (this includes the type of service or the level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit);
    - Reduces, suspends, or terminates a previously authorized service;
    - Denies, in whole or in part, payment for a service;
    - Fails to provide services in a timely manner, as determined by DHCS; and/or
    - Fails to act within the timeframes provided in 42 CFR 438.408 (b)(1), (2) and (3) for a disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
    - The denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
- A ***Standard Appeal*** is a request for review of an adverse benefit determination.
- An ***Expedited Appeal*** is used when the ICHHS-BH determines or (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- A ***Grievance*** is an expression of dissatisfaction about any matter other than an adverse benefit determination. Any problem that a client may have which does not involve an adverse benefit determination must be filed as a grievance.
    - Possible grievances include, but are not limited to, access to services; the quality of care or services provided; aspects of interpersonal relationships such as rudeness of a provider or staff member; or failure to respect the client's rights.

Resolution Policies

- Contract providers shall utilize the ICHHS-BH "Client Problem Resolution Guide" to inform the beneficiary of their rights and processes to file a grievance.

- A beneficiary may choose not to discuss his/her grievance with the contract provider prior to initiating the problem resolution process through ICHHS-BH.

- A client may authorize another person, including his/her attorney, to act on his/her behalf.
    - In the appeal process, the client may also select a provider as his/her representative.

- Information regarding grievances and appeals shall be maintained in a confidential manner and shall only be discussed with those directly involved in the matter, or as required by state or federal laws or regulations.

- ICHHS-BH and its providers will not subject any client who may file a request for problem resolution to discrimination or penalty. Any report of retaliatory behavior by ICHHS-BH or contract staff shall be investigated and may be cause for disciplinary action, including possible dismissal depending on the seriousness of the retaliatory action.

- The ICHHS-BH Administrative Secretary will aid clients in the problem resolution process. These individuals will also provide status of a client's grievance or appeal, upon request.

- The ICHHS-BH Director or a designated clinician will make decisions regarding grievances and appeals. These individuals shall not be involved in any previous level of review or decision-making.
    - **If the situation is clinical in nature, the person(s) making the decision must be a mental health care professional with the appropriate clinical expertise in treating the beneficiary's condition.** Such situations requiring clinical expertise include:
        - Appeals based on lack of medical necessity;
        - Grievances regarding denial of expedited resolution of an appeal; and/or
        - Grievances/appeals that involve clinical issues.

- The ICHHS-BH Administrative Secretary shall confidentially maintain a Grievance and Appeal Log for tracking problems reported by clients.

State Fair Hearings

- Clients have a right to request a State Fair Hearing after completing the ICHHS-BH Problem Resolution Process.
    - Clients must first exhaust the county Problem Resolution Process before filing for a State Fair Hearing.

Providing Information to Clients

- ICHHS-BH staff provide clients with the Client Problem Resolution Guide at admission and at the time of the annual assessment.
  - Clerical staff shall ensure that a Client Problem Resolution Guide is attached to each annual Assessment form.

- Problem resolution materials, including self-addressed envelopes, are available at all provider sites. This material will be maintained in visible locations.

- Problem resolution materials are available in English, and in the Inyo County threshold languages, currently Spanish. Clients who are visually impaired shall be able to access the information via audiotape. Bilingual and interpreter services are also available to assist with the process.

- Information regarding the ICHHS-BH problem resolution process is also available through the toll-free 24-hour telephone system.

- Changes to the problem resolution process and/or clients' rights shall be posted in a prominent location at all provider sites.
  - Brochures and informing materials except for provider directories will be updated as soon as possible, but at least within 90 days, to reflect any new regulations. Provider directories will be updated at least monthly and electronic provider directories will be updated no later than 30 days after ICHHS-BH receives updated provider information.

Grievance Process

1. Clients may file a grievance verbally or in writing.

2. A client may authorize another person, including his/her attorney, the Patient's Rights Advocate or a Provider, to act on his/her behalf.

3. When an ICHHS-BH provider receives a grievance, he/she shall submit the grievance to the ICHHS-BH Administrative Secretary. If the grievance is written, the provider or designated staff shall date/time stamp the written document and fax/forward it to I the ICHHS-BH Administrative Secretary immediately.

4. The ICHHS-BH Administrative Secretary shall record the grievance (verbal or written) in the confidential Grievance and Appeals Log within one (1) working day of the date that the provider received the grievance.

5. The ICHHS-BH Administrative Secretary shall promptly acknowledge receipt of the verbal or written grievance to the client in writing.

6. A decision regarding the grievance must be made within ninety (90) calendar days of receipt of the grievance. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
   - This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if ICHHS-BH determines that the delay is necessary and is in the best interest of the client.

7. ICHHS-BH will notify the client (or his/her representative) of the grievance decision in writing.
   - If a client cannot be reached (i.e., returned mail), ICHHS-BH will document the notification effort in the Grievance and Appeals Log.

8. ICHHS-BH will also notify any provider(s) or staff persons cited in the grievance of the final decision, in writing.

9. If ICHHS-BH fails to notify the client or other affected parties of its grievance decision within the allowable timeframe, the client will be given a NOABD advising that he/she has a right to request an appeal and/or a State Fair Hearing.
   i. The NOABD will be given on the date that the timeframe expires.
   ii. **NOTE:** Clients cannot request a State Fair Hearing before, during, or after the **grievance process**, *unless* ICHHS-BH has failed to act within the timeframe required by the grievance process.

10. Inyo County Health and Human Services - Behavioral Health will strive to provide resolution of a client's grievance as quickly and simply as possible.

Appeals Processes

Standard Appeals

1. Clients may file an appeal verbally or in writing. The appeal must be made in response to an action.
   a. The appeal must be filed within ninety (90) days of the date of the action.
   b. A client must follow up a verbal appeal with a signed, written appeal.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf.
   a. In the appeal process, the client may also select a provider as his/her representative.

3. When a provider receives an appeal, he/she shall date/time stamp the appeal and immediately fax/forward it to the ICHHS-BH Administrative Secretary.

4. The ICHHS-BH Administrative Secretary shall record the appeal (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt by the provider. The appeal will then be forwarded to the ICHHS-BH Director.

5. The ICHHS-BH Administrative Secretary shall promptly acknowledge receipt of the verbal or written appeal to the client in writing.

6. The client will be given the opportunity to present evidence and allegations of fact or law. This component may be done in person or in writing.

7. Before and during the appeal process, the client and/or his/her representative will be allowed the opportunity to examine the client's chart and any other documents relevant to the appeal.

8. A decision regarding the appeal must be made within thirty (30) calendar days of receipt of the appeal.
    a. If request for an appeal was first given verbally, the timeline requirements begin on that day, not the day when the written follow-up is received from the client.
    b. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
    c. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if ICHHS-BH determines that the delay is necessary and is in the best interest of the client.

9. The ICHHS-BH Director will notify the client or his/her representative in writing of the appeal decision. The notice will include:
    a. The results of the appeal process and the date the appeal was made.
    b. Information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.

10. ICHHS-BH will also notify any provider(s) or staff person(s) cited in the appeal of the final decision in writing.

11. If ICHHS-BH fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a NOABD, advising that the client has a right to request a State Fair Hearing.
    a. The NOABD will be given on the date that the timeframe expires.

Expedited Appeals

1. Clients may file an expedited appeal verbally or in writing. The expedited appeal must be made in response to an action.
    a. The expedited appeal process may ONLY be used when the standard appeal process could jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function.
    b. **NOTE**: A client does NOT need to follow up a verbal expedited appeal with a signed, written appeal.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf. In the appeal process, the client may also select a provider as his/her representative.

3. When a provider receives a written expedited appeal, he/she shall date/time stamp the appeal and immediately fax/forward it to the ICHHS-BH Administrative Secretary.

4. The ICHHS-BH Administrative Secretary will record the appeal (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt. The appeal will then be forwarded to the ICHHS-BH Director.

5. The ICHHS-BH Administrative Secretary shall promptly acknowledge receipt of the verbal or written appeal to the client in writing.

6. The ICHHS-BH Director will review the request for an expedited appeal.
    a. If the request for an expedited appeal is denied, the appeal will be transferred to the standard appeal process and resolved within the timeframe specified in that process.
        - ICHHS-BH will make reasonable efforts to give the client prompt verbal notice of the denial of the expedited appeal process and follow up with a written notice within two (2) calendar days.
    b. If the request for an expedited appeal is granted, the client and/or his/her representative may present evidence in person or in writing and may examine his/her case file and any other records pertaining to the appeal, before and during the appeal process.

7. A decision regarding the appeal must be made within **72 hours** of receipt of the appeal. All affected parties (including client, providers, staff members, etc.) must be notified verbally, as well as in writing, of the decision within this timeframe.
    a. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if ICHHS-BH determines that the delay is necessary and is in the best interest of the client.

8. ICHHS-BH will notify the client or his/her representative of the expedited appeal decision verbally and in writing. The notice will include:
    a. The results of the appeal process and the date the appeal was made.
    b. Information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.

9. ICHHS-BH will also notify any provider(s) or staff persons cited in the expedited appeal of the final decision, verbally and in writing.

10. If ICHHS-BH fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a Notice of Adverse Benefit Determination (NOABD-Timely Access) advising that he/she has a right to request a State Fair Hearing.
    a. The Notice of Adverse Benefit Determination (NOABD-Timely Access) will be given on the date that the timeframe expires.

Aid Paid Pending

In certain instances, ICHHS-BH will provide aid paid pending (APP) to beneficiaries who request continued services and have filed a timely request for an **appeal or state fair hearing**.

1. A beneficiary receiving specialty mental health services will have a right to file for continuation of specialty mental health services pending the outcome of a fair hearing.

2. ICHHS-BH will continue the beneficiary's benefits while an appeal is in process if all of the following occur:
   a. The beneficiary files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice;
   b. The appeal involves the termination, suspension, or reduction of a previously authorized service;
   c. The beneficiary's services were ordered by an authorized provider;
   d. The period covered by the original authorization has not expired; and,
   e. The request for continuation of benefits is filed on or before the later of the following:
      i. Within 10 calendar days of ICHHS-BH sending the notice of adverse benefit determination; or
      ii. The intended effective date of the adverse benefit determination.

3. If, at the beneficiary's request, ICHHS-BH continues the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits must be continued until the beneficiary withdraws the appeal or request for state fair hearing, the beneficiary does not request a state fair hearing and continuation of benefits within 10 calendar days from the date ICHHS-BH sends the notice of an adverse appeal resolution, or a state fair hearing decision adverse to the beneficiary is issued.

4. A timely request is ten (10) days from the date the Notice of Adverse Benefit Determination () was mailed, or ten (10) days from the date the NOABD was personally given to the beneficiary, or before the effective date of the change, whichever is later.

5. The beneficiary must either have an existing service authorization which has not lapsed, and the service is being terminated, reduced, or denied for renewal by the MHP; or, the beneficiary must have been receiving specialty mental health services under an exempt pattern of care.
   - An exempt pattern of care is the denial of a provider's request to continue a pattern of care that has been exempt from authorization by the MHP and would require an NOABD.
   - An exempt pattern of care may exist in a situation when a county has a policy that permits a predetermined amount of services to be provided without prior authorization. (For example, a county allows providers three

visits without prior authorization. A provider subsequently requests authorization for an additional three visits.)

6. This action will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, the date an appeal is resolved, or a hearing decision is rendered; or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

Please note: A beneficiary may file an appeal or a state fair hearing request about an action whether or not a NOABD has been issued. However, clients must first exhaust the ICHHS-BH Problem Resolution Process before filing for a state fair hearing.

Quality Management

Beneficiary grievances, appeals, and fair hearings – All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings will be reviewed by the Behavioral Health Director if appropriate and may include Inyo County Risk Management. Monitoring shall be accomplished by ongoing review of the complaint/grievance log for adherence to timelines for response. In addition, the nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review will include an analysis of any trends in cultural issues or disparity in care addressed by our consumers. A summary of trends will be presented to the Quality Improvement Committee (QIC) meetings as appropriate for feedback on policy changes. A summary of these findings will recorded in the QIC meeting minutes.

PROBLEM RESOLUTION PROCESSES

Provider

The Inyo County Mental Health Plan will work cooperatively to resolve any problems identified by providers in a sensitive and timely manner, utilizing both a Provider Problem Resolution Process and a Provider Appeal Process. These processes may be accessed by ICHHS-BH providers to address payment authorization issues and other complaints and concerns.

ICHHS-BH shall work closely with providers to resolve disputes in a timely, efficient manner, and will strive to provide a means for clients to continue receiving medically necessary services while disputes are being resolved.

Provider Problem Resolution Process

1. A provider, whether an individual professional or an organization, may contact ICHHS-BH at any time to resolve payment authorization issues or other complaints and concerns.
   a. ICHHS-BH will work cooperatively with the provider to resolve problems in a simple, informal, and timely manner.
   b. The provider may notify ICHHS-BH of the complaint or concern verbally (via the Administrative Secretary or designee) or in writing.

2. In most cases, if the ICHHS-BH Director or designee cannot immediately resolve the matter, a response to the provider's concern will occur.
   a. In cases involving Residential Treatment Program Providers, ICHHS-BH shall accelerate the time line to respond.

3. Whenever ICHHS-BH produces a written response to a provider complaint, the response is filed in ICHHS-BH Grievance Log.

Provider Appeal Process

1. A provider may appeal a denied or modified request for ICHHS-BH payment authorization or a dispute with ICHHS-BH concerning the processing or payment of a provider's claim to ICHHS-BH.

2. A provider may initiate the appeal process orally, but will need to follow up with a signed written appeal or through a written request submitted to the ICHHS-BH Administrative Secretary or designee.
   - The Administrative Secretary will document the date of receipt of the appeal in the ICHHS-BH Grievance and Appeal Log. The resolution and date of response to the appeal are also recorded in the log.
   - The appeal should clearly identify the provider's concerns and may include any supporting documentation that will assist in the problem resolution.

- The written appeal shall be submitted to ICHHS-BH within ninety (90) calendar days of the date of receipt of the non-approval of payment, or within ninety (90) calendar days of the ICHHS-BH failure to act on the request for payment.

3. The ICHHS-BH Director or designee shall review the written appeal and any associated documentation.
    - If the appeal concerns the denial or modification of ICHHS-BH payment authorization request, ICHHS-BH shall utilize staff who were not involved in the initial denial or modification decision.

4. ICHHS-BH shall respond to the provider's appeal with a decision in writing within sixty (60) calendar days from the receipt of the provider's appeal request.
    - The written response shall include a statement of reasons for the decision that address each issue identified by the provider, and any action required by the provider to implement the decision.
    - If the appeal is denied or not granted in full, the provider shall be notified of any right to submit an appeal to the California Department of Mental Health.

5. If applicable, ICHHS-BH may request a provider to submit a revised request for ICHHS-BH payment authorization.
    - The provider shall submit a revised request within thirty (30) calendar days from receipt of the ICHHS-BH decision to approve the ICHHS-BH payment authorization request.
    - ICHHS-BH shall process the provider's revised request for payment within fourteen (14) calendar days from the date of receipt of the provider's revised request for payment authorization.

6. **If ICHHS-BH does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied by ICHHS-BH.**

Provider Appeals to the CA Department of Health Care Services

1. Hospitals and inpatient services providers may appeal directly to the California Department of Health Care Services (DHCS) when an ICHHS-BH payment authorization request for emergency services has been denied or modified via the provider resolution process. Such denials or modifications are eligible for DHCS appeals if the ICHHS-BH decision was based on the following issues:
    a. The provider did not comply with the required timelines for notification or submission of the ICHHS-BH payment request, or
    b. The medical necessity criteria were not met.
2. If a provider chooses to appeal to DHCS, the appeal shall be submitted in writing, along with supporting documentation, within thirty (30) calendar days from the date of the ICHHS-BH written decision of denial.
    a. The provider may appeal to DHCS within thirty (30) calendar days after sixty (60) calendar days from submission to ICHHS-BH, if ICHHS-BH fails to respond.

b. Supporting documentation shall include, but not be limited to:
    i. Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.
    ii. Clinical records supporting the existence of medical necessity if at issue.
    iii. A summary of reasons why ICHHS-BH should have approved the ICHHS-BH payment authorization.
    iv. A contact person(s) name, address and phone number.

3. DHCS shall notify ICHHS-BH and the provider of its receipt of a request for appeal within seven (7) calendar days.
    a. The notice to ICHHS-BH shall include a request for specific documentation supporting denial of the ICHHS-BH payment authorization and for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal.
        i. ICHHS-BH shall submit the requested documentation within twenty-one (21) calendar days or DHCS shall decide the appeal based solely on the documentation filed by the provider.

4. DHCS shall have sixty (60) calendar days from the receipt of the ICHHS-BH documentation, or from the twenty-first (21st) calendar day after the request for documentation (whichever is earlier), to notify the provider and ICHHS-BH of its decision, in writing.
    a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider and the ICHHS-BH, and any adverse benefit determination required by the provider and ICHHS-BH to implement the decision.
    b. At the election of the provider, if DHCS fails to act within the sixty (60) calendar days, the appeal may be considered to have been denied by DHCS.
    c. DHCS may allow both a provider representative(s) and the ICHHS-BH representative(s) an opportunity to present oral argument to DHCS.

5. If the appeal is upheld, the provider shall submit a revised request for ICHHS-BH payment authorization within thirty (30) calendar days from receipt of the DHCS decision to uphold the appeal.
    a. If applicable, ICHHS-BH shall have fourteen (14) calendar days from the receipt of the provider's revised ICHHS-BH payment authorization request to approve the ICHHS-BH payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the ICHHS-BH payment authorization.

BILLING AND PAYMENT

Overview

Payment policies and procedures contained herein are intended to provide a general overview of how providers receive reimbursement from ICHHS-BH. However, each individual provider's contract with ICHHS-BH supersedes any information contained herein.

- ✓ Providers must agree to the Inyo County Mental Health Medi-Cal fee schedule negotiated rate within the provider's contract for the specific authorized services. Reimbursement levels are determined by the practitioner's licensure (not degree) and the type of service, assessment, or therapy provided.

- ✓ Medi-Cal guidelines do not allow payment of sessions for which a **beneficiary fails to show**.

- ✓ Professional services for beneficiaries residing in Long-Term Care Facilities require preauthorization. The following Medi-Cal schedule will continue to be used as a guideline:

  - Two hours per seven-day period during the first two months of treatment;
  - One hour per seven-day period for the third through seventh month of treatment;
  - One hour per 14-day period for each month after the seventh month of treatment; and
  - One hour per seven-day period during the month prior to discharge.

Payment Policies

Payment will be authorized for valid claims for specialty mental health services if:

- ✓ The services were pre-authorized by members of the ICHHS-BH Authorization Team.

- ✓ Services were delivered by a contract or otherwise authorized provider.

- ✓ Services were within the range of pre-selected service codes allowed by the provider's scope of practice and contract agreements.

- ✓ The beneficiary is eligible for Medi-Cal. *Note: Service authorization does not guarantee Medi-Cal eligibility. It is the provider's responsibility to assure that the client is eligible. The provider may call ICHHS-BH for assistance in verification of eligibility.*

Billing Procedures

The provider's billing must be on the CMS-1500 form (standardized insurance claim format). All billings should be sent to:
Inyo County Health and Human Services - Behavioral Health
Attention: Mental Health Plan Analyst/Administrative Secretary
162 J Grove Street
Bishop, CA 93541
760-873-6533 or 760-872-2590

Billings must contain the following information, at a minimum:
- ✓ Beneficiary name
- ✓ Beneficiary Social Security number
- ✓ Beneficiary Medi-Cal ID number
- ✓ Date, service code, description, total minutes, and fee for each service
- ✓ Total amount being billed

PSYCHIATRISTS ONLY
Laboratory Services: All laboratory services for Specialty Mental Health Services will continue to be funded through the Department of Health Services.

Important Points Regarding Claims

- ✓ Treatment of any Medi-Cal beneficiary must be performed by the practitioner whom services were authorized. A provider shall not bill for treatment provided by another practitioner or an assistant.
- ✓ Providers may not legally bill a Medi-Cal beneficiary for services authorized by ICHHS-BH.
- ✓ All services must be preauthorized in order to receive reimbursement.

Payment Procedures

Payments will be made within thirty (30) days of receipt. The processing and payment of claims involves the following steps:
1. All claims are processed on a line-by-line basis, except for inpatient facility claims. Inpatient claims are paid on a total claim basis.
2. Claims are subjected to a comprehensive series of edits and audits.
3. Claims that meet all edit and audit requirements, and are in compliance with payment policies, are processed for payment by the Inyo County Auditor.
4. Checks are printed once monthly.

Note: Hospitals that bill Medi-Cal directly will be paid through the State's automated payment system.

Payment Inquiries

Payment inquiries may be made by calling 760-873-6533 or 760-872-2590, or in writing with a copy of the original billing attached.

CONTRACT PROVIDER

Responsibilities

Providers who treat ICHHS-BH Medi-Cal beneficiaries have responsibilities to:

- ✓ At the beginning of each month, verify Medi-Cal eligibility of:
  - o All clients served, and
  - o Beneficiaries for whom they seek service authorization.

- ✓ Inform beneficiaries of their right to access the ICHHS-BH grievance and appeals processes, including the right to access a State Fair Hearing after completing the ICHHS-BH Beneficiary Problem Resolution Process. The contract provider shall give each beneficiary a copy of ICHHS-BH Client Problem Resolution Guide during the first meeting with the client and again at the annual assessment.

- ✓ Ensure the following beneficiary rights:
  - o The right to receive information in accordance with 42 CFR, Section 438.10;
  - o The right to be treated with respect and with due consideration for his/her dignity and privacy;
  - o Beneficiary rights concerning the confidentiality and integrity of his/her protected health information in accordance with HIPAA;
  - o The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand;
  - o The right to participate in decisions regarding his or her health care, including the right to refuse treatment;
  - o The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion;
  - o The right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR, Sections 164.524 and 164.526; and
  - o The right to be furnished health care services in accordance with 42 CFR Sections 438.206 – 210.

- ✓ Provide culturally-competent services that are sensitive to the needs and preferences of the beneficiary;

- ✓ Schedule an initial visit with the client within twenty (20) working days from authorization approval for clinic service providers; or, schedule an initial visit within seven (7) working days from authorization approval for private network providers.

- ✓ Request consultation with a member of the ICHHS-BH Team regarding any potentially planned admission of a beneficiary into an inpatient facility.

- ✓ Provide services to beneficiaries in accordance with legal and ethical standards as stipulated by all relevant professional, federal, state, and/or local regulatory and statutory requirements, and as outlined in the provider contract with ICHHS-BH.

- ✓ Maintain clinical records according to ICHHS-BH standards. Records must be legible and kept in detail consistent with appropriate medical and professional practice in order to:
  - Permit effective internal professional review and external medical audit process, and
  - Facilitate an adequate system for follow-up treatment.
  - Maintain clinical records for at least seven (7) years from the last date of service to the beneficiary; produce and maintain documentation that pertains to the services provided to beneficiaries under the contract provisions of ICHHS-BH, available for inspection, examination or copying;
    - By ICHHS-BH, the Department of Health, the Department of Health Care Services, and the United States Department of Health and Human Services;
    - At all reasonable times at the provider's place of business or at another mutually agreed upon location; and
    - In a form maintained in accordance with the general standards applicable to such record keeping.

- ✓ Use DSM-V diagnostic codes, or the most recent version of the DSM Manual. *ICD-9-CM codes are not acceptable.*

- ✓ Follow strict confidentiality guidelines to assure the beneficiary's privacy when referrals to other agencies and providers are necessary. Information regarding the beneficiary will not be provided without written permission from the beneficiary or the beneficiary's legal representative.

- ✓ Maintain a log of beneficiary grievances and appeals. For more information, see the section on the beneficiary problem resolution procedure.