Sutter-Yuba Mental Health Plan Provider Manual

1965 Live Oak Boulevard, Suite A
PO Box 1520
Yuba City, CA 95992

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Welcome to the Sutter-Yuba Mental Health Plan

Welcome! Thank you for choosing to become a provider for the Sutter-Yuba Mental Health Plan (SYMHP). The mental health plan is committed to providing community based, culturally-sensitive and high quality mental health services to Sutter and Yuba Medi-Cal beneficiaries. Your participation gives Sutter and Yuba beneficiaries expanded access to mental health care.

The provider manual contains important information about the Sutter Yuba Mental Health Plan (MHP). This manual outlines the process through which a Medi-Cal beneficiary seeking mental health treatment can access our services and it explains how a provider can obtain pre-authorization for services and submit a claim for payment. In addition, this manual also describes the complaint and grievance process.

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Introduction

This manual serves to guide providers in their treatment of Sutter-Yuba Mental Health Plan beneficiaries and gives information on a wide range of topics, such as authorizations, documentation standards, problem resolution and data collection. Because only general guidance is provided herein, providers should refer to their respective contracts for more detailed and specific information. For items not specified in contracts, this manual serves as a blueprint to which providers should refer.

It is expected that all providers will comply with the Sutter County Health and Human Services Mission Statement:

"The Sutter County Health and Human Services Department provides a client centered, outcome oriented, integrated, cost effective delivery of services. Staff of this department are committed to safeguarding the physical, emotional, and social well-being of others while promoting self-sufficiency and quality of life and health for those we serve."

Medi-Cal Managed Care Mental Health Services

Historically, there have been two separate Medi-Cal funded mental health systems. One was the Short-Doyle Medi-Cal system, or County operated mental health program. The other was the Fee-For-Service system, which was composed of private hospitals, psychiatrists, and psychologists who billed the State for services they provided. These two systems had separate providers, separate billing processes, separate rules for reimbursable services, and different rates or fees for reimbursement. The same beneficiary could receive services from each system, with some limitations under the Fee-For-Service system.

Introduction

To improve Medi-Cal beneficiaries' access to quality and coordinated services, the State of California moved to a managed care model of service delivery where Short-Doyle and Fee-For-Service Medi-Cal mental health programs were consolidated into a single system. On January 1, 1995, Phase I of the managed care plan consolidated inpatient services. Counties entered into an agreement with (what was then) the Department of Mental Health to manage Fee-For-Service and Short-Doyle inpatient services. This change resulted in a single and coordinated system, and decreased expenditures.

On April 1, 1998, the Sutter-Yuba Mental Health Plan (SYMHP) implemented Phase II Consolidation for all specialty mental health services provided under the Short-Doyle and Fee-For Service system. The SYMHP is responsible for providing specialty mental health services to Medi-Cal beneficiaries who meet medical necessity criteria, through contracted providers or through Sutter-Yuba Behavioral Health service sites.

How To Contact Us

Quick Telephone Reference

Directory of Personnel with Managed Care Responsibilities:

SUTTER-YUBA BEHAVIORAL HEALTH
PERSONNEL SERVICE DIRECTORY - HOW TO REACH US

1. Claims/Payment
   Medical Fiscal Manager
   (530) 822-7200
   Fax: (530) 822-7108

   Mail Claims To:
   Sutter-Yuba Behavioral Health
   P.O. Box 1520
   1965 Live Oak Boulevard, Suite A
   Yuba City, CA 95992

   Contracts
   Staff Analyst
   Rob Davis
   (530) 822-7000

2. Member Complaints/Grievances
   Deputy Director, Clinical Services
   Shannon Secrist, LCSW
   (530) 822-7200
   1-888-923-6800
   (TTY-CRS) 1-800-735-2929

   Patient Rights Advocate
   Christine Leonard
   (530) 822-7200, press 8

   State Hearings Division (State Fair Hearing)
   California Department of Social Services
   P.O. Box 944243
   Mail Station 19-37
   Sacramento, CA 94244-2430
   1-800-952-5253
   TDD 1-800-952-8349

3. Physical Health Care Relations
   Psychiatric Health Facility (PHF)/Assessment Services
   Program Manager
   Susan Williamson, LCSW
   (530) 822-7200

4. Primary Care Physician Consultation
   Hardeep Singh, MD
   (530) 822-7200

How To Contact Us

Personnel Service Directory - How To Reach Us Continued:

5. Provider Relations
   Staff Analyst
   Beverly Griffith
   (530) 822-7200

6. Intake/Assessment
   For times of adult intake/assessments please call:
   Adult: (530) 822-7200

   For youth intake/assessment please call:
   Youth: (530) 822-7513

7. Re-Authorization, Out of County Authorizations, Inpatient Managed Care Authorizations
   Quality Assurance Office
   (530) 822-7200
   Fax: (530) 822-7108
   Sutter-Yuba Behavioral Health
   P.O. Box 1520
   1965 Live Oak Boulevard, Suite A
   Yuba City, CA 95992

FOR PROVIDERS:

To request service authorizations please call:

- **Adult & Youth Services** – Quality Assurance Office
  (530) 822-7200

For **urgent** situations, providers may call any time at:

(530) 673-8255 **(673-TALK)** *or* Toll Free 1-888-923-3800

Section 1: Access and Referral

All Sutter-Yuba Mental Health Plan (SYMHP) beneficiaries have the right to immediate access to emergency services and timely access to appropriate, culturally sensitive, mental health services that are provided by competent staff and/or contract providers.

1.0 Access Points (All Languages)

- **Consumer Toll-Free Telephone Line: (1-888-923-3800)**

- **Sutter-Yuba MHP Provider Site:**

  Sutter-Yuba Behavioral Health
  1965 Live Oak Boulevard
  Yuba City, CA 95991

  Adult Services: Main Building (530) 822-7200, press 0 then 1
  Youth Services: Modular Building (530) 822-7200, press 0 then 2

- In addition to the above, the Spanish Language Open Access Clinic is available on Thursdays from 9:00 am to 11:00 am at the Latino Outreach Center, located at 545 Garden Hwy, Suite B, Yuba City, CA 95991. The phone number for the Latino Outreach Center is (530) 674-1885, press 4.

1.1 Requests for Service

When a beneficiary requests services in person or by phone, the following will occur:

- **Adults:** Adults will be informed of the days and times of the Open Access Clinic, where drop-in triages and assessments occur. Once a triage is completed, an assessment will be completed either the same day or the next Open Access day. Adult beneficiaries may call **(530) 822-7200, press 0 then press 1** for more information.
- **Youth:** Youth will be informed of the days and times of Youth Triage, where drop-in triages occur. Once a triage is completed, an appointment is scheduled for an assessment. Youth beneficiaries

may call **(530) 822-7200, press 0 then 2** for more information. For beneficiaries who are unable to come during drop-in triage times, an appointment will be scheduled.

Beneficiaries with emergent psychiatric needs will be directed to the SYMHP's 24-hour Psychiatric Emergency Services, where the individual will be assessed. If needed, beneficiaries will be admitted to the SYMHP's Psychiatric Health Facility (PHF), or another psychiatric hospital. Youth under the age of eighteen (18) requiring inpatient psychiatric treatment will be referred to a hospital that treats youth.

- Before a clinical assessment occurs, staff obtains consent for treatment, financial eligibility forms are completed and the beneficiary is provided with a brochure that clearly explains services as well as the complaint, grievance and State Fair Hearing process.

1.2 Consumer Access Line

The consumer access line **(1-888-923-3800)** is available 24 hours a day, 7 days a week for all requests for specialty mental health services.

These additional numbers can be called for access:
Adults: (530) 822-7200, press 0 then press 1
Youth: (530) 822-7200, press 0 then press 2

For beneficiaries with hearing impairment, please call the California Relay System TTY **(1-800-735-2929).**

1.3 Provider Access Line

The provider access line **(530/822-7200, press 6** for the Business Office) is available Monday through Friday, 8:00 am to 5:00 pm (except holidays) for all providers seeking information about the MHP.

Providers may also call the consumer access line toll free at **(1-888-923-3800)** and ask to be connected to Business Office.

1.4 Who Can Make Referrals?

Referrals to the SYMHP for specialty mental health services may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to:

- Physical Health Care/Primary Care Providers
- Schools
- Other County Departments
- Other Mental Health Plans
- Conservators/Public Guardians
- Family Members
- Law Enforcement Agencies
- Private Practice Mental Health Providers in the Community

1.5 Out of County Referrals

- Beneficiaries requiring specialty mental health services when outside of Sutter-Yuba Counties will call 1-888-923-3800 for information about how to access services. Child or Youth beneficiaries who have a foster aid code, aid to adoptive parents' aid code and Kin-Gap aid code will contact Quality Assurance for managed care authorization at (530) 822-7200.

If there is an urgent need, beneficiaries may call 911 or go to the nearest psychiatric facility for emergency treatment. Specialty mental health services provided to a beneficiary to treat an urgent condition do not require preauthorization. The provider must notify the MHP (1-888-923-3800) within 24 hours of service delivery.

1.6 Interagency Referrals, Referrals from Primary Care Physicians or Other Sources

- The access point for all other referrals is through the Consumer Access Line (1-888-923-3800) or through Adult Services Reception (530/822-7200, press 0 then press 1), Youth Services Reception (530/822-7200, press 0 then press 2), or Quality Assurance (530/822-7200).

1.7 What Happens When A Request For Service Is Received?

- A licensed/waivered clinician will screen the request and determine if there is a mental health need.

- If a mental health need is determined to be present, a licensed/waivered clinician will refer the beneficiary for an assessment.

- Mental health assessments may be done by licensed/waivered clinical staff at Sutter-Yuba Behavioral Health (SYBH).

- If SYBH clinical staff determine that the client meets medical necessity criteria, the client will be scheduled with a provider (internal or network provider) who is best able to meet the beneficiary's mental health needs.

- When SYBH clinical staff determine that medical necessity criteria is not met after an initial assessment, the staff member will:

  - Complete and send a "Notice of Action –A" form.
  - Inform the beneficiary verbally of his or her right for a second opinion. This information is also given in writing during the assessment.
  - Give the beneficiary brochures explaining the complaint, grievance, appeal or state fair hearing process and assistance available. This information is provided to the beneficiary during the assessment.

The California Department of Health Care Services requires that the beneficiary be provided a Notice of Action and be informed of his/her right to a State Fair Hearing within three working days once services are denied due to the absence of medical necessity.

How to Obtain Authorization For Mental Health Services

Section 2: Service Authorization

The Sutter-Yuba Mental Health Plan (SYMHP) is strongly committed to providing quality services to its beneficiaries, while supporting a philosophy of brief-oriented treatment.

SYMHP staff typically perform the initial assessment which determines medical necessity. Providers who are able to meet the beneficiary's clinical need for continuing treatment and who provide medically necessary services will be authorized. Authorizations may range from treatment with private practice providers to treatment in a psychiatric hospital.

AUTHORIZATION PROCEDURES:

2.0 Pre-Authorization of Non-Emergency Services

All planned (non-emergency) services to members **MUST BE PRE-AUTHORIZED** by the SYMHP. **Services to members without authorization will not be reimbursed.** Pre-Authorization is not required for urgent or emergency services.

2.1 Initial Authorization Process

The SYMHP responds to requests for specialty mental health services from its members, providers and other referring agencies. After confirming member eligibility and screening for medical necessity, the Quality Assurance Office will provide authorization and a referral to a licensed network provider or organizational provider when services will not be provided at Sutter-Yuba Behavioral Health.

An addition to the above process, the SYMHP youth services contractor may receive authorization to provide services from SYBH's Youth and Services Program Manager.

How to Obtain Authorization For Mental Health Services

- The SYMHP follows the Department of Health Care Services' standards regarding medical necessity criteria for specialty mental health services *(refer to section 5 of this manual for medical necessity criteria).*

- During the assessment, each beneficiary will receive a thorough evaluation of their needs in the areas of education, housing, social needs, legal history, employment, mental health needs, physical health needs, substance use, and financial needs. Intake/Assessment Staff will identify each beneficiary's individual needs and will determine appropriate referral(s) and/or services to be initiated.

2.2 Service Reauthorization Request

- Reauthorization will be determined by a licensed/waivered clinician in the **Quality Assurance Office.**

- The provider must submit a reauthorization request by using the SYMHP's Reauthorization form. *Please see the end of this chapter for the Reauthorization Form.*

- Requests for reauthorization of services may be mailed or faxed to:

Quality Assurance Office
Sutter-Yuba Mental Health Plan
1965 Live Oak Boulevard, Suite A
Yuba City, CA 95991
Phone: (530) 822-7200
Fax: (530) 822-5061

2.3 Reauthorization Consultation

For guidance and consultation regarding the reauthorization process, providers may contact the **Quality Assurance Office**.

Telephone: (530) 822-7200

2.4 Time Frame for Processing Service Requests

- Though most authorizations or reauthorizations occur within 2-3 business days, the SYMHP has up to fourteen (14) calendar days to process your request. If further information is needed, an additional fourteen (14) calendar days may be used to respond to the authorization/reauthorization request. Providers are expected to submit a reauthorization request in advance of the expiration of the current authorization in order to allow sufficient time for review and processing. This will result in no disruption of services to the beneficiary.

- The SYMHP will fax or mail the reauthorization response.

2.5 Pending Reauthorization Requests

If information submitted by the provider is insufficient to make a decision regarding reauthorization, the Quality Assurance Office will contact the provider to request additional information. The provider has 14 calendar days to submit the additional information. If the requested information is not received by the SYMHP within 14 calendar days, the reauthorization will be denied.

2.6 Approved Reauthorization Requests

If the reauthorization is approved, the provider will receive a fax confirmation from the SYMHP.

2.7 Denied Reauthorization Requests

If the reauthorization request is not granted, the SYMHP will provide the beneficiary with a Notice of Action B (NOA-B) and will send a copy to the provider. If the beneficiary is a minor, the NOA-B will be sent to the minor with a copy to the minor's parent or legal guardian, except in minor consent cases, where the NOA-B will either be given to the minor in person, given to the minor's eligibility worker to give to the minor, or held by the SYMHP until the minor comes to the clinic.

2.8 Authorization Standards

- The authorization expires when approved visits have been expended, or when the authorized period ends, whichever comes first. Services that continue beyond the authorization period or beyond approved visits will not be reimbursed.

- All services must be pre-authorized except those services provided to beneficiaries with emergency psychiatric conditions.

- The SYMHP reserves the final right of assignment of the beneficiary to a service provider, while taking into consideration the beneficiary's provider choice, past treatment history, or other service needs.

2.9 Procedure for Psychiatric Inpatient Hospital Professional Services

- The medical necessity criteria for psychiatric inpatient hospital professional services follows the reimbursement criteria for psychiatric inpatient hospital services *(refer to section 5 for medical necessity criteria for inpatient services).*

- The SYMHP does not require pre-authorization of psychiatric inpatient hospital professional services, however, medical necessity must be met.

- The hospital submits a Treatment Authorization Request (TAR) to the SYBH Quality Assurance Office, providing notification of the beneficiary's admission within 24 hours.

- Billing for psychiatric inpatient hospital professional services may be denied if documentation does not support medical necessity for inpatient acute or administrative stays.

2.10 Procedure for Requesting Other Mental Health Services

When a contract provider determines that the beneficiary needs additional mental health services but these services are beyond the provider's capability or scope of practice to provide, the provider shall contact the Quality Assurance Office at (530) 822-7200.

2.11 Example of Request for Outpatient Treatment Re-Authorization Form

CONFIDENTIAL SUTTER-YUBA BEHAVIORAL HEALTH MANAGED CARE PLAN
1965 LIVE OAK BOULEVARD, SUITE A, YUBA CITY, CA 95991
(530) 822-7200 FAX: (530) 822-5061

REQUEST FOR OUTPATIENT TREATMENT RE-AUTHORIZATION
(Fax or mail required information C/O Rick Bingham, LMFT)

BENEFICIARY INFORMATION:

Name:_____

Authorization Effective Date:_____ Authorization Expiration Date:_____

Medi-Cal #: _____ Date of Birth: _____

Provider: _____ Phone: _____ FAX: _____

CLIENT REASSESSMENT: Please complete all of the following questions. Mark N/A for items that do not apply but do not leave blank.

How to Obtain Authorization For Mental Health Services

Client's current presenting problem(s)/mental health disorder symptoms:

History of Illness & Treatment Provided/Response to Treatment:

Inpatient Hospitalization Date(s)/Locations (if applicable):

Updated Psychosocial factors impacting Client's mental health:

Updated Physical Health/Medical Issues:

Updated Substance Use/Abuse (Include substances used/amounts/12-Step participation/recovery status etc.):

Client's Current Risk Factors (include potential danger to self/others/potential for exploitation or situations that present risk of decompensation and/or escalation of symptoms etc.):

What are the Client's personal Strengths that are going to assist in their mental health recovery?

How is the Client's on-going daily functioning negatively impaired by the symptoms of the mental health disorder?

MENTAL STATUS EXAMINATION: (Circle all that apply)

- ***APPEARANCE/HYGIENE***: WNL Disheveled Dirty Meticulous Odd/Bizarre Dress Fatigued Frail Appears older/younger than stated age Bruises Scars Tattoos Birthmark Obese Thin
  Comments:

- ***MOTOR ACTIVITY***: WNL Hyperactive Restless Fidgety Lethargic Tics Tremor Odd behavior Intrusive/Boundary problems Compulsive/Rituals
  Comments:_____
- ***ATTITUDE***: Cooperative Uncooperative Angry/hostile Guarded/evasive Seductive Defensive Scared/fearful Apathetic
  Comments:_____
- ***SPEECH***: WNL Incoherent Mute Loud Soft Rapid Pressured Slurred Echolalia Stutter Articulation Problems
  Comments:_____
- ***SENSORIUM/INTELLECT***: Oriented to: Person Place Time Situation Confused/disoriented Able to Name: President
  Comments:_____
- ***MEMORY***: WNL Recent memory impaired Remote memory impaired
  Comments:_____
- ***CONCENTRATION:*** WNL Inability to participate in interview Variable Impaired Serial 3's (100-3=97-3=94-3=91-3=88) or spell the word "world" backward
  Comments:_____
- ***AFFECT*** (like weather): WNL Inappropriate Flat Labile Restricted Silly/giddy Sad Elated Angry/irritable
  Comments:_____
- ***MOOD*** (like climate): WNL Depressed Hopeless/helpless/worthless Sad/Anhedonia Fearful/Anxious Grandiose/Expansive Hostile/angry/irritable
  Comments:_____
- ***THOUGHT PROCESS***: WNL Tangential Loose associations Scattered Blocking Flight of ideas Illogical Concrete Perseveration Psychomotor retardation/agitation
  Comments:_____
- ***THOUGHT CONTENT***: WNL Poverty of content Ideas of reference Obsessions/ruminations (specify) Suicidal Homicidal Paranoid Sexual themes Guilt/shame/loss Somatic preoccupation Hyper-religiosity Aggressive/Violent Delusions (specify) Hallucinations (specify)
  Comments:_____

- ***JUDGEMENT***: Adequate Impaired

  Comments:_____

- ***INSIGHT***: Adequate Impaired Denial of illness Externalization of blame
- ***MOTIVATION FOR TREATMENT***: Good Fair Poor

  Comments:_____

UPDATED DSM-5 DIAGNOSIS CODE(S) & DESCRIPTION(S):

_____

_____

_____

_____

_____

_____

Updated Client Treatment Plan

Examples of Appropriately Written Goals:

- Client will reduce feelings of depression and sadness evidenced by a reduction of suicidal ideation from daily thoughts to no more than 2x /per week by (target date).

- By (target date), Client will no longer be at risk of losing her employment. Client will successfully manage feelings of anxiety/panic as evidenced by zero days missed at work due to anxiety/panic symptoms. Client's current baseline is she has called in sick to work at least 2 out of 5 days, every week for the past 2 months.

Treatment Goal(s):

1. _____

_____

_____

_____

2. _____

_____

_____

_____

3. _____

_____

_____

_____

Specify the therapeutic Interventions that will be utilized to achieve the above TX Plan Goal(s):

1. _____
2. _____
3. _____

CURRENT MEDICATIONS:

MEDICATION ALLERGIES/ADVERSE REACTIONS:_____

Does client follow medication regimen?	☐ Yes	☐ No	☐ N/A
Is the Client compliant with medication regimen?	☐ Yes	☐ No	☐ N/A

Current **Psychiatric** Medications:

Drug Name	Dosage/Frequency	Side Effects	Prescribed By

Current **Physical Health** Medications (other than psychiatric):

Drug Name	Dosage/Frequency	Side Effects	Prescribed By

NUMBER OF ADDITIONAL SESSIONS REQUESTED: _____ (Total # of units requested up to the maximum of 52 sessions per year).

TYPE OF SERVICES REQUESTED:

Individual Therapy (procedure code 90834): ___units

Collateral with client present/Family Therapy (procedure code 90847): _____ units

How to Obtain Authorization For Mental Health Services

Collateral without client present/Family Therapy (procedure code 90846): _____units

***If the above-noted approved units are exhausted prior to the expiration date of this authorization, you must wait to submit a new authorization until the expiration date. No services will be payable that are not authorized

PROVIDER SIGNATURE:_____

SYBH ONLY:

Authorized By QA Staff:_____Date:_____

Number of Visits Authorized:_____

Comments:_____

Sutter-Yuba Mental Health Plan
Reimbursable Provider Services

Section 3: Description of SYMHP Reimbursable Services

3.0: Outpatient Services

The Quality Assurance Office will inform providers of the specific service authorized as well as the number of visits, frequency and time frame. Providers must have services authorized in order to bill.

Mental Health Services are interventions designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency (CCR, Title 9, 1810.227). Services shall be directed toward achieving the beneficiary's goals, desired results or personal milestones.

Listed below are descriptions of Specialty Mental Health Services for which providers may be reimbursed. Providers should refer to their contract to determine for which services they may be reimbursed.

Assessment
Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures (CCR, Title 9, 1810.204).

Collateral
Collateral means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of meeting the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist

in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity (CCR, Title 9, 1810.206).

Family counseling may be billed under Collateral, either with or without the client present. Family is defined as natural parents, brothers, sisters, grandparents, uncles, aunts, cousins, and other blood-related relatives. Also, adoptive parents, stepparents, legal guardians, and live-in non-relatives who have an ongoing parental type of relationship, i.e., mother's boyfriend or father's girlfriend are included.

Crisis Intervention

Crisis Intervention is defined as services to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to assessment, collateral, and therapy (CCR, Title 9, 1810.209).

Crisis Intervention may be viewed as a service that occurs outside of regularly scheduled times, without which, the beneficiary would be at imminent risk of hospitalization. Documentation must include the acute nature of the client's presentation along with any individual or situational risk factors which jeopardize the beneficiary's ability to maintain community functioning. A description of what was attempted and/or accomplished at the time of the service and a plan for subsequent intervention is needed.

Crisis Stabilization

Crisis Stabilization means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis Stabilization is distinguished from Crisis Intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348 (CCR, Title 9, 1810.210).

Day Rehabilitation
Day Rehabilitation means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

Day Treatment Intensive
Day Treatment Intensive means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

Medication Support Services
Medication Support Services means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary (CCR, Title 9, 1810.225).

Plan Development
Plan Development means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress (CCR, Title 9, 1810.232).

Rehabilitation
Rehabilitation means a service activity which includes, but is not limited to assistance in improving, maintaining or restoring a beneficiary's or group of beneficiary's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education (CCR, Title 9, 1810.243).

Targeted Case Management
Targeted Case Management means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development (CCR, Title 9, 1810.249).

Therapy
Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present (CCR, Title 9, 1810.250).

Group therapy is billed using this formula:

Formula:

Length of group time *multiplied by* the number of therapists *divided by* **the number of Medi-Cal beneficiaries per group sessions, plus documentation time. (Note: This equals the maximum billable amount).**

Example:

If one therapist runs a 60 minute group with four Medi-Cal beneficiaries plus 5 minute documentation time, the therapist

would bill 20 minutes for each of the four Medi-Cal beneficiaries.

3.1 Service Lockouts (Non-reimbursable services)

- Mental Health Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facilities (PHF) Services are reimbursed, *except* on the day of admission and the day of discharge to either service.

- Mental Health Services are not reimbursable during the actual time Day Treatment Services are being provided.

- Mental Health Services are not reimbursable when provided by Day Treatment Intensive staff during the same time period that Day Treatment Intensive Services are being provided.

- Mental Health Services are not reimbursable when provided by Day Rehabilitation staff during the same time period that Day Rehabilitation Services are being provided.

- Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time.

- Mental Health Services are not reimbursable when provided during the same time that Crisis Stabilization Services are provided.

3.1.0 Lockout Exceptions

- Mental Health Services are not reimbursable on days when Inpatient Services are reimbursed *except* for the day of admission and the day of discharge.

- While an individual is in an institutional setting, Short-Doyle/Medi-Cal (SD/MC) reimbursement is limited to placement services which

are provided within thirty (30) calendar days immediately prior to the individual's discharge from a facility.

3.2 Authorized Billing Codes and Rates

Please see your contract for a listing of billing codes and current reimbursement rates. If you have questions, please contact the Medical Fiscal Manager at (530) 822-7200.

3.3 Description of SYMHP Inpatient Reimbursable Provider Services

Inpatient Psychiatric Services

Inpatient Psychiatric Services are billed as a bundled, daily rate. The SYMHP requires written documentation that certifies that a beneficiary met medical necessity criteria on the day of admission and for any subsequent days prior to discharge during which the beneficiary received hospital services. The hospital must provide this documentation to the SYMHP within 14 calendar days of discharge.

Inpatient services are authorized after treatment has been provided through the Treatment Authorization Request (TAR) process.

Section 4: Eligibility, Claims Process and Payment

4.0 Beneficiary's Eligibility

4.0.0 Initial Eligibility Determination and Authorization

The SYMHP will determine a beneficiary's Medi-Cal eligibility before authorizing him/her for services with a provider for specialty mental health services.

4.0.1 Ongoing Eligibility Determination and Authorization

The provider is responsible for determining the beneficiary's Medi-Cal eligibility after the initial referral. Having an authorization for services that lasts more than one calendar month does not guarantee the beneficiary's eligibility.

At the beginning of each month, the provider must verify and determine the eligibility of beneficiaries who will continue to receive services. This may be accomplished by various methods:

- **Provider may contact the MHP for verification**
  Providers may call Sutter-Yuba Behavioral Health's Business Office at (530) 822-7200 to verify a beneficiary's Medi-Cal eligibility. Out of area providers may call toll free at 1-888-923-3800.

- **Automated Eligibility Verification System (AEVS)**
  Providers may refer to the automated eligibility verification system. To do so, Providers must have a Medi-Cal Provider Identification Number (PIN).

- **Point of Service (POS) Device**
  To use a point of service device, a Provider must have a Medi-Cal Provider Identification Number (PIN).

Eligibility, Claims Process and Payment

4.1 Beneficiaries with Share of Cost or Third-Party Insurers

4.1.0 Share of Cost

Depending on a beneficiary's monthly income, Medi-Cal may determine that he/she must meet a share of cost (SOC) before Medi-Cal will pay for medical expenses. Therefore, the beneficiary may not be eligible for Medi-Cal covered benefits until the SOC is met.

4.1.1 Third-Party Insurers

Medi-Cal is the payer of last resort. The provider must bill the beneficiary for his/her authorized share of cost (SOC) and any third-party insurers before requesting payment from the SYMHP. The SYMHP will only reimburse the difference between the SYMHP service rate and the payment amount by the primary payer, minus the SOC. The total reimbursement will not exceed the SYMHP's service rate schedule.

Medi-Cal Beneficiaries with Medicare A & B or B Only Coverage

Providers treating Medi-Cal beneficiaries that also have Medicare A & B or B only coverage must submit claims directly to Medicare. Medi-Cal and the SYMHP are not responsible for outpatient or professional services with these types of Medicare coverage.

4.2 Claims

4.2.0 Claim Submission

- Claims for payment must be submitted no later than 30 days after the month services were provided. The SYMHP may deny payment for invoices submitted beyond this time frame. An exception applies to claims billed to third party payers, which are "balance-billed" to the SYMHP for Medi-Cal reimbursement (See 4.2.1, Third Party Insurers).

- Each claim will be submitted for one beneficiary only and must include the name of the beneficiary, type of service provided

(indicated by the SYMHP service code), date and duration of service.

- Providers must use the HCFA-1500 form to submit all claims for services provided. **Please see form completion instructions in this section.**

- **To submit a Medi-Cal claim for a beneficiary with a third-party payer, the provider must:**

- Submit a claim to the SYMHP along with a copy of the third-party payer denial letter or Explanation of Benefits (EOB) **within 30 days** of the date of the denial or EOB.

- Remit all claims to:

Sutter-Yuba Mental Health Plan
ATT: Business Office – Provider Claims
P.O. Box 1520
Yuba City, CA 95992

4.2.1 Claims/Billing Audit

Each claim/billing is subject to audit for compliance with federal and state regulations.

4.2.2 Disapproved Claims

In the event that a claim is disapproved by the SYMHP, compensation may be withheld, or, if already paid, offset from future payments.

Provider May NOT:

- Bill in his/her name for treatment provided by another practitioner or an assistant.

- Bill the beneficiary for amounts over the contracted rate.

4.3 HCFA 1500 – Completion Instructions
Quick Reference/Medi-Cal Only
REQUIRED INFORMATION

Box #1a Insured's correct Medi-Cal Identification Number/Social Security Number

Box #2 Consumer's Full Name as recognized by Medi-Cal or as indicated on their Benefit Identification Cared, last name, first name and initial (if applicable).

Box #3 Correct Date of Birth and Gender (male or female).

Box #5 Complete home address and telephone number

Box #11 Enter the Insured's Policy Group or FECA number

Box #11d Is there another Health Benefit Plan? If so, Provider is to bill the carrier and then submit a Medi-Cal claim with a copy of the Denial letter or Explanation of Benefits (EOB) **within 30 days** of the date of the denial or EOB. (If yes, complete items 9, 9a, and 9d)

Box #12 & 13 Patient's signature or noted that signature is "On File".

Box #21 Diagnosis #1 **must** be an included diagnosis code or a "rule-out" diagnosis for assessments.

Box #23 Attach a copy of the authorization to the billing form.

Box #24
a) Date of Service must match date in chart notes.
b) Place of Service
d) SYMHP Service Codes must be those on the Provider Fee schedule
e) Diagnosis must equal item #1 in Box 21
f) Charges should not be less than reimbursable rate.
g) Units (minutes) must be correct.
j) Provider's 10 digit NPI number

Box #25 Federal Tax ID Number is required as indicated in Provider Contract.

Box #28 Total of all charges

Box #29 Indicate the Share of Cost (SOC) amount (whether collected or not). (SOC Information may be obtained from SYBH Business Office.)

Box #30 Balance Due = Total charge less SOC/EOB.

Box #31 Original signature required of Provider or authorized biller for the Provider.

Box #32 Name and Address of Facility where services were rendered is required for Inpatient Claim or outpatient service as appropriate.

4.3 HCFA 1500 – Other Completion Instructions
Quick Reference/Other

Box #33 Provider or Group Name and complete address with telephone number.

- Other insurance information (blocks 6, 7, 9-9d) – **These sections are completed if the Patient has other insurance.**

Box #6 Patient's Relationship to Insured (used in conjunction with information on

Box #7 Insured Address (used in conjunction with information on block 9)

Box #9 Other Insured's Name. Enter the last name, first name, and middle initial of the enrollee in the other insurance policy

a) Other Insured's Policy or Group Number
b) Other Insured's Date of Birth, Sex
c) Other Insured's Employer's Name
d) Insurance plan Name or Program Name

Please see under Section 4.2, Beneficiaries with Share of Cost or Third Party Insurers, for more information. SYMHP is the payer of last resort; therefore, claims for patients who are covered under Medi-Cal and another insurance plan must include a copy of the insurance Explanation of Benefits or Claim Denial Letter in order for SYMHP to determine payment liability. Medicare/Medi-Cal crossover claims are sent to the State's fiscal intermediary (EDS) or the Medicare fiscal intermediary. They are not processed by SYMHP Claims Unit.

- Patient's Condition (blocks 10a-c) – **This section is completed if the Patient's Condition is related to Employment, Auto Accident or other Accident.**

Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24. Any item checked "YES: indicates there may be other insurance primary to Medi-Cal. Identify primary insurance information on Item 11.

Enter the State postal code (i.e.: CA for California)

4.4 Payment Policies

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

- Services were pre-authorized by the SYMHP.
- Services were delivered by a contracted provider.
- Billed service codes were allowed by the clinician's scope of practice and contract agreements.
- The beneficiary was Medi-Cal eligible at the time services were provided. Following the initial authorization, it is the provider's responsibility to ensure beneficiary eligibility.

Terms of payment are as follows:

Payment will be based on the SYMHP fee schedule. Reimbursement will be determined by the terms of the agreement. Reimbursement rates shall be considered payment in full and are subject to third party liability and beneficiary share of cost for the specialty mental health services (the SYMHP will only reimburse the difference between the SYMHP service rate and the payment amount by the primary payer, minus the SOC. The total reimbursement will not exceed the SYMHP's service rate schedule.)

- The SYMHP pays the provider in arrears, within 45 days after receipt and verification of provider's invoices.
- **The SYMHP will not pay for sessions for which a beneficiary fails to show or for cancelled appointments.**

Specialty mental health services provided to a beneficiary with an emergency psychiatric condition do not require pre-authorization.

4.5 Beneficiary Who Loses Medi-Cal Benefits During an Authorization Period

A Medi-Cal beneficiary who becomes ineligible for Medi-Cal benefits during an authorization period may continue to receive services. However, the provider must notify the beneficiary and the SYMHP that eligibility has changed. The SYMHP will determine the best course of treatment, which may include authorizing continued services, or transitioning the client back to Sutter-Yuba Behavioral Health, or another provider, as appropriate.

Claims/Billing inquiries may be made by calling the Sutter-Yuba Behavioral Health Business Office at (530) 822-7208, or toll free (for out of area callers) at 1-888-923-3800.

Section 5: Medical Necessity Criteria
(Title 9, Chapter 11, 1830.205 & 1830.210)

5.0 Definition of Medical Necessity

Medical necessity is the principal criteria by which the SYMHP decides authorization and/or reauthorization for covered services. Medical necessity for specialty mental health services must exist before and during ongoing treatment to be eligible for reimbursement.

5.1 Specialty Mental Health Services

Specialty Mental Health Services are:

- Rehabilitative services, including mental health services, medication support services, day treatment intensive, day treatment rehabilitation, crisis interventions, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatrist services
- Psychologist services
- Psychiatric nursing facility services

5.2 Medical Necessity for Outpatient Specialty Mental Health Services

5.2.0 Included Diagnoses for Outpatient Services

A beneficiary must have one of the following diagnoses listed in the most recent version of the International Classification of Diseases (ICD) and/or Diagnostic and Statistical Manual (DSM), which will be the primary focus of the intervention being provided:

- Pervasive Developmental Disorders, <u>except</u> Autistic Disorder
- Attention Deficit and Disruptive Behavior Disorders

- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Early childhood
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other diagnosis

5.2.1 Excluded Diagnoses for Outpatient Services

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunction
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions That May Be a Focus of Clinical Attention, except Medication Induced Movement Disorders which are included

5.2.2 Impairment Criteria

The beneficiary must have one of the following as a result of a mental disorder identified in 5.2.0 above:

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

5.2.3 Intervention Related Criteria

The beneficiary must have all of the following:

1. The focus of the proposed intervention is to address the condition identified in the impairment criteria above,
2. It is expected that the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate, and
3. The condition would not be responsive to physical health care treatment.

5.3 Medical Necessity for Acute Psychiatric Inpatient Hospital Services (Title 9, Chapter 11, 1820.205)

Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital occurs when the beneficiary meets the medical necessity criteria set forth below:

(1) The beneficiary is diagnosed with one of the following diagnoses from the most recent version of the International Classification of Diseases (ICD) and/or Diagnostic and Statistical Manual (DSM):

- Pervasive Developmental Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Cognitive Disorders (only Dementia with Delusions, or Depressed Mood)
- Substance Induced Disorders, with Psychotic, Mood, or Anxiety Disorders only
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Intermittent Explosive Disorder
- Pyromania
- Adjustment Disorders
- Personality Disorders

(2) A beneficiary must have both (A) and (B):

(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. The beneficiary has symptoms or behaviors due to a mental disorder that result in at least one of the following:

   - The beneficiary being a current danger to self or others, or of causing significant property destruction.
   - The beneficiary being unable to provide for, or utilize food, clothing or shelter.

- The beneficiary presenting a severe risk to his/her physical health.
- The beneficiary representing a recent, significant deterioration in ability to function.

2. The beneficiary requires admission for one of the following:

   - Further psychiatric evaluation
   - Medication treatment
   - Other treatment that can reasonably be provided only if the patient is hospitalized

(3) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

- The continued presence of the criteria listed above, which meet the medical necessity criteria.
- A serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
- The presence of new indications which meet medical necessity criteria.
- The need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

5.4 Medical Necessity for Psychiatric Inpatient Hospital Administrative Day Service (Title 9, Chapter 11, 1810.202)

"Administrative Day Services" means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential

placement options at non-acute treatment facilities that meet the needs of the beneficiary.

Requests for SYMHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week for placement of the beneficiary subject to the following requirements.

1. The MHP or its designee can waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

    a. The status of the placement option.
    b. Date of the contact.
    c. Signature of the person making the contact.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

Title 9, Chapter 11, 1820.230 (d), (2)

Section 6 : Documentation Standards

The SYMHP requires its providers to follow the documentation standards set by the Department of Health Care Services (DHCS).

6.0 Assessment

The following elements must be included in a comprehensive patient assessment:

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

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

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

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

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

or adverse reactions to medications, and documentation of an informed consent for medications;

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

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

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

i) Mental Status Exam;

j) Diagnosis - A diagnosis from the most current Diagnostic and Statistical Manual (DSM), or from the most current International Classification of Diseases (ICD). The DSM or ICD code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,

k) Additional clarifying formulation information as needed.

6.1 Progress Notes

6.1.0 Progress Note Standards

- The client record provides timely documentation of relevant aspects of beneficiary's care.

- Providers use beneficiary's records to document encounters, including relevant clinical decisions and interventions.

- All entries in the medical record include the signature of the person providing the service, professional degree or licensure or job title, and the relevant identification number,

if applicable. All entries include the date that service(s) were provided.

- The record is legible.
- The medical record documents referrals to community resources and other agencies, when appropriate.
- The medical record documents follow-up care, or, as appropriate, a discharge summary.
- The medical record documents beneficiary's progress in treatment or impediments to treatment.

6.2 Reauthorization Request Includes Client Plan

When providers request reauthorization, the client plan, consistent with the items below, must be submitted:

6.2.0 Client Plan Contents

The beneficiary's Client Plan must:

- State specific, observable or quantifiable goal(s).
- Identify the proposed type(s) of intervention(s).
- State a proposed frequency, duration and modality of intervention(s).
- Be signed by the person providing the service(s).
- Be signed by the client and/or guardian.

6.2.1 Client Plan Standards

- Client Plan is consistent with the diagnoses.
- Interventions are consistent with the plan goals.

- Beneficiary's participation in and understanding of the plan is documented.

Section 7 : Medical Records

7.0 Security of Medical Records

- The medical record must be secure and inaccessible to unauthorized access to prevent loss, tampering, and disclosure of information, alteration, or destruction of the record.

- Information must be accessible only to:

  1. Authorized staff within the provider's office.
  2. The SYMHP staff with identification.

- As per the Provider Agreement/Contract, provisions must be made for the SYMHP to have appropriate access to the beneficiary's medical records for purposes of quality and utilization review.

7.1 Storage and Maintenance

- Medical records must be stored in one central medical records area and must be inaccessible (locked) to unauthorized persons.

- Inactive records must be accessible for a period of time which meets state, federal, and licensing board requirements.

7.2 Availability of Medical Records at Each Encounter

- The medical records system must allow for prompt retrieval of the medical records and must be available to the provider at each encounter.

7.3 Release of Medical Records and Distribution

- The privacy of the beneficiary's information and records will be protected according to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR 164.500 et seq.] and the Confidentiality of Medical Information Act (CMIA)

[CA Civil Code § 56 et seq.], which generally prohibit a provider of health care from disclosing any individually identifiable health information regarding a beneficiary's medical history, mental or physical condition or treatment without the beneficiary's authorization or specific legal authority.

- Medical Records may only be released under the following conditions:

  - The beneficiary or personal representatives of the beneficiary may receive a copy of the medical records after presenting a written request and appropriate identification.

  - The beneficiary or the beneficiary's personal representative may authorize release of the beneficiary's record or portions thereof to another party by signing an Authorization for Release of Protected Health Information that complies with the HIPAA Privacy Rule and the CMIA.

  - The beneficiary's records must be available to the SYMHP staff and the Department of Health Care Services for the purpose of fiscal audits, program compliance and beneficiary complaints.

  - Minors, in certain circumstances, have the right to access confidential services without parental consent. Therefore, medical records and/or information regarding medical treatment specific to those confidential services must not be released to parent(s) without the minors' consent.

  - Copies of the beneficiary's records may be transferred to requesting providers upon request.

  - Issues regarding release of medical records on receipt of a subpoena are complex. Providers must ensure that any release of records pursuant to a subpoena complies with the HIPAA Privacy Rule, the CMIA, and other applicable laws and regulations.

7.4 Obtaining Consent for Treatment

- Consent for treatment must be given at the initial office visit by the beneficiary, parent, or guardian by signing a consent form. This form must be maintained in the beneficiary's medical record.

- Minors, in certain circumstances, have the right to access confidential services without parental consent, therefore minors are authorized to sign the Consent form for any confidential services and/or information regarding medical treatment specific to those confidential services. In certain circumstances, records and information are not to be released to parent(s) without the minor's consent.

7.5 Medical Record Copy Charges

- The provider may not bill the SYMHP for charges associated with copying of records.

- If you have questions regarding confidentiality, releases of information or requests for information, you may call the SYMHP's Medical Records Office for assistance at (530) 822-7200.

7.6 Department of Health Care Services (DHCS) Medical Records Standards

In addition to the standards identified above, the MHP monitors provider records against the following medical record standards:

- Each beneficiary must have a separate medical record.

- All pages in the record are filed chronologically.

- Each page in the record contains the beneficiary's name or I.D. number for identification.

- Personal, biological, and demographic data includes age, sex, address, telephone number, marital status and is updated as appropriate.

- A copy of the Consent for Treatment form is maintained in the medical record.

- All entries are signed and dated.

- The author of all entries is identified by name and title.

- The records are legible, documented accurately and in a timely manner.

- Allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies) is noted if the beneficiary has no allergies.

- Medical history, including serious accidents, operations, illnesses, etc., is recorded. For children, medical history also includes birth information and mother's prenatal care.

7.7 Monitoring Procedures for Providers' Compliance with Medical Records Standards

- When site audits occur, they include a review of a predetermined number of randomly selected medical records to assess the content, completion, and conformance to the SYMHP's Medical Records standards.

- Any deficiencies that are identified will be communicated to the provider via a post-facility audit summary. Corrective actions must be instituted if standards are not met. The SYMHP may withhold payment if medical records do not conform to its' standards.

7.8 Medication Consent

The provider must obtain the beneficiary's consent for medication treatment before any psychotropic medication is prescribed. The consent must be kept in medical records at all times.

7.9 Compliance to Regulations

The SYMHP expects the provider to adhere to Title XIX of the Social Security Act and conform to all applicable Federal and State statutes and regulations.

Section 8: Site Certification/Medical Record Review

8.0 Site Certification/Recertification – Organizational Provider, Group Provider or Day Treatment Site

The SYMHP will conduct an initial site certification (which may include "piggy-packing" on another County's certification) to ensure compliance with all federal and state guidelines. Compliance with site certification standards is monitored by the SYMHP staff.

Site recertification will be conducted when the previous certification or recertification expires, or when the provider changes an office or treatment site during the contract period. The SYMHP may revisit the site, as necessary, to follow-up on any areas requiring compliance correction. The provider is required to correct any deficiency(ies) and demonstrate compliance of the deficiency(ies) to the SYMHP within 30 days of notification.

Failure to provide evidence of correction of or compliance with the deficiencies within the 30 days will result in withholding payments for current and future claims and/or contract termination.

8.0.0 Change of Location

The SYMHP must be notified in writing at least **sixty (60) days** prior to change of location for Medi-Cal certified programs. Failure to comply may result in a temporary decertification, delay, or actual loss of Medi-Cal revenue for services provided during the non-certified period. Providers will not be reimbursed for any services provided during a non-certified period.

Provider will report the following:

- The current provider name, number, and date of termination, if applicable.
- Name of the new provider, if applicable.

- New address of provider, if applicable.
- Date of ownership or location change.
- Any major staff or program changes.
- A new fire safety inspection and corrections for the new address.
- Involuntary changes of location due to disasters should be reported as soon as possible and are not subject to the sixty (60) day prior notification requirement.

8.0.1 Facility Safety

All individual, group and organizational providers will maintain a safe facility in accordance with Title 9, Chapter 11, Section 1810.435 (b)(2).

8.0.2 Medication

Individual, group and organizational providers will store and dispense medications in compliance with all applicable state and federal laws and regulations.

Section 9: Coordination of Physical and Mental Health Care

9.0 Referral to Physical Health Care

When an SYMHP beneficiary who is receiving specialty mental health services has an identified physical health problem, the SYMHP physician or therapist will coordinate services with the beneficiary's Primary Care Provider (PCP). If a PCP has not been established, a referral to an appropriate provider will be made.

9.1 Physical Health Care Consultation

The SYMHP will make clinical consultation and training available for physical health care providers, including Federally Qualified Health Clinics, Rural Health Clinics, and Indian Health Clinics.

9.1.0 Informal Referral

PCPs may, at any time, refer patients to Sutter-Yuba Behavioral Health (SYBH) for screening assessments. Referred patients may access SYBH in the same manner as any other individual accessing services.

9.1.1 Formal Consultation Request Form

The PCP of a Medi-Cal recipient may at any time FAX a completed Consultation Request Form requesting an evaluation for psychiatric problems to (530) 822-7108. *See below for Consultation Request Form.*

CONFIDENTIAL

PRIMARY CARE PHYSICIAN CONSULTATION REQUEST FORM

DO NOT USE THIS FORM FOR EMERGENCY PSYCHIATRIC CARE OR ROUTE PSYCHIATRIC SERVICES: FOR EMERGENCY CALL (530) 673-8255 OR 1-888-923-3800; FOR ADULT REFERRALS CALL (530) 822-7200; FOR YOUTH REFERRALS CALL (530) 822-7513

Date:_____

To: Sutter-Yuba Behavioral Health
1965 Live Oak Boulevard, Suite A
Yuba City, CA 95992
(530) 822-7200 Adult
(530) 822-7513 Youth
Emergencies: (530) 673-8255
FAX: (530) 822-7108 Adult
FAX: (530) 822-7514 Youth

From:_____

Clinic/Group:_____

Address:_____

_____

Phone:_____ FAX:_____

Client Name:_____ Phone:_____

Age:_____ Sex:_____ DOB:_____ SSN:_____

Medi-Cal #:_____ Medicare #:_____ Other Ins:_____

Client Address:_____

Person to contact (if other than client):_____ Phone:_____

Parent/Spouse/Significant Other:_____ Legally Responsible Person:_____

Physical Health Problems (list):_____

_____

Psychiatric History:_____

_____

Medications:_____

_____

Reason for Consultation (questions to be addressed):_____

_____

_____

Referring Physician's Signature:_____

Sutter-Yuba Behavioral Health will contact your patient and set-up an appointment. The patient will be notified of the appointment within one week after receiving this referral. Following the appointment, Sutter-Yuba Behavioral Health **will fax the PCP results of their consultation and recommendations for treatment** when there is an appropriate Release of Information.

Consulting Psychiatrist Impression and Recommendations:_____

_____

Section 10: Quality Management

10.0 Quality Management Overview

The SYMHP is responsible for assuring that high quality services are provided to behavioral health consumers in a cost-effective and efficient manner. Quality Management has a broad scope, reflecting a range of clinical care, service and organizational issues that are relevant to consumers and providers. More importantly, it is designed to provide the framework within which the SYMHP monitors and improves quality of care, service, and organizational performance.

The SYMHP staff reviews services and programs of all providers to ensure:

- Accessibility
- Meaningful and beneficial services to the consumer
- Culturally and linguistically competent services
- Desirable results through the efficient use of resources

10.1 Provider Training

The SYMHP will provide training to providers regarding medical necessity criteria, patient's rights issues, billing and claims, documentation requirements and other relevant topics upon request.

Providers are regularly invited to training through the SYMHP.

10.2 Provider Credentialing

The SYMHP requires its providers to comply with and maintain professional competencies in their fields of expertise. To ensure competence, a provider credentialing process is followed for all new and current providers.

10.2.0 Credentialing Standards

- All SYMHP providers will have a verified and approved credentialing packet on file.

- The SYMHP will verify that individual contractors:
  - are not on the Office of the Inspector General's List of Excluded Individuals/Entities
  - are not on the DHCS Medi-Cal List of Suspended or Ineligible Providers
  - are not in the Social Security Administration's Death Master File
  - have accurate information in the National Plan and Provider Enumeration System
  - are not in the Excluded Parties List System/System Award Management database

- The SYMHP Credentialing Coordinator or designee will verify all information concerning licensure, certificates, malpractice coverage, letters of reference, exclusions and education.

- Organizational providers will perform the above-noted verifications for their employees and providers.

- If any query discovers information concerning competency, malpractice, exclusions, limitation of privileges, ongoing ethical investigations or other factors presenting potential risk to the SYMHP, the application will be referred to the SYMHP Quality Assurance Officer, who will perform a confidential review of the application. The review may include a face-to-face interview of the applicant.

- All licenses, certificates, and insurance coverage must remain current at all times.

- All providers will be re-credentialed at annual, biennial or triennial intervals, depending on their contract.

10.3 Contract Requirements

A provider will typically enter into a contractual agreement with the SYMHP before rendering specialty mental health services to a Sutter-Yuba

Medi-Cal beneficiary, but exceptions may occur in emergent situations. Otherwise, the contract agreement is effective upon execution by the SYMHP and the provider. Contracts will be renewed annually, biennially or triennially, subject to terms and conditions specified in the agreement.

The SYMHP may immediately suspend or terminate the agreement, in whole or in part, when the SYMHP determines any of the following:

- failure to follow the regulations of the state Medi-Cal program
- illegal or improper use of funds
- failure to comply with any term of the agreement
- suspension or loss of malpractice insurance
- suspension or loss of licensure to practice
- being placed on an excluded list
- inability to meet the SYMHP's credentialing standards
- improperly performed services
- charges to a beneficiary other than the authorized share of cost payment or for non-covered services
- failure to abide by the SYMHP's decision.

Other terms and conditions related to termination of the agreement are described in the contract. Upon termination of the agreement for any reason, the provider will cooperate with the SYMHP in ensuring an orderly transition of care for beneficiaries in treatment, including, but not limited to, the transfer of the beneficiaries' medical records.

10.4 Potential Tort, Causality, or Worker's Compensation Awards

The provider must notify the SYMHP immediately of any potential tort, casualty insurance, or Worker's Compensation awards that may reimburse the provider for any covered specialty mental health service rendered by the provider to a beneficiary.

10.5 Licensure and Insurance Coverage Requirements

10.5.0 The provider must submit a copy of his/her license(s) to provide services in the State of California. Failure to provide evidence of an active, valid license will result in withholding of payments for current and future claims and/or contract termination.

10.5.1 The provider must notify the SYMHP immediately of any changes in his/her licensure status imposed by the State of California.

10.5.2 The provider must submit evidence of his/her malpractice insurance. Failure to provide evidence of current and adequate insurance coverage will result in withholding of payments for current and future claims and/or contract termination.

10.6 Satisfaction Surveys

The overall objective of the monitoring and evaluation process is to ensure that consumers receive appropriate care from competent providers at a fair and manageable cost. The Quality Improvement Council will monitor consumers' satisfaction with services they receive from providers through consumer satisfaction surveys. The SYMHP will also monitor providers' satisfaction with the SYMHP through provider satisfactions surveys.

10.7 Consent to Treatment

The SYMHP requires its providers to obtain a beneficiary's consent before the beginning of treatment. A provider's credentialing status may be affected if he/she does not obtain beneficiaries' consent prior to beginning treatment.

10.8 Medication Consent Form

The SYMHP also requires contracted psychiatrists to obtain a consent to prescribe medication. A provider's credentialing status may be affected if he/she does not obtain beneficiaries' consent prior to prescribing medication.

Section 11: Problem Resolution and Appeal Process

The SYMHP has developed a provider problem resolution and appeal process that enables providers to resolve SYMHP payment authorization issues or other complaints and concerns (CCR 1850.305(a).

11.0 Provider Problem Resolution and Appeal Process

11.0.0 Informal Provider Problem Resolution Process

- If a provider has a complaint or concern, s/he may call the following individual:
  - **Quality Assurance Officer (530) 822-7200**
    - Staff will attempt to settle the complaint or concern with the provider. If the attempt is unsuccessful or if the provider chooses to forego the informal complaint process, the provider will be advised to file an appeal with the SYMHP.

11.0.1 Formal Provider Appeal Process

The provider has the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun when the complaint concerns a denied or modified request for SYMHP payment authorization, or the processing or payment of a provider's claim to the SYMHP.

A provider may appeal a denied or modified request for SYMHP payment authorization or a dispute with the SYMHP concerning the processing or payment of a provider's claim. The written appeal shall be submitted to the SYMHP within ninety (90) calendar days of the date of the postmark on the denial letter or other means used to notify the provider of payment denial.

The appeal must include a letter stating the reason the appeal is being requested with any supporting documentation.

Additional documentation may be requested, including:

- A copy of the denial letter.

- A copy of the authorization letter, if applicable.

The above information should be mailed or faxed to:

Sutter-Yuba Mental Health Plan
Attention: Quality Assurance Officer
P.O. Box 1520
Yuba City, CA 95992
Telephone: (530) 822-7200
Fax: (530) 822-5061

- The SYMHP shall have sixty (60) calendar days from its receipt of the appeal to inform the provider in writing of its decision.
- If the appeal concerns a denial or modification of an SYMHP payment authorization request, the SYMHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.
- If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the Department of Health Care Services pursuant to Section 1850.320 or 1850.350.
- When the SYMHP agrees to overturn the appeal, where applicable, the provider will be asked to submit a revised request for payment within thirty (30) calendar days of receipt of the decision and the SYMHP shall have fourteen (14) calendar days from the receipt of the revised request to submit the documentation for payment processing.
- If the SYMHP does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied in full by the SYMHP.

Provider Appeals – Claims Payment

- Providers who receive payment from the State's fiscal intermediary, may file appeals concerning the processing or payment of their claim directly to the fiscal intermediary within ninety (90) calendar days of the date the payment was due.

11.0.2 Appeal to the Department of Health Care Services

Should the SYMHP deny the provider's formal appeal, the provider may appeal to the State as outlined in California Code of Regulations, Sections 1850.320 and 1850.350.

Section 12: Cultural and Linguistic Standards

12.0 General Overview

The population of California is one of the most culturally and linguistically diverse in the country. The SYMHP is committed to providing mental health services in a manner that considers the cultural and linguistic needs of our beneficiary population.

12.1 Cultural and Linguistic Standards

Mental health services will be provided in a culturally and linguistically appropriate manner. The SYMHP will support health providers in the delivery of these services through training, services, materials and consultation.

12.2 Cultural and Linguistic Definitions

12.2.0 Culture

Culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs. An individual's cultural identity may involve, but are not limited to, the following parameters: ethnicity, race, language, acculturation, gender and gender identity, socioeconomic class, religious/spiritual beliefs, and sexual orientation.

12.2.1 Consumer (Client) Culture

Mental health clients bring a set of values, beliefs and lifestyles that are molded, in part, by their personal experiences with mental illness, and their culture. When these personal experiences are shared, mental health clients are better understood and empowered to effect positive system changes.

12.2.2 Cultural Sensitivity

Cultural sensitivity is being aware that cultural differences and similarities between people exist without assigning them a value—positive or negative, better or worse, right or wrong.

12.2.3 Cultural Appropriateness

Cultural appropriateness includes a sensitivity to the differences among ethnic, racial, and/or linguistic groups and awareness of how people's cultural background, beliefs, traditions, socioeconomic status, history, and other factors affect their needs and how they respond to services, including interventions and practices.

12.2.4 Cultural Competence

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and which enable that system, agency or those professionals to work effectively in cross-cultural situations.

Cultural competence includes the possession of a set of clinical and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons from the community in developing focused interventions, communications, and other supports.

The SYMHP views cultural competence as an on-going learning process.

12.3 Cultural Training

The SYMHP offers and provides cultural training to all department staff and contracted providers.

12.4 Language Assistance Services

Providers working with beneficiaries who are limited-English proficient (LEP) or non-English speaking must use either bilingual staff members proficient in the language of the beneficiary or interpreter services. The Sutter-Yuba Mental Health Plan will share its list of certified interpreters, but the provider will be responsible for the cost of these services. Providers may use telephone translation services (such as a Language Line) for making appointments or getting information from beneficiaries. In no case will the beneficiary be billed for the use of interpreter services.

The SYMHP strongly discourages the use of adult family members, guardians, conservators, or friends as interpreters. If the beneficiary insists on providing his/her own interpreter, the provider will document his/her request in the beneficiary's record and have the beneficiary sign both a release and a third- party confidentiality acknowledgement. These forms will be filed in the beneficiary's medical record. Minor children should not be used as interpreters.

12.5 Consumer Forms

All written communication with beneficiaries must be translated into the beneficiary's preferred language. Examples include consent for treatment forms, medication consent forms, and material explaining the side effects of medication.

12.6 Consumer Access Brochure

The SYMHP's Medi-Cal Beneficiaries Member Information Brochure provides a description of available services, how to access services, and members' rights and also explains the complaint, grievance and state fair hearing process. The SYMHP will make these brochures available in threshold languages. Providers may contact the SYMHP for copies.

Section 13: Legal Requirements

13.0 Patients' Rights

As required by State law, the Sutter-Yuba Mental Health Plan (SYMHP) contracts with Patients' Rights Advocacy Services to investigate and resolve patient complaints and infractions of mandated rights and to train staff in compliance with these rights. All providers are required to cooperate with patients' rights activities.

13.1 Confidentiality/Release of Information

The Sutter-Yuba Mental Health Plan (SYMHP) providers are expected to maintain client confidentiality.

If a provider has concerns regarding release of client records required by an external source such as subpoenas and court orders, the provider is advised to contact their counsel and the SYMHP Privacy Officer.

13.2 Consent for Mental Health Services

Consent for treatment must be given at the initial office visit by the beneficiary, parent or guardian by signing a consent form. This form must be maintained in the beneficiary's medical record.

Under Family Code section 6924 and Health and Safety Code section 124260, children 12 years of age or older may provide legal consent to mental health treatment or counseling on an outpatient basis without the consent of their parent or legal guardian. In certain circumstances, records and information are not to be released to parent(s) without the minor's consent.

13.3 Consent for Medication

Providers must acquire a beneficiary's consent to prescribe psychotropic medication. This is indicated by the beneficiary's

signature on a medication consent form. Documentation on consent forms 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.

For minor consent cases, the authority to consent to treatment does not extend to psychotropic medication. Family Code section 6924(f) and Health and Safety Code section 124260(e) clarify that, ***a parent or guardian's consent is needed for a child to receive psychotropic medication***. In the case of foster children, a court will determine who is authorized to consent to psychotropic medication on the child's behalf (Welfare and Institutions Code sections 369.5(a) and 739.5(a)). If the medication is not a psychotropic medication and all statutory requirements are met, a child 12 years of age or older may be the sole signatory of a medication consent form.

13.4 Scope of Practice/Treatment Approaches

SYMHP providers will only provide services that are within their scope of practice**.**

SYMHP providers use treatment approaches based on accepted national standards of professional practice. Psychotherapeutic modalities must be generally accepted by national mental health and professional associations and recognized in professional journals and standard psychological/psychiatric references.

13.5 Reporting Child, Elder or Dependent Adult Abuse

Providers are expected to follow legal requirements and guidelines related to reporting child, elder or dependent adult abuse.

13.6 Duty to Warn/Tarasoff

Providers are expected to follow legal requirements related to Tarasoff reporting requirements.

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Section 14:
Provider Responsibilities for Beneficiary Informing Materials

The SYMHP and its providers shall:

- Provide information in a manner and format that is easily understood and readily accessible to beneficiaries. (42 C.F.R. § 438.10(c)(1).)

- Provide all written materials for beneficiaries in easily understood language, format, and alternative formats that take into consideration the special needs of beneficiaries. (42 C.F.R. § 438.10(d)(6).)

- Inform beneficiaries that information is available in alternate formats and how to access those formats. (42 C.F.R. § 438.10.)

- Make its written materials that are critical to obtaining services available to beneficiaries in SYMHP's threshold languages, including, at a minimum:
    1. Provider directory
    2. Beneficiary handbook
    3. Grievance and appeal notices
    4. Denial and termination notices

  Regulations:
    - CFR, title 42, section 438.10(d)(i), (ii)
    - CCR, title 9, chapter 11, sections 1810.110(a) and 1810.420(e)(4)
    - CFR, title 42, section 438.10 (d)(2)
    - MHP Contract
    - SYMHP Acknowledgement of Receipt Form (see sample below)

Provider Responsibilities for Beneficiary Informing Materials

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Sutter-Yuba Counties Mental Health Plan
Acknowledgement of Receipt

I have received the following items at the start of service with this Provider:

Document Provided
Counties of Sutter and Yuba, Guide to Medi-Cal Mental Health Services (AKA: Beneficiary Booklet/Medi-Cal Guide) The MHP Member's Handbook contains information about how a member is eligible for mental health services, how to access mental health services, who our service providers are, what services are available, what your rights and responsibilities are, our Grievance and State Fair Hearing process and includes important phone numbers regarding our Mental Health Plan.
Advance Directive Brochure The Advance Directive Brochure explains your rights to make decisions about your medical treatment. It includes how to appoint a health care agent who can make decisions on your behalf and how to change your directives at anytime. ***Each adult beneficiary (and emancipated minor) must be given a copy of the Advance Directive Brochure.***
Sutter-Yuba Counties Mental Health Plan (MHP) Provider list – For Medi-Cal Beneficiaries Only This is a list of Sutter-Yuba Counties MHP contract Providers. The MHP must <u>authorize all outpatient non-emergency services.</u> You may contact the MHP for further information regarding this list. Adult Services: (530) 822-7200, press 0 then 1 Youth and Family Services: (530) 822-7200, press 0 then 2 Psychiatric Emergency Services: (530) 673-8255 Toll Free (All Services): 1-888-923-3800 TTY-CRS to Voice: 1-800-735-2929

I, _____ (client's name), have been given a copy of the above documents and have had a chance to ask questions regarding these documents.

I understand that I have a right to free language assistance services in my preferred language. This includes the right to interpreter services and sign language. In order to access free language assistance services, I understand that I may request them from the Reception staff or any staff member, and that they will be provided by Sutter-Yuba Behavioral Health.

_____ _____
Client Signature Date

_____ _____
Legal or Personal Representative of Client (if applicable) Date

Relationship to Client: _____

Provider Responsibilities for Beneficiary Informing Materials

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Plan de Salud mental de los Condados de Sutter y Yuba

Declaración de Recibo

He recibo los siguientes documentos al comenzar los servicios con este Proveedor:

Documento Proveído
Los condados de Sutter y Yuba, Guía de Medi-Cal para los Servicios de Salud Mental (Folleto de Beneficiario / Guía de Medi-Cal) El Manual del Plan de Salud Mental (PSM) contiene información acerca de cómo un miembro es elegible para los servicios de Salud Mental y como obtener acceso a los servicios de salud mental, quiénes son nuestros proveedores de servicios, cuáles servicios están disponibles, cuáles son sus derechos y responsabilidades, nuestro procedimiento para Agravio y Audiencia Justa del estado e incluye números de teléfono importantes para nuestro Plan de Salud Mental.
Folleto de Disposición Anticipada El folleto de Disposición Anticipada explica sus derechos para hacer decisiones acerca de su tratamiento médico. Incluye como asignar a un agente para su cuidado médico quien puede hacer decisiones por usted y como cambiar sus disposiciones en cualquier momento. ***Cada adulto beneficiario (y menor emancipado) debe ser dado una copia de Folleto de Disposición Anticipada.***
Lista de Proveedores del PSM de los Condados de Sutter y Yuba - Solamente para los beneficiarios del Medi-Cal Esta es una lista de los proveedores bajo contrato con el PSM de los condados de Sutter y Yuba. El PSM debe **autorizar todos los servicios del paciente que no sean de emergencia**. Usted puede comunicarse con el PSM para más información acerca de esta lista. Servicios de Adultos: (530) 822-7200 presione 0 y después 1 Servicios de Jóvenes y Familia: (530) 822-7200 presione 0 y después 2 Servicios de Emergencias Psiquiátricas: (530) 673-8255 Gratis (Todos los servicios): 1-888-923-3800 TTY-CRS para Voz: 1-800-855-3000

Yo,_____(nombre del cliente), he recibido una copia de los documentos y he tenido la oportunidad para hacer preguntas acerca de estos documentos.

Yo entiendo que tengo el derecho de obtener asistencia en servicios de idioma en mi lenguaje preferido. Esto incluye el derecho de servicios de intérprete y el uso de lenguaje para sordomudos. Para poder obtener los servicios de asistencia en lenguajes gratuito, yo entiendo que puedo requerirlo al personal de recepción u otro miembro del personal, y ellos proveerán el servicio por medio del departamento de Salud y Bienestar de Sutter-Yuba.

_____ _____
Firma del cliente Fecha

_____ _____
Firma del representante legal o personal (si es aplicable) Fecha

Relación con el cliente: _____

Provider Responsibilities for Beneficiary Informing Materials

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The SYMHP and its providers will obtain the client, or personal representative of client (if applicable) or legal guardian's signature on the Acknowledgement of Receipt Form for the following informing materials:

- Sutter-Yuba Counties Mental Health Plan's Member Handbook
- Advance Directive Brochure (Each adult beneficiary and emancipated minor will be given a copy of the Advance Directive Brochure).
- SYMHP's Provider List
- And client was informed they have a right to free language assistance services in their preferred language. This includes the right to interpreter services and sign language. Clients may request free language assistance services from the Reception staff or any staff member, and that they will be provided by Sutter-Yuba Behavioral Health.

14.0 Posting Beneficiary Informing Materials

The SYMHP has developed user friendly beneficiary materials in English and in the SYMHP's threshold language of Spanish that provide a general understanding of services offered. All beneficiary materials listed below must be posted in prominent locations where Medi-Cal beneficiaries obtain outpatient specialty mental health services, including waiting areas of a provider's place of service:

- Grievance Form with self-addressed envelope
- Appeal / Expedited Appeal Form with self addressed envelope
- Problem Resolution Process Poster (see sample below)
- Patient Rights Poster (see sample below)
- Limited English Proficient (LEP) Free Language Assistance Poster (see sample below)
  - CCR, title 9, chapter 11, section 1810, requires that there be policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the Specialty Mental Health Services (SMHS) or related services available through "key points of contact."

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- CFR, title 42, section 438.10(c) (4) and (5) requires the MHP and its providers to make oral interpretation services available and make these services available free of charge to each potential beneficiary and beneficiary. This applies to all non-English languages, not just those that the State identifies as threshold languages.
  - Interpreter services mean oral and sign language.

14.1 Ordering Beneficiary Informing Materials

If you need any of the above SYMHP beneficiary informing materials or require a specific translation, please contact Sutter-Yuba Behavioral Health's transcription office at (530) 822-7200. For your convenience, you can fax requests to (530) 822-7270 or request information by mail.

14.2 Beneficiary Grievance and Appeal Process

This Poster should be posted in your waiting rooms. Please contact SYBH for poster. All information posted must be in 12 pt. font, at a minimum.

14.3 Beneficiary Rights Poster

SUTTER-YUBA COUNTIES MENTAL HEALTH PLAN
PROBLEM RESOLUTION PROCESS

Sutter-Yuba Counties Mental Health Plan, hereinafter referred to as "SYMHP", encourages the resolution of problems at the least formal level possible. **The beneficiary will not be subject to any penalty or discrimination for filing a grievance, appeal or for requesting a State Fair Hearing.** A beneficiary may authorize a person of their choice to act in his/her behalf at any time.

Grievance

A grievance is an expression of dissatisfaction about any matter other than a Notice of Adverse Benefit Determination (NOABD). The beneficiary may submit a grievance orally or in writing to the SYMHP.

❖ The beneficiary will receive a written resolution within 90 days.

Standard Appeal

An Appeal is a request to review a NOABD. A NOABD occurs when the SYMHP denies, or limits, an authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; reduces, suspends or terminates previously authorized services; denies in whole or in part, payment for a service; fails to provide services in timely manner; denies a request to dispute financial liability, including cost sharing and other

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beneficiary financial liabilities; or fails to act within the timeframes for the disposition of grievance, standard appeal or expedited appeals.

- ❖ The beneficiary may submit an appeal orally or in writing. Unless the beneficiary requests an expedited appear, an oral appeal must be followed up by a written signed appeal.
- ❖ Following the receipt of a NOABD, a beneficiary has 60 calendar days from the date of the NOABD in which to file a request for an appeal.
- ❖ The beneficiary will receive a written resolution within 30 days.

Expedited Appeal

The Expedited Appeal is filed when the SYMHP determines, or the beneficiary and/or the beneficiary's provider certifies, that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

- ❖ The SYMHP will resolve and notify within 72 hours after receipt of the expedited appeal.
- ❖ If the expedited appeal is denied, a written notice will be sent to the beneficiary and the standard appeal process will begin.

State Fair Hearing

If you are a Medi-Cal beneficiary, you have the right to file for a State Fair Hearing if you are dissatisfied with the appeal decision (State Hearings Division, California Department of Social Services, PO Box 944243, Mail Station 19-37, Sacramento, CA 94244-2430, Phone: 1-800-952-5253 or TDD 1-800-952-8349). State fair hearings must be filed no later than 120 calendar days from the date of the appeal resolution. State Fair Hearing may be filed by the beneficiary, his or her representative or the representative of a deceased beneficiary's estate. The beneficiary is required to exhaust the SYMHP's problem resolution process prior to filing a State Fair Hearing. Beneficiaries that meet the Aid Paid Pending (APP) criteria will have services continued while their appeal or state fair hearing is pending. The beneficiary may request a State Fair Hearing whether or not the beneficiary has received a NOABD.

Notice

Grievance forms, Standard Appeal forms, or Expedited Appeal forms are available at all provider sites or can be obtained by contacting SYMHP's Quality Improvement/Assurance staff. The beneficiary will be notified in writing that the Behavioral Health Deputy Director of Clinical Services received his/her grievance or appeal. The beneficiary may submit additional information to support a claim either in writing or in person. The beneficiary may receive the assistance in filing a grievance, appeal, or state fair hearing from:

Deputy Director of Clinical Services:	(530) 822-7200	Toll Free:	1-888-923-3800
Quality Improvement Staff Analyst:	(530) 822-7200	TTY-CRS:	1-800-735-2929
Patient Rights Advocate:	(530) 822-7200 Press 8		

Provider Responsibilities for Beneficiary Informing Materials

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SUTTER-YUBA COUNTIES MENTAL HEALTH PLAN (MHP)
YOUR RIGHTS

This Poster should be posted in your waiting rooms. Please contact SYBH for poster. All information posted must be in 12 pt. font, at a minimum.

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment.
- You have the right to participate in treatment planning.
- You have the right to request a change in the level of care, change of therapist, and a second opinion.
- You have the right to informed consent to treatment.
- You have the right to informed consent to prescribed medications and options available.
- You have the right to make an Advance Directive.
- You have the right to be free from any form of restraint or seclusion used as a means to coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- You have the right to request and receive a copy of your medical records, and to request that they be amended or corrected, as specified in CFR, Title 45, Sections 164.524 and 164.526.

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- You have the right to receive a copy of your treatment plan upon request.
- You have the right to be furnished health care services in accordance with CFR, Title 42, and Section 438.206.210.
- You have the right to access services 24 hours a day, 7 days a week, when medically necessary.
- You have the right to have services provided in a safe environment.
- You have the right to protection of personal health information.
- You have the right to free language assistance services. Please see reception staff for details.

14.4 Limited English Proficient (LEP) Free Language Assistance Poster

This Poster should be posted in your waiting rooms. Please contact SYBH for poster. All information posted must be in 12 pt. font, at a minimum.

Sutter-Yuba Behavioral Health

Hmong

Koj muajcai thov kom muaj txhaislus pab dawb tau.
(Askiv, Hmoob, Mev, thiab lwm yamlus)
Thov ntsib tus teb xovtooj yog xav paub ntau ntxiv.

Provider Responsibilities for Beneficiary Informing Materials

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English

You have the right to free language assistance services.
(English, Spanish, Hmong and Other Languages)
Please see reception staff for more information.

Español

Usted tiene el derecho de recibir asistencia gratis en su idioma. Favor de hablar con la recepcionista para recibir más información.

Section 15: Data Collection & Reporting Requirements

15.0 Beneficiary and Service Utilization Data

The collection of beneficiary and service utilization data by Fee-For-Service (FFS) network providers is mandatory. Federal (Health Care Financing Administration), State of California (Department of Health Care Services), and County (Division of Behavioral Health) all mandate reporting of beneficiary-based information regarding the individuals served in county Mental Health Plans.

All FFS network providers will be required to collect beneficiary-based information and report this data to the Sutter-Yuba Mental Health Plan when:

- Registering a beneficiary *(SYMHP & Organizational Providers)*
- Submitting claims *(All Providers)*

Beneficiary-based registration data will be entered into the Mental Health Management Information System by Mental Health Plan staff.

15.1 Other Required Data

The Department of Health Care Services requires the collection of data and financial information for all clients who receive services from the SYMHP. For the majority of clients, this information is collected by Sutter-Yuba Behavioral Health at the intake process, which occurs prior to referral to an outpatient provider or at Psychiatric Emergency Services prior to hospitalization.

If Sutter-Yuba Behavioral Health permits a provider to accept SYMHP beneficiaries without first being assessed by Sutter-Yuba Behavioral Health, the provider is responsible to collect all required information, which is found in the Electronic Health Record. The "Demographic Form" is an assessment found on a client's home page, while the California Client Financial Review Maintenance form is found under Client Data.

Section 16: Notices of Action

16.0 What Is A Notice of Action?

A *Notice of Action* is a required document that is given to Medi-Cal beneficiaries informing them of denials, terminations, reductions or modifications of requested mental health services from Mental Health Plans. They notify beneficiaries of their rights to appeal, including the right to have a State Fair Hearing if an appeal is denied.

16.1 When Is A Notice Of Action Issued?

There are five different types of Notices of Action (NOA). All NOAs include the "NOA-Back" form, which is copied to the backside of an NOA, regardless of NOA type. While all the NOAs are explained below, only some apply to providers.

NOA-A: This Notice of Action is issued by the provider when a Medi-Cal beneficiary is denied specialty mental health services due to not meeting specialty mental health medical necessity criteria. The beneficiary receives the original (within 3 working days of the decision) and copies are placed in the beneficiary's record and an NOA binder, provided by the SYMHP.

NOA-B: This Notice of Action is issued by the SYMHP when requests by a provider for authorization for specialty mental health services are denied, modified, reduced or terminated. The beneficiary receives the original (within 3 working days of the decision) and a copy is sent to the provider.

NOA-C: This Notice of Action is issued by the SYMHP when payment for a service that has been given by the provider is denied. The beneficiary receives the original (within 3 working days of the decision), while the provider receives a denial letter.

NOA-D: This Notice of Action is issued by the SYMHP when it fails to act within the timeframes for disposition of grievances, standard appeals and expedited appeals.

Notices of Action (NOA)

NOA-E: This Notice of Action is issued by the provider when they have not provided timely services as identified by the SYMHP. The beneficiary receives the original and copies are placed in the beneficiary's record and an NOA binder, provided by the SYMHP. If a binder has not been provided, a copy of the NOA will be sent to the SYMHP at:

Sutter-Yuba Behavioral Health
ATTN: Quality Assurance Officer
1965 Live Oak Boulevard, Suite A
Yuba City, CA 95991

TBS NOAs: When a beneficiary is already receiving specialty mental health services, but does not qualify for TBS, an NOA-A will be issued following the procedures outlined above. All other TBS NOAs will follow the procedures outlined above for the various types of NOAs.

When any NOA is for a minor consent case, the NOA must not be mailed to the minor's address and the minor's parent/guardian must not receive a copy or be otherwise notified. In these cases, the NOA should be handled in one of the following ways:

i. Given to the minor in person
ii. Given to the minor's eligibility worker to give to the minor
iii. Held by the provider until the next time the minor comes into the office/clinic

Section 17: Forms and Definition of Terms

17.0 Assessment

Assessment is defined as a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and, the use of testing procedures.

Please refer to Section 6 of this manual for elements required in an assessment.

17.1 Progress Notes

Progress notes are used to document all beneficiary contacts or other important information while in treatment.

17.2 Discharge Summary

This form is used when a provider discharges a beneficiary from treatment.

17.3 Mental Health Services Referral Form

The provider will use this form when making a referral for a service that the provider is unable to deliver, or which is beyond his or her scope of practice. Examples are medication referrals, case management, or psychological testing.

17.4 Reauthorization Form

If a provider is requesting a service reauthorization a Reauthorization Form must be submitted.

17.5 Definition of Terms

- **Beneficiary**
  Refers to Sutter or Yuba County Medi-Cal Beneficiaries.

Forms and Definition of Terms

- **Consumer/Client**
  An individual who is currently requesting or receiving mental health services from any SYMHP site, and/or has received services in the past.

- **Consumer Access Line (1-888-923-3800)**
  A statewide, toll-free telephone line with linguistic capability available to consumers/beneficiaries 24 hours a day, 7 days a week. The 24-hour line provides information on how to access specialty mental health services, including services needed to treat a consumer's urgent condition, and how to use the consumer problem resolution and state fair hearing process.

- **Contract Provider**
  A licensed mental health practitioner who enters an agreement with the SYMHP to provide specialty mental health services to Sutter or Yuba County Medi-Cal beneficiaries. A contract provider may be an individual, group, or organizational provider.

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Mental Health Services**
  EPSDT is a Medi-Cal entitlement program that provides comprehensive health care services for beneficiaries 0-21 years of age.

- **Medical Necessity**
  The principal criteria by which the SYMHP decides authorization and/or reauthorization for covered specialty services.

- **Primary Care Physician**
  A physician responsible for supervising, coordinating, and providing initial and primary care to beneficiaries. Other responsibilities include initiating referrals for specialty care and maintaining the continuity of beneficiary's care.

- **Provider**
  This is a contracted individual, group, or organization who provide mental health services to Sutter and Yuba County mental health consumers. This includes Sutter-Yuba Behavioral Health staff.

- **Provider Access Line**
  The Provider Access Line provides information on authorization requests for specialty mental health services, claims submission, and the consumer and provider grievance process.

- **Specialty Mental Health Services**

  - Rehabilitative Services which include mental health services, medication support services, day treatment intensive, day treatment rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.
  - Psychiatric Inpatient Hospital Services
  - Target Case Management
  - Psychiatric Services
  - Psychological Services
  - EPSDT Supplemental Specialty Mental Health Services
  - Psychiatric Nursing Facility Services

- **Sutter-Yuba Medi-Cal Beneficiary**
  A Sutter or Yuba County Medi-Cal eligible individual who is requesting mental health treatment or receiving mental health treatment. This also includes individuals who are Medi-Cal eligible and who have a Medi-Cal aid code of 51 or 58.

- **Sutter-Yuba Behavioral Health Clinical Staff**
  A licensed or waivered behavioral health practitioner within Sutter or Yuba County service sites. These practitioners are employees of Sutter-Yuba Behavioral Health.

- **Sutter-Yuba Mental Health Plan (SYMHP)**
  The county organization responsible for the mental health needs of all Medi-Cal eligible residents of Sutter and Yuba Counties.

- **Urgent Condition**
  A clinical situation experienced by a beneficiary that without timely intervention is likely to result in an emergency psychiatric condition.