Optum

COUNTY OF SAN DIEGO Health and Human Services Agency | LIVE WELL SAN DIEGO

Fee-for-Service Provider Handbook

Adult/Older Adult, Child and Adolescent Mental Health Services

Edition September 2024

optumsandiego.com

Funding for services is provided by the County of San Diego Health and Human Services Agency

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Introduction

This *Fee-for-Service (FFS) Provider Operations Handbook* was developed to give providers the information needed to participate in the Medi-Cal FFS network in the County of San Diego Mental Health Plan (MHP). The County of San Diego, the state's local MHP, is responsible for the administration of inpatient and outpatient Medi-Cal and realignment-funded Specialty Mental Health Services (SMHS).

Services for the County of San Diego MHP are governed by the requirements of Title 9 of the California Code of Regulations, Chapter 11, Specialty Mental Health Services, 42 Code of Federal Regulations, Behavioral Health Information Notice 20-043 and the policies and procedures outlined in the Medi-Cal Provider Manual. Many of the policies and procedures outlined in this Handbook are based on the Title 9 requirements and the procedures described in the State of California Medi-Cal Provider Manual Behavioral Health Information Notice 20-043. Providers are encouraged to review these documents closely.

On January 1, 2022, the Department of Health Care Services (DHCS) initiates the implementation of the California Advancing & Innovating Medi-Cal (Medi-Cal Transformation) initiative. The MHP will implement Medi-Cal Transformation and applicable updates to specialty mental health medical necessity criteria for beneficiaries 21+ and applicable updates to specialty mental health medical necessity criteria for beneficiaries under 21. The MHP will implement Medi-Cal recoupment requirements as indicated by the Medi-Cal Transformation initiative.

To view the FFS Provider Operations Handbook electronically, providers may visit optumsandiego.com > Fee for Services Providers > Manuals > FFS Operations Handbook. Title 9 regulations can be viewed at the Department of Health Care Services or by calling (800) 888-3600.

The Role of Optum Public Sector San Diego

In its role as the Administrative Services Organization (ASO) for the County of San Diego's publicly funded mental health system, Optum Public Sector San Diego, hereinafter referred to as "Optum":

- Operates a 24-hour Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care, including mental health and
- substance use disorder services, referrals, and information
- Facilitates access to emergency mental health services for residents of San Diego County
- Conducts medical necessity and utilization management review on Adult/Older Adult and Child/Adolescent inpatient hospital, outpatient FFS services, Crisis Residential, SUD, and Child/Adolescent Day program services
- Authorizes the reimbursement for FFS services provided by individual, and group based FFS providers, non-emergency inpatient care providers, and MHP payment for day program services and certain mental health services that occur on the same day as day program services
- Authorizes the payment for Adult/Older Adult and Child/Adolescent inpatient hospital services
- Credentials and contracts with individual and group based FFS providers
- Processes and pays FFS claims

The Optum Provider Line can be reached at (800) 798-2254. In addition, the Optum website provides links to the Medi-Cal FFS Provider Handbook and helpful forms and documents about the FFS network procedures.

Please refer to the Treatment and Evaluation Resource Management (TERM) Provider Handbook for the policies and procedures that govern the TERM network requirements. The TERM Provider Handbook can be found at optumsandiego.com > TERM Providers > Manuals > TERM Provider Handbook.

Providers can access the Medi-Cal Manual at optumsandiego.com > MHP Provider Documents > Manuals.

Directory

Optum Public Sector San Diego Contact Information		
Optum • General information	P: (800) 798-2254	Website: optumsandiego.com

Optum Provider Line
• Bed availability – Press 1
• Utilization Management - Authorization related inquiries – Press 3
  ○ Psychiatric Inpatient - Press 1
  ○ Substance Use Disorder Residential – Press 2
  ○ Outpatient – Clinical – Press 3
  ○ Outpatient Administrative – Press 4
  ○ Long Term Care – Press 5
  ○ Crisis Residential – Press 6
	P: (800) 798-2254
	Monday to Friday 8am – 5pm	

Optum Claims • Billing questions • Medi-Cal eligibility/verification • Claims status • Request for check tracer • Corrected claims	P: (800) 798-2254 Option 2 F: (877) 364-6945	E-mail sdffsclaims@optum.com
Optum Provider Services • Contracting • Credentialing/Recredentialing • To update information	P: (800) 798-2254 Option 7 F: (877) 309-4862	E-mail: sdu_providerserviceshelp@optum.com
Optum TERM	P: (877) 824-8376 F: (877) 624-8376	Website: TERM Providers
Optum Medi-Cal funded Outpatient Utilization Management	F: (866) 220-4495	
Optum Help Desk	P: (800) 834-3792	
Optum MIS/Finance	F: (619) 641-6729	
Addresses		
Optum Public Sector San Diego Attn: Utilization Management P.O. Box 601340 San Diego, CA 92160-1340	To mail authorization requests	
Optum Public Sector San Diego Attn: Provider Services P.O. Box 601340 San Diego, CA 92160-1370	To submit changes/updates to the provider profile or update referral status	

Optum Public Sector San Diego Attn: Claims P.O. Box 601340 San Diego, CA 92160-1340	To submit: • Medi-Cal FFS claims • Refunds (Check must be made payable to “County of San Diego”) • Appeals
Optum Public Sector San Diego Attn: Appeals P.O. Box 601340 San Diego, CA 92160-1340	To mail written provider appeals with relevant documents

Important Contact Information		
San Diego ACL	P: (888) 724-7240 F: (619) 641-6975	Website: Access & Crisis Line
County of San Diego	(858) 694-3900	Website: sandiegocounty.gov
California Department of Mental Health	(888) 452-8609	Website: dhcs.ca.gov
California Medi-Cal	(800) 541-5555	Website: medi-cal.ca.gov
County of San Diego Behavioral Health Services Administration	(619) 563-2700	Website: Behavioral Health Services
Jewish Family Services Patient Advocacy	(800) 479-2233	Website: Patient Advocacy - JFSSD
Consumer Center for Health, Education, and Advocacy (CCHEA)	(877) 734-3258	Website: lassd.org
CA Automated Eligibility Verification System (AEVS)	(800) 456-2387	
California Medi-Cal Provider Manuals	Website: Publications	

List of Acronyms

Acronym	Meaning
ACL	Access and Crisis Line
ABMS	American Board of Medical Specialties
ASO	Administrative Services Organization
BHS	Behavioral Health Services
CANS	Child and Adolescent Needs and Strengths
CAQH	Council for Affordable Quality Healthcare
DHCS	Department of Health Care Services
DSM	Diagnostic and Statistical Manual
E/M	Evaluation and Management
EOB	Explanation of Benefits
FFS	Fee For Service
HIPAA	Health Insurance Portability and Accountability Act
ITP	Initial Treatment Plan
MCP	Managed Care Plan
MHP	Mental Health Plan
NOA	Notice Of Action
NOABD	Notice Of Adverse Benefit Determination
NPDB	National Practitioner Data Bank
OAR	Outpatient Authorization Request
PCP	Primary Care Physician
PHI	Protected Health Information
POS	Point of Service
PSV	Primary Source Verification
RCA	Root Cause Analysis
SMHS	Specialty Mental Health Services
SIR	Serious Incident Report
SOC	Share Of Cost
TPU	Treatment Plan Update
TERM	Treatment and Evaluation Resource Management

Provider Contracting

Optum, on behalf of the County of San Diego Behavioral Health Services/ Mental Health Plan, is responsible for developing and maintaining a network of FFS and TERM providers. All FFS and TERM providers must be contracted with Optum, either individually or within a group in order to receive reimbursement for professional services rendered to clients. Both the Optum individual and group-based provider contracts contain:

- General terms applicable to all contracts delivering County reimbursable services
- A description of work or services to be performed
- Exhibits specific to FFS and/or TERM network requirements
- CPT codes and reimbursement schedules as approved by the County of San Diego MHP
- Statutes and/or regulations particular to Medi-Cal managed mental health care and/or TERM network participation
- This handbook is included by reference in the contract; the requirements, workflows protocols are part of the contract

All providers whether individual or group based FFS and/or TERM providers are required to follow the contract requirements. Please contact Optum Provider Services at (800) 798-2254, option 7, with any questions related to the contract.

Agreements/Contracts

In addition to the Individual or Group Provider Agreement, each FFS Provider must complete a State Medi-Cal Enrollment and Point of Service (POS) Agreement.

Please note: Providers are NOT required to apply directly to the State and pay a fee to become a provider. By completing the two (2) agreements, Optum is directly enrolling the provider with the State through the San Diego County Behavioral (Mental) Health Plan.

State Medi-Cal Enrollment Agreement

All providers applying to render services to Medi-Cal Beneficiaries through the San Diego County FFS Medi-Cal Network must be enrolled in the Medi-Cal Program. Optum will assist in facilitating the process with the provider during the contracting process.

Point of Service (POS) Agreement

All providers applying to render services to Medi-Cal Beneficiaries through the San Diego County FFS Medi-Cal Network must sign a State POS Agreement.

This Agreement allows the provider access to the State Medi-Cal Site to verify the benefit status of Medi-Cal Beneficiaries. Claims can only be paid for dates of services when the beneficiary’s benefits are active.

Please note: Optum cannot contract with providers who are employed by the County or public agency for which the Board of Supervisors is a governing body.

Providers are encouraged to read the contract carefully. The contract should be in a place where providers can easily refer to it. For any questions regarding the contract with Optum, providers may contact the Provider Services Department at: (800) 798-2254, Option 7.

Credentialing

Credentialing Standards

Optum, on behalf of the Mental Health Plan, contracts with Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Psychiatric Physician Assistants, Marriage and Family Therapists, Licensed Clinical Social Workers and Licensed Professional Clinical Counselors to provide specialty Medi-Cal mental health services to Adults/Older Adults, and Children and Adolescents. (Please see Credentialing Criteria)

Council for Affordable Quality Healthcare (CAQH) participation is mandatory to join our network(s). Providers are required to register for a CAQH ID, complete a CAQH Provider Profile and attach the appropriate supporting documentation. This completed profile serves as the provider's credentialing application.

All providers are required to complete the most recent Optum practitioner clinical application(s), a web based documentation training course, and a site review as part of the initial contracting process. Credentialing is completed per National Committee of Quality Assurance (NCQA) guidelines and is facilitated by Optum Provider Services. It includes approval by the MHP Credentialing Committee and a documentation review or primary source verification (PSV) of the following:

- Education and medical residency, if applicable
- Professional license
- Board certification from American Board of Medical Specialties (ABMS) or equivalent osteopathic certification, if applicable
- DEA certificate, if applicable
- Professional liability insurance
- Malpractice history and complaints documented with the National Practitioner Data Bank (NPDB), Regional Medicare/ Medi-Cal offices, and the State Medical Boards or other appropriate State agencies
- Medi-Cal Provider number.
- Medicare Provider number, if applicable
- Individual Provider NPI (National Provider Identifier) and Taxonomy Code
- Group NPI and Taxonomy Code, if applicable
- Clinical privileges in good standing at an institution, as applicable
- Any certifications, additional training/ areas of specialty, service location, telephone, and office hours
- Review of Board Certification, CME hours and experience for psychiatrists that wish to treat children or adolescents. Psychiatrists who treat 12 years old children and under, must be board certified or eligible in Child & Adolescent Psychiatry. Psychiatrists treating children ages 13-17 may be authorized to do so without board certification; however, may be required to submit documentation of their experience with this population to the MHP Credentialing Committee.

In order to ensure that providers meet minimum qualification standards, Optum, adheres to the credentialing policies and qualification standards developed by Optum, as well as sections 1810.436 and 1810.438 of Title 9, and County of San Diego malpractice coverage requirements. Credentialing policies and qualification standards may be obtained by contacting Optum Provider Services at (800) 798-2254, option 7.

Please refer to the TERM Provider Handbook for additional specific requirements necessary to be paneled onto the Optum TERM Network. All providers contracting with TERM must attest to specific experience and/or training prior to rendering services to the TERM Network population.

Recredentialing

A recredentialing process occurs at a minimum of every thirty-six (36) months from the most recent credentialing or recredentialing date. This recredentialing process enables Optum to update demographic information and verify that providers continue to meet the credentialing criteria required to continue a contract with Optum. Recredentialing of all providers is facilitated by Optum Provider Services and includes approval by the MHP Credentialing Committee, primary source verification and a reverification of documents reviewed during the original credentialing process.

Additional areas reviewed during the recredentialing process include:

- Provider data such as complaints or grievances, results of client satisfaction surveys, quality management reviews and site and chart reviews, in addition to compliance with the goals of the MHP
- Compliance with contract obligations and the Optum authorization procedures, standards established in the MHP QM Plan, and cultural competency standards established by the County and the State
- Medi-Cal Sanctions Report. (*This report is reviewed monthly, as well as at the time of provider credential and recredentialing - If a provider is identified as on the Exclusion and Debarment list, the provider shall not receive a contract, or contract that is in effect shall be reviewed for termination.*)

Providers can help avoid delays at recredentialing time by maintaining their CAQH ProView Profile, attestations, and credentialing documents, DEA, ANCC, Professional Liability Insurance and Professional License on an on-going basis. Providers who delay updating documentation may be unable to obtain ongoing authorizations, referrals or claims reimbursement until all documentation is up to date.

A provider may be required to furnish additional background information or authorize a background investigation based upon new or additional information. Providers who do not appropriately complete the required recredentialing process shall have their contracts terminated.

Mental Health Plan (MHP) Credentialing Committee

The MHP Credentialing Committee reviews and recommends for approval providers who meet the credentialing or recredentialing requirements. In addition, the MHP Credentialing Committee is responsible for recommending disciplinary actions or terminations of providers from the network. The MHP Credentialing Committee membership includes but is not limited to the following:

- County Clinical Director, or designee
- Optum Medical Director or designee
- Optum Director of Behavioral Health Network and Quality Improvement or designee
- Optum Director of Clinical Operations or designee
- Optum Manager of Provider Services
- Optum Manager of TERM team or designee
- Director of Adult/Older Adult Mental Health Services or designee
- Director of Quality Improvement of County of Behavioral Health Services
- Director of Child, Youth and Family Services or designee
- A contracted FFS psychiatrist and psychologist
- A quorum of 50% of committee members must be present in order to conduct business. A majority consensus is required for implementation of credentialing and contracting decisions.

Disciplinary Actions

The MHP Credentialing Committee may restrict or suspend the participation of a Provider and/or may recommend any action deemed appropriate to improve and monitor performance. In addition, Optum or the County of San Diego Behavioral Health Director may, at their sole discretion, take corrective action, discipline, suspend or restrict any provider's participation for failure to follow participation agreement terms, the FFS Provider Handbook, the Plan or any other reasons set forth in the participation agreement, Plan or under applicable law.

Examples of such disciplinary actions include, but are not limited to the following:

- Monitoring of the provider
- Requiring peer consultation
- Requiring additional training
- Limiting the scope of practice in treating clients
- Submission by the provider, and adherence to a plan of correction and/or corrective action plan
- Ceasing referrals or authorization of any new or existing clients
- Temporarily restricting, limiting or suspending the provider's participation status
- Referral to the Peer Review Committee
- Terminating the provider's contract/agreement

Contract Termination

Contracts may be terminated at the request of the provider, by Optum or at the request of the County MHP. To review the conditions, responsibilities, and provider rights upon termination, please refer to Section 11, Term and Termination, in the provider contract.

Providers, who wish to terminate their contract to provide mental health services to MHP Medi-Cal beneficiaries, must notify Optum in writing thirty (30) days prior to the date of termination. The provider contract requires completion of authorized episodes of treatment for current clients unless clinically contraindicated. Optum can assist the client in locating a new provider.

There may be occasions when a provider's contract is terminated by Optum. The provider is notified by email and USPS mail. The provider may have the right to appeal the termination and request a hearing. Please contact Provider Services at (800) 798-2254, option 7 to obtain more information about the provider disciplinary, termination and termination appeals processes.

When a provider's contract is terminated, the provider is required to complete a treatment transition or termination process with clients unless it is clinically contraindicated. When necessary, the provider is expected to work with Optum to transition the clients to a new provider in a clinically appropriate manner.

Reporting Requirements – 805 Reports and National Practitioner Data Bank (NPBD)

Optum reports all adverse Actions designated as reportable adverse actions, pursuant to applicable state and federal to state licensing boards, the Medical Board of California and the NPBD in the event that a provider's network participation is restricted or terminated due to quality issues.

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Provider Obligations

To ensure that clients receive the highest quality care, contracted providers are required to maintain a safe facility and practice within ethical and legal guidelines. Obligations include storing and dispensing medications in compliance with State and Federal laws and regulations and promoting effective clinical treatment and service responsiveness that results in positive outcomes.

The following pages outline the provider's contractual obligations as a MHP provider of Medi-Cal funded services.

Professional Will

A professional will is a document used by mental health care providers to outline how the closing of a practice should be handled in the event of unexpected closure or termination of services.

Clinical Orientation

Recovery Model of Psychosocial Rehabilitation

Providers are encouraged to become familiar with psychosocial rehabilitation as well as the principles and procedures of cost-effective, outcomes-oriented behavioral healthcare. The Recovery Model of Psychosocial rehabilitation is designed to empower individuals with severe and persistent mental illness to achieve improved levels of competence, independence, and involvement in their community. It provides people who have a psychiatric illness with the opportunities, abilities, and support to achieve their own goals within their cultural context. Recovery, as defined by the client, is the goal of psychosocial rehabilitation.

The MHP embraces the Recovery Model of psychosocial rehabilitation. Self-determination, empowerment, and recovery form the foundation of a recovery-based system. Research has demonstrated that consumers who have the most opportunity to control their own care have the greatest potential for recovery. For some individuals, recovery is the ability to live a fulfilling and productive life. For others, recovery implies the reduction or complete remission of symptoms and for some, recovery is the ability to make choices concerning their own lives and future.

Coordination of Care

Coordination of care is essential for a mental health system to work efficiently. Coordination of care includes inpatient and outpatient services and providers of mental health, physical health, and substance use disorder treatment providers. Coordination supports clients' efforts to achieve and maintain the highest possible level of stability and independence. In addition, providers are required to inform consumers about community-based opportunities to maximize recovery.

For more information about community-based services and opportunities for clients, including substance use disorder treatment, please contact the San Diego ACL at (888) 724-7240.

Providers are required to coordinate the client's mental health services with other professionals treating the client and to refer the client to appropriate community services when indicated, based on the client's goals, a clinical assessment and the response or lack of response to treatment provided. Please review the Requesting Authorizations section for more information on provider obligations in coordination of care and how to get authorization for these services.

Acceptance of Contracted Rate

Providers agree to the MHP negotiated rate for services as payment in full. This means that the client/family may not be "balance billed" for the difference between the contracted rate and the provider's usual and customary fees. In addition, Medi-Cal does not reimburse providers for "no show" appointments. If a provider is being reimbursed for services rendered to a Medi-Cal client by the Child and Family Wellbeing Department (CFWB) or Probation, a provider agrees to the negotiated rates and may not bill the client/family.

Full Scope Medi-Cal

Clients with Full Scope Medi-Cal are not required to pay the provider co-pay. There are Medi-Cal clients that do not have Full Scope Medi-Cal. These clients have Share of Cost Medi-Cal and the required co-payment is determined by the Uniform Method for Determining Ability to Pay (UMDAP) process, which is based on their financial resources. Refer to the Share of Cost (SOC) section of this manual for detailed information on Share of Cost Medi-Cal.

Availability

The MHP has identified standards for access to emergency, urgent, and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for an assessment.

Emergency Services

“Emergency Psychiatric Condition” is a condition in which the person, due to a mental disorder, is a current danger to self or others, or is gravely impaired in the ability to provide for or utilize food, shelter, or clothing. These situations require psychiatric inpatient hospital or psychiatric health facility services.

There may be an occasion in which one of a provider's current Medi-Cal clients presents (in person or by telephone) in an emergency condition. In that situation, the provider is responsible for scheduling the necessary emergency services for that client. The standard that must be met for emergency services is: **clinical assessment within one (1) hour of initial client request or referral.**

Urgent Services

“Urgent Condition” is a condition that, without timely intervention, is certain to result in an immediate emergency psychiatric condition. The standard that must be met for urgent services is: **clinical assessment within forty-eight (48) hours of initial client request of referral.**

Routine Services

This is a situation in which a person is relatively stable and in need of initial assessment for SMHS. The standard that must be met for routine services is: **clinical assessment within ten (10) business days of initial client request or referral.**

Providers are expected to arrange coverage for emergencies, after-hours inquiries, and when the provider is ill or on vacation. If a provider is treating a client in an acute care setting, the provider must arrange for another contracted provider to follow the client’s care in their absence. If the provider is unable to take on any additional clients for a period of time, the provider must notify Optum Provider Services to stop/prevent referrals. Likewise, when the provider becomes available again, Provider Services must be contacted to open/commence referrals once more. Provider Services can be reached at (800) 798-2254, option 7.

Hours of Service Availability

Providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial and private pay clients. If the provider serves only Medi-Cal clients, the hours-of-service availability must be the same for fee-for-service and managed care plan clients. Providers are also expected to ensure that hours of operation are convenient to the cultural and linguistic needs of clients in the surrounding geographic area.

Wait Time Attestation

In order to ensure compliance with Senate Bill 1135 standards of forty-eight (48) hours for Urgent appointments and ten (10) business days for Non-Urgent Appointments providers are required to complete a Wait Time Attestation twice a year to reflect the time a client must wait to get an appointment at each office in which the provider renders services. This attestation is available online and can be completed in conjunction with the required Practice Information Verification and

Validation attestation. Providers whose wait times exceed the standards should close themselves to new referrals until the wait times are back within standards. Providers may close an office to new referrals by contacting Provider Services at: sdu_providerserviceshelp@optum.com.

Telehealth Attestation

Optum FFS Providers may provide services through telehealth to Medi-Cal beneficiaries, when clinically appropriate. FFS Providers must complete and submit the Telehealth Services Provider Attestation for the provisions of telehealth services to Medi-Cal Beneficiaries found at optumsandiego.com > Provider Services > Telehealth. FFS Providers must be licensed within their scope of practice to perform telehealth services. FFS Providers must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other State and Federal laws pertaining to patient privacy. Telehealth services must use interactive telecommunications system that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a provider. Services do not include telephone conversations, chart review(s), electronic mail messages, facsimile transmission, or setting up equipment required to provide telehealth services. Telecommunication equipment and telehealth operations must meet the technical safeguards required by Title 45 of the Code of Federal Regulations (CFR) 164.312, where applicable.

Verification of Providers Demographic and Practice Information

FFS Medi-Cal beneficiaries may be referred to you by the ACL or through self-referral based on a review of information available in the FFS Providers Directory located at optumsandiego.com > Community Resources. Referrals, timely access to appropriate services, and your receipt of claim payments rely on the information you provide. It is critical that this information be kept current and accurate.

As a network provider, you must notify us when there is a demographic change pertaining to your practice, your specialties change, when you practice is full, or when you are not able to accept new FFS clients/patients for any reason.

Requirement to Notify in Case of Incident

Providers are required to notify Optum Provider Services in writing within ten (10) business days of the occurrence of any of the following:

- Any action, including but not limited to investigation which may result in the revocation, suspension, restriction, probation, termination, voluntary relinquishment of, sanction condition, limitation, qualification or material restriction on Provider's licenses, certifications or permits
- Any legal action pending against Provider for professional negligence
- Any indictment, arrest, or conviction for a felony or for any criminal charge related to the practice of Provider's profession
- Any judgments against Provider which might materially impair Provider's ability to carry out responsibilities under this Agreement
- Any change in name or ownership or Federal Tax I.D number
- Any lapse or material change in liability insurance required by this Agreement
- Any limitation on, restriction, suspension, revocation, voluntary relinquishment of or any other adverse action taken against Provider's medical staff membership or clinical privileges at any health care facility. Provider need not notify of any action which lasts thirty (30) days or less.

Requirement to Notify in Case of Status and Practice Changes

Providers are required to notify Optum Provider Services within ten (10) business days of changes to the status of their practice and demographics including:

- Name (legal change)

- Practice Address
- Phone number(s)
- Area of specialty/expertise, including board certification(s), if applicable
- Office email address (for client use), if applicable (Please note: must be “Secure” and HIPAA compliant)
- Business email address (If this email is also used by client’s, it must be “Secure” and HIPAA compliant)
- (MD Only) Hospital admitting privileges, if applicable *(County contracted facilities)*
- * Accepting New Patients/Clients
    - (** Accepting new referrals through the Access and Crisis Line (ACL), FFS Providers Directory on the Consumer & Families section of the Optum Website, and/or Optum online FFS Provider Directory).*

Practice Information Verification and Validation

Optum will be outreaching to providers semi-annually to verify the accuracy of their demographic and clinical specialty information as well as whether or not new referrals are being accepted by the provider through the ACL and Provider Directory. The regulations require that we obtain a response from the provider in thirty (30) days, either verifying that the information is accurate or providing any needed updates.

Optum requires that all providers cooperate fully with the outreach efforts and respond promptly and thoroughly to the outreach efforts. Failure of providers to validate/attest to the accuracy and status of their practice information may result in a delay of payments and administrative termination from the network.

Providers are required to register for an Optum ID to access their practice information including demographics and clinical specialties on the Optum Provider Portal. Detailed instructions to facilitate registration for an Optum ID can be found at optumsandiego.com > BHS Provider Resources > Fee for Service Providers > Applications > New Provider Requirements > Optum Website Registration.

Submitting Changes, Updates and Validation Attestations

Providers are required to register for an Optum ID to access their personal provider profile including office locations, contact information and clinical expertise/specialties. Providers can attest to the accuracy of the information or request updates/changes at this link.

Providers may also submit changes/updates to:

Optum Public Sector San Diego
Attn: Provider Services
P.O. Box 601370
San Diego, CA 92160-1370
Email: sdu_providerserviceshelp@optum.com
Fax: 877-309-4862

Information Privacy and Security Provisions

The provider must protect the privacy and security of Optum and County information that the provider may create, receive, access, store, transmit and/or destroy. In addition to the below responsibilities the provider shall be in compliance with the following rules, regulations, and agreements as applicable:

- Health Insurance Portability and Accountability Act, specifically, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, 42USC section 17921 et seq., and 45CFR Parts
- 160 and 164, collectively referred to as “HIPAA;”

- County agreements with the State of California, collectively referred to as State Agreements, are posted on the County's Business Assurance and Compliance page.

- Title 42 Code of Federal Regulations, Chapter 1, Subchapter A, Part 2

Definitions

- Protected Health Information (PHI) shall have the same meaning as PHI under HIPAA, specific to PHI under the provider's contract/agreement

- "Breach" of PHI shall have the same meaning given to the term "breach" under HIPAA

- County Protected Information: includes, but is not limited to, consumers' names, photographs, phone/fax numbers, social security numbers, dates, email addresses, medical record numbers, client charts, computers, voicemails, text messages, client sign-in sheets, etc.

Responsibilities of Provider

- Use and Disclosure of PHI: Providers shall use the minimum PHI required to accomplish the requirements of their contracts or as required by law. Providers may not use or disclose PHI in a manner that would violate HIPAA or any other applicable State Agreement(s).

- Safeguards: Providers shall develop and maintain a HIPAA-compliant information privacy and security process to prevent use or disclosure of PHI, other than as required by their contract.
    - IE: locked offices/cabinets, screen savers/time outs, codes to identify client names on charts, sign-in sheets with blacked out or removal stickers for office, workstation locations, fax cover sheets, etc.

- Data Security: Providers shall comply with data security requirements as specified by HIPAA and any applicable State Agreement(s), including but not limited to:
    - Anyone (employees, volunteers, subcontractors, interns, etc.) with access to County protected information shall:
        - Complete privacy and security training to include a signed certification within thirty (30) days of hire/contracting, and at least annually thereafter.
        - Sign a confidentiality statement, prior to access of County protected information.
        - Wear an identification badge at facilities that contain County protected information.

- Cooperation with Optum and the County of San Diego:
    - Providers shall provide access to PHI, as well as internal practices and records related to county PHI at the written request of Optum or the County of San Diego within ten (10) calendar days.
    - Providers will assist Optum and/or the County of San Diego regarding a client's access, copy, amendment, accounting of disclosure, and other requests for PHI, in the time and manner designated by Optum and/or the County of San Diego.

- Breach Reporting: Providers shall report breaches and suspected privacy incidents to the County Contracting Officer's Representative and HHSA Privacy Officer at sandiegocounty.gov/content/sdc/hhsa/.
    - Initial Report:
        - Immediately Upon Discovery: Any incident that involves information related to the Social Security Administration

        - Within one (1) Business Day of the Discovery: Any suspected privacy incident or suspected breach of PHI.

    - Investigation Report: Provider shall immediately investigate such suspected security incident or breach and provide the County a complete report of the investigation within seven (7) working days using the County's Privacy Incident Report Form.

    - Notification: Contractor will comply with County's request to notify individuals and/or media and shall pay any costs of such notifications, as well as any costs associated with the breach. County shall approve the time, manner and content of any such notifications before notifications are made.

Reportable Privacy Incidents

Reportable Privacy Incidents include but are not limited to:

- Misplacing or losing a client's chart
- Client A receiving Client B's paperwork (even if returned immediately)
- Emailing client information to the wrong person
- Emailing Protected Information outside of your network in an unencrypted email (include replying to someone else's email).
- Losing a laptop, phone or tablet containing client information
- Mailing client information to the wrong person
- Throwing away client information, rather than taking appropriate steps to ensure confidential shredding
- Making copies of client information at a local copy shop
- Throwing away client information, rather than taking appropriate steps to ensure confidential shredding
- Car was stolen containing client information (charts, laptop, phone, tablet)

Privacy Incident Reporting

- Should a reportable privacy incident occur, complete the following steps:
    - A Privacy Incident Report must be completed and submitted to the County Contracting Officer's Representative and HHSA Privacy Officer
        - The report is submitted online: sandiegocounty.gov/content/sdc/hhsa/hhsa-privdb-landing
    - Notify Optum Quality Improvement at SDQI@optum.com

Serious Incident Reporting (SIR)

All providers are required to report unusual occurrences or "serious incidents" involving clients in active treatment to San Diego County BHS, in accordance with policies and procedures established by the MHP. Serious incidents are identified below:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet).
- Death of a client by suicide, under questionable circumstances or by homicide.
- Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or significantly injurious.
- Alleged homicide committed by or attempted by a client, alleged homicide attempt on a client.
- Injurious assault on a client (client is victim) occurring on the program's premises resulting in severe physical damage or loss of consciousness, respiratory, or circulatory collapse.

- Injurious assault by a client (client is perpetrator) occurring on the program's premises resulting in severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Tarasoff Notification is made by or received by provider or program.
- Serious allegations of or confirmed inappropriate staff behavior, such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.
- Serious physical injury resulting in a client experiencing severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Adverse medication reaction resulting severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Medication error in prescription or distribution resulting severe physical damage or loss of consciousness, respiratory, or circulatory collapse.
- Apparent overdose, whether fatal or injurious, requiring medical attention.
- Major confidentiality breach (lost or stolen laptop, large number of client files/ records accessed, etc.)
- Use of physical restraints only during program operating hours (applies to CYF mental health clients and excludes ADS programs, Hospitals, Long-Term Care Facilities, San Diego Psychiatric Hospital/EPU, ESU and PERT).

For a **Level One** Serious Incident, providers are required to call the BHS Serious Incident Report Line **immediately at 619-584-3022 and fax the Level One SIR within 24 hours (Fax: 619-236-1953).** A **Level One** Serious Incident is the most sever type of indicant and must include one of the following:

- The event has been reported in the media or has the potential for significant **adverse media involvement**, i.e. TV, newspaper, internet.
- The event has resulted in a death or serious physical injury on the program premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health.

All other serious incidents are reported as Level Two incidents.

Providers are required to fax the Level Two SIR within seventy-two (72) hours of the occurrence, using the BHS Serious Incident Form found at optumsandiego.com > BHS Provider Resources > Fee for Service Providers > Compliance. This report should be faxed to the County of San Diego BHS at (619) 236-1953. Questions regarding the reporting of serious incidents may be directed to the QM Program Manager at (619) 563-2700.

A Root Cause Analysis (RCA) is required for any serious incident that results in: 1) a completed suicide or 2) a major breach of confidentiality. The RCA shall be completed within thirty (30) days of a reported serious incident. The program COR, in consultation with the QM unit, may ask the provider to complete an RCA for other serious incidents.

Additionally, FFS providers must maintain a log of any serious incidents involving their MHP clients. This log may consist of photocopies of all serious incidents reported by the provider to the MHP QM Department, kept in a binder. The log may be requested for review by the MHP at any time, including at the time of a site review.

Clinical Records and Documentation

All providers are required to prepare and maintain appropriate medical records on all clients receiving services. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. Medical records are to be kept in a locked storage area to assure confidentiality and safety. Providers are expected to meet minimum requirements for records retention as designated by the DHCS or their licensing body, whichever is longer.

Providers are required to take reasonable precautions to ensure that billing and/or coding of client services are prepared and submitted accurately, timely, and in compliance with all applicable federal, State, local laws, rules and regulations and HHSA's policies and procedures.

Providers must only bill for eligible services actually rendered and fully documented. When coding for services, only billing codes that accurately describe the services and the time spent on delivering the services provided shall be used. Providers may not engage in billing for services rendered by another individual (e.g. an MD/DO, PNP, PA, LMFT/LCSW/LPCC intern or psych assistant). In addition, providers are expected to act promptly to report and correct problems, if errors in claims or billings are discovered.

In accordance with the documents referenced above, it is the provider's responsibility to provide and document the following for services delivered:

- Client data and identifying information
- An initial assessment identifying target symptoms
- Progress Notes that reflect progress towards treatment goals and the appropriate level of treatment intensity
- Administrative or legal documentation reflecting collaboration with other social service providers
- Evidence of cultural competence when necessary to meet the needs of a client

If co-existing substance use disorder or medical problems exist, the provider is expected to make collateral referrals, and coordinate care with other providers working with the same client. Providers should coordinate ongoing treatment with the client's PCP, the client's Medi-Cal MCP, and other behavioral health providers involved in the client's care.

Non-Discrimination and Cultural Competence Requirements

Optum makes every effort to refer to providers with the ethnic and cultural background requested by the client. A client has the right to a second opinion and referral to a new provider if the client is not satisfied with the cultural expertise of a provider.

The State and County requires cultural competency requirements to be met in the provision of the following services:

- Interpreter services
- Culturally appropriate assessments and test interpretation (as indicated)
- Utilization of peer consultants (as indicated)

To this end, all providers are required to obtain a minimum of four (4) hours of cultural competence training per calendar year on the effect of ethnicity and culture on mental health issues and treatment. By understanding a person's cultural background, treatment providers can provide effective treatment strategies that elaborate on the beneficiary's natural resources and strengths.

Written materials pertaining to client rights (e.g., Complaint and Grievance brochures, complaint filing forms, Beneficiary Handbooks, NOA-As and NOA-Bs) are available in English, Spanish, Vietnamese, Arabic, Farsi, and Tagalog. Please refer to the Beneficiary Rights section of this handbook for further information regarding these materials.

Interpreter Services

Providers requiring initial authorization for interpreter services, including American Sign Language should complete an Interpreter Request Form located at optumsandiego.com. Providers must complete the required fields on both pages of this form and fax it to Optum at (866) 220-4495 at least two (2) days prior to the initial appointment. Optum will issue an authorization and set up the interpreter services for the initial appointment ONLY. This authorization will cover all subsequent visits with that specific provider if ongoing sessions are authorized after submission of the OAR. The provider is responsible for requesting interpreter services for ongoing sessions directly with the interpreter services. The interpreter services agency will receive the Service Authorization Request Form, which includes the authorization number and dates of service authorized.

The MHP covers the cost of interpreter services. Providers are not permitted to use family members to interpret for other family members. In addition, clients must be informed, in a language they understand, that they have the right to free language assistance services. Clients cannot be billed for interpreter services. Questions regarding provider cultural competence requirements may be directed to MHP Quality Management Department at (619) 563-2700.

Second Opinions

In accordance with Title 9, Section 1850.210, a client has the right to a second opinion, if they disagree with a decision by the MHP or a provider to deny, reduce, or modify services.

An Optum Utilization Manager will arrange for an assessment by a Second Opinion provider. The Second Opinion provider conducts an assessment and forwards a recommendation to Optum Utilization Management. Optum informs the client and original provider of the second opinion decision by letter via certified mail.

NOABDs, Appeals and Grievances, State Fair Hearings

Please review the Beneficiary Rights section of this manual for a description of beneficiary rights and provider responsibility to protect those rights in accordance with Title 9 of the California Code of Regulations.

San Diego Child and Adolescent Needs and Strengths

(SD CANS – Ages 6 – 21 & SD CANS-EC – ages 0 - 5) & Pediatric Symptom Checklist (PSC & PSC-Y)

The County of San Diego is mandated by the State to implement and manage Outcome Tools to measure treatment outcomes. These tools for Children and Adolescents are the “County of San Diego Mental Health Plan for Needs and Strengths (CANS)” and the “Pediatric Symptom Checklist (PSC - 35)” for all youth ages 0 - 21 entering services effective 07/01/19 and after.

The **Child and Adolescent Needs and Strengths (CANS)** is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the San Diego CANS (SD CANS) is to accurately represent the shared vision of the child/youth serving system—children, youth, and families. As such, completion of the SD CANS and SD CANS-EC is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system.

Completed by:

- Licensed Psychologist
- Licensed/Registered Social Worker or Marriage and Family Therapist
- Licensed/Registered Professional Clinical Counselor
- Physician (MD or DO) - Medication ONLY cases are exempt from completing the CANS at this time
  Psychiatric Nurse Practitioners (PNP) - Medication ONLY cases are exempt from completing the CANS at this time

Compliance Requirements:

- Clinical staff administering the SD-CANS must be trained and certified.
- Certified clinical staff will complete the SD-CANS measure for clients 6-20 years of age receiving services from a mental health provider.
  - Youth who are within six (6) months of turning 21 at intake are excluded from CANS assessment requirements.

- Certified clinical staff will complete the appropriate measure (SD CANS- EC or SD CANS) for clients 0-21 years of age receiving therapy services from a mental health provider

- Completed and submitted to Optum:
    - With Initial Authorization Requests (or Initial Treatment Plan (ITP))
    - With Continued Authorization Requests (or Treatment Plan Update (TPU)) or every six (6) months (whichever occurs first)
    - Upon discharge

Documentation Standards:

- For each Domain Item, a rating of 0-3 must be determined, along with the corresponding documentation in the client's chart for ratings of a '2' or '3' on the initial or reassessments and documentation in the Discharge Summary for the discharge assessment.

- Clinicians must receive annual certification to administer the tool by completing an on-line training course and passing a post test. The training can be accessed here the CANS Coupon Request Form.

- Medication only cases are exempt from completing the CANS.

If you have any questions, please contact the Provider Services Department at: sdu_providerserviceshelp@optum.com

Pediatric Symptom Checklist (PSC & PSC-Y)

Completed by:

- Parent/guardian
- Client
- When no parent/guardian is available, staff may be in the role of caregiver and complete measure, notating it was completed by clinician/staff.

Compliance Requirements:

- Provided to caregivers of children and youth 3 -18 years of age (PSC).

- Provided to youth 11 -18 years of age (PSC-Y).
    - Upon Initial Assessment
    - At the time of the Continued Outpatient Authorization Request (OAR or TPU) or every six (6) months (whichever occurs first)
    - Upon discharge

- Omit questions 5,6,17 and 18 when completing for children 3-5 years of age.
    - All questions should be completed for children/youth ages 6-18 years of age.
    - Completed and submitted to Optum
        - With Initial Authorization Requests (OAR or ITP) and CANS/CANS-EC
        - With Continued Authorization Request (OAR or TPU) and CANS/CANS-EC or every six (6) months (whichever occurs first)
        - Upon discharge with CANS/CANS-EC

Documentation Standards:

- Completed tools and summary sheets are to be filed in the client chart.
- If score is above the clinical cutoff, document in progress note for action to address the need.
- Medication only cases are exempt from completing PSC/PSC-Y

Provider Steps:

- Provider must be CANS Certified (San Diego CANS 1.0)

  Provider will administer CANS and the CYF mHOMS Client Information Sheet with required fields. Example of Client Information Sheet with required fields highlighted is located at optumsandiego.com > BHS Provider Resources > Fee for Service Providers > CANS/PSC

- Provider will collect the PSC and PSC-Y (when applicable) from youth and caregiver as outlined above

  Provider will submit the CYF mHOMS Client Information Sheet, CANS, and PSC tools to Optum for data entry and tracking

- Provider will receive reports from outcome data to review and utilize in treatment planning
- Provider may need to complete Provider/Family Letter to have in client file
- Provider will receive reports on past due tools
- Provider will need to complete recertification for the CANS on a yearly basis (1x per year)

If you have any questions, please contact the Provider Services Department at: sdu_providerserviceshelp@optum.com

CAN01 – Training and Certification

Providers are required to be CANS certified prior to administering the SD CANS-EC and/or the SD CANS.

- Provider will send a copy of the completed certification to: sdu_providerserviceshelp@optum.com
- The certificate will be considered a claim and processed for payment

CAN02 - CANS Report

CANS Reports are completed by the provider and submitted to Optum with:

- Initial Outpatient Authorization Request (OAR or ITP) and
- Continuing Outpatient Authorization Request (OAR)/6 months (or TPU) and
- Discharge
- Provider will use the billing code CANS02 on a standard Form 1500 (0212)
- Rates were provided with your most recent amendment

Optum staff:

- Will enter the data from the CANS Form into the CYF mHoms database system.
- Will create an authorization for the CANS02 to facilitate payment of the claim.

CAN03 - Recertification

Providers are required to complete a recertification process annually.

- Provider will send a copy of the completed certification to: sdu_providerserviceshelp@optum.com
- The certificate will be considered a claim and processed for payment

Outcomes Crosswalk Effective 07/01/2019 The State collects data to evaluate County programs and Network performance.		
Clinician Completed Measure		
	***SD CANS-EC** San Diego Child and Adolescent Needs and Strength – Early Childhood	***SD CANS** San Diego Child and Adolescent Needs and Strength
Completed by:	Provider	Provider
Age Range	0-5	6-21
**Timeframe:	Submit to Optum with: • Initial Auth Request (OAR or ITP) • Continuing Auth Request/6 months or (OAR or TPU) • Discharge	Submit to Optum with: • Initial Auth Request (OAR or ITP) • Continuing Auth Request/6 months or (OAR or TPU) • Discharge
Parent/Youth Completed Measure		
	+PSC Pediatric Symptom Checklist - Caregiver	**+PSC-Y** Pediatric Symptom Checklist - Youth
Completed by:	Parent	Youth
Age Range	<>3-18	11-18
**Timeframe:	Submit to Optum with: • Initial Auth Request (OAR or ITP) • Continuing Auth Request/6 months or (OAR or TPU) • Discharge	Submit to Optum with: • Initial Auth Request (OAR or ITP) • Continuing Auth Request/6 months or (OAR or TPU) • Discharge

***SD CANS/SD CANS - EC:**	Requires certification renewed annually
****Timeframe:**	State mandates administration of measures within 6 month-intervals maximum; the majority of continuing auth requests take place within 6 months
+PSC/PSC-Y:	Is client/parent completed; training certification is not required
<>:	For clients 3 – 5, omit questions 5, 6, 17, 18 on the Parent PSC

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Accessing Services

Optum has been operating the County of San Diego Access and Crisis Line on behalf of the Mental Health Plan since 1997. The ACL may be the client's, or the family's initial access point into the County of San Diego MHP. The ACL is a free, telephonic service available 24 hours a day, 7 days a week for the residents of San Diego County at (888) 724-7240 or California Relay 711. The ACL provides crisis intervention, suicide prevention, information and referrals for mental health and substance use disorders.

The San Diego ACL is operated by a sophisticated clinical team comprised of licensed and master's level counselors that have earned the highest evaluations by the leading national program evaluators, the American Association of Suicidology (AAS) and CONTACT USA for online emotional support, CHAT.

The ACL offers online emotional support via CHAT Mon-Fri 4pm-10pm by logging onto any computer, smartphone or tablet at up2sd.org or optumsandiego.com

Our clinical team has established a foundation of clinical management practices that includes an emphasis on evidence based best practices, holistic health, suicide prevention, recovery/resiliency and community partnerships. Our multicultural and multilingual team enables us to better meet the diverse needs of our community. We have bicultural and bilingual Spanish/English counselors available during the highest call times. We also utilize The Language Line which enables us to assist our community in over 150+ languages with the same priority of 911 operators. ACL clinicians are all trained in Motivational Interviewing as a best practice technique for engaging callers. All our ACL clinicians receive training in access to care time frames based on acuity. Our clinicians are trained to triage and identify each caller's needs to facilitate assessment and intervention within one hour for emergencies, seventy-two (72) hours for urgent referrals, and twenty-eight (28) calendar days for routine assessments. ACL clinicians utilize their formal clinical training, years of experience, crisis intervention skills, and knowledge of the system of care to effectively manage callers in crisis.

The following section provides guidelines on making referrals to, and receiving referrals from, the ACL.

"The accreditation of the Access and Crisis Line recognizes the stellar processes Optum has put in place to ensure those in crisis get the resources they need." – Nick Macchione, Director of San Diego County Health and Human Services Agency

"The accreditation is validation that the partnership between the County and Optum is effective in supporting people during a crisis and linking them to community resources." – Former Chairman Ron Roberts, San Diego County Board of Supervisors

Referrals to the ACL

It is appropriate to refer to the ACL those persons who need:

- Access to publicly funded Specialty Mental Health and Substance Use Disorder Services
- Crisis intervention for urgent situations such as:
    - Suicide attempts or threats
    - Symptoms of mental illness (e.g., depression, manic behavior, anxiety)
    - Symptoms of dual or multiple diagnoses, including substance use disorder, HIV, or AIDS
    - Spouse, elder, or child abuse
    - Marital and/or family relationship problems
- Information about mental health and mental illness

- Information about alcohol or other drug abuse
- Referrals to community resources for vocational, financial, medical, and other concerns

Provider Interface with the ACL

Providers may use the ACL as an adjunct to services in emergencies and after hours, to provide effective emergency response and back up. Office voicemail messages may state, “If this is a mental health emergency or crisis, please contact the San Diego ACL at (888) 724-7240. If this is a life-threatening situation, please hang up and dial 911”. Please note that providers must have emergency contact information available (e.g., on-call pager, 911, or the ACL) on their voice messaging system for 24-hour a day crisis calls. However, the ACL is *not* appropriate for routine use for clients whose clinicians are out of town or out of the office for an extended period of time. In these types of situations, it is best to proactively connect your client with another mental health provider to oversee your clients in your temporary absence.

If a client is high risk and may be calling the ACL for additional support, providers may call the ACL in advance on behalf of the client. To facilitate the most effective response to the high-risk client’s needs when they call, please give the ACL the following information:

- Client name and date of birth
- Client address and telephone number
- Provider name, program name, and telephone number
- Summary of clinical information (diagnosis, medications and medication compliance, pertinent treatment)
- Current issues (including suicide or homicide risk)
- Current resources, such as supportive family members
- Safety plan, behavioral intervention plan, etc.
- Recommended coping methods and recommended response

Request that the client sign a Release of Information before giving the information to the ACL staff and maintain the signed release in the client’s file.

Receiving Referrals from the ACL

ACL staff make appropriate referrals using their clinical judgment and knowledge of medical necessity criteria. Referrals also take into consideration the following items:

- Urgency of need
- Level of Care
- Type of treatment or services indicated
- Geographic location
- Cultural issues
- Any specific client requests, such as provider language or ethnicity

Access Standards

The MHP has identified standards for access to emergency, urgent, and routine services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for initial assessment.

Emergency Cases: Assessment within one (1) hour of client request or referral

Urgent Cases: Assessment within forty-eight (48) hours of client request or referral

Routine Cases: Assessment within ten (10) business days of client request or referral

Emergency Psychiatric Condition

Title 9 defines an “Emergency Psychiatric Condition” as a condition in which the person, due to a mental disorder, is a current danger to self or others or is immediately unable to provide for or utilize food, shelter, or clothing. These situations indicate the need for psychiatric inpatient hospital or psychiatric health facility services.

All ACL staff are trained in crisis intervention with client safety as the primary concern. Staff evaluates the degree of immediate danger, and determines the most appropriate intervention (e.g., Psychiatric Emergency Team (PERT), welfare checks, referral to an appropriate treatment facility for evaluation, notification to Child or Adult Protective Services, or law enforcement in a dangerous situation).

In an emergency, ACL staff makes direct contact with 911 to initiate active rescue services for any individual who is at risk. A follow-up call is made to police dispatch by ACL staff to determine the status of the client and to ensure that the client was evaluated, and appropriate crisis services were provided.

“Emergency Psychiatric Condition” is a condition in which the person, due to a mental disorder, is a current danger to self or others, or is gravely impaired in the ability to provide for or utilize food, shelter, or clothing. These situations require psychiatric inpatient hospital or psychiatric health facility services.

There may be an occasion in which one of a provider's current Medi-Cal clients presents (in person or by telephone) in an emergency condition. In that situation, the provider is responsible for scheduling the necessary emergency services for that client. The standard that must be met for emergency services is: C**linical assessment within one (1) hour of initial client request or referral.**

Urgent Psychiatric Condition

Title 9 defines an “Urgent Psychiatric Condition” as an imminent unstable condition, which, without timely intervention, is certain to result in an emergency psychiatric condition.

If the client’s condition is serious, but does not warrant immediate admission to a facility, ACL staff performs a telephonic risk screening and may utilize PERT. If the problem is urgent, the ACL staff may contact the provider directly to confirm that the provider is available to assess the client within seventy-two (72) hours. The ACL staff may refer the client to one of the County walk-in assessment clinics for evaluation. The ACL staff may contact the clinic in advance to inform the clinical staff of the referral.

“Urgent Condition” is a condition that, without timely intervention, is certain to result in an immediate emergency psychiatric condition. The standard that must be met for urgent services is: C**linical assessment within forty-eight (48) hours of initial client request of referral.**

Routine Condition

Title 9 defines “Routine Condition” as a condition in which the person is in a relatively stable condition or in need of an initial assessment for SMHS.

The caller is encouraged to call back to the ACL, if they have trouble scheduling an appointment within twenty-eight (28) calendar days of the initial call to the provider. The caller is also reminded of the ACL 24 hours a day, 7 days a week availability.

This is a situation in which a person is relatively stable and in need of initial assessment for SMHS. The standard that must be met for routine services is: C**linical assessment within ten (10) business days of initial client request or referral.**

Providers are expected to arrange coverage for emergencies, after-hours inquiries, and when the provider is ill or on vacation. If a provider is treating a client in an acute care setting, the provider must arrange for another contracted provider to follow the client’s care in their absence. If the provider is unable to take on any additional clients for a period of time, the provider must notify Optum Provider Services to stop/prevent referrals. Likewise, when the provider becomes

available again, Provider Services must be contacted to open/commence referrals once more. Provider Services can be reached at (800) 798-2254, option 7.

Walk-In Cases

Pre-authorization for initial assessments is not required. Please see the Requesting Authorizations of this Handbook.

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Authorization for Reimbursement for Services

Medical Necessity

Optum, on behalf of the Mental Health Plan, authorizes reimbursement for services for all San Diego Medi-Cal adult/older adult inpatient care, FFS outpatient care, SUD, Crisis Residential Treatment Services and certain outpatient services that occur on the same day as another SMHS. For children and adolescents, Optum authorizes reimbursement for day program services, therapeutic behavioral services, intensive home-based services, therapeutic foster care, inpatient care, and outpatient FFS.

Medi-Cal medical necessity criteria for SMHS are described in WIC Section 14184.402,WIC Section 14184.402, and Behavioral Health Information Notices: 20-043 and 21-073. For a complete description of Medical Necessity for SMHS for MHP Reimbursement, providers may view, though not print, from the State Office of Administrative Law website at oal.ca.gov and clicking on California Code of Regulations (CCR) or by accessing the state website at dhcs.ca.gov.

Authorizing Outpatient Services

Medical Necessity for Outpatient Services

Services provided to clients by outpatient FFS providers are reimbursed if the client meets criteria for SMHS. The FFS Medi-Cal network is part of the MHP and is intended to serve those that have more severe impairment and meet medical necessity for SMHS. Providers should evaluate all new clients to determine if they meet the MHP target population. Providers should refer clients not meeting SMHS criteria to services with their Medi-Cal Managed Care Plan (MCP). Tools available at optumsandiego.com > SMHS Providers > Standardized Screening and Transition of Care Tools, may be utilized when considering referral to the MCP, entitled Adult Screening Tool for Medi-Cal Mental Health Services and Youth Screening Tool for Medi-Cal Mental Health Services. If the client has no identified MCP, the MHP will support the client's needs as applicable.

Services provided to new and/or existing clients by outpatient providers are reimbursed, if the following SMHS Medical Necessity criteria are met:

For beneficiaries 21 years of age or older, a county mental health plan shall provide covered Specialty Mental Health Services for beneficiaries who meet both of the following criteria, (1) and (2) below:

(1) The beneficiary has **one or both** of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

b. A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under the age of 21, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following criteria**, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

(2) The beneficiary meets **both of the following** requirements in a) and b), below:

a) The beneficiary has **at least one** of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

General Authorization Reminders

Optum works closely with the County of San Diego BHS Division to maintain an authorization process for the FFS Network that incorporates the following treatment philosophy:

- Care Should Promote Recovery: Clients have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery.
- Many clients can improve using treatment that focuses on the specific mental health need of the client.
- Clients are more likely to improve when involved in community services, such as self-help programs, peer support groups, substance use disorder treatment support, and when Optum works closely with these resources.

Therefore, any treatment offered to FFS clients is expected to be consistent with this treatment philosophy.

Please be aware that the number of sessions authorized in the FFS network is assessed on a case-by-case basis and must meet medical necessity. For both adults and children, the maximum authorization for therapy is up to twelve (12) sessions per request form submitted and for medication services up to twenty-six (26) sessions per request form submitted; both forms allow the provider to request a frequency based on client need. Initial authorization requests will be processed, and, unless the provider opts out of verbal notification on each initial authorization request form, the provider will be notified of determination via telephone within four (4) business days of fax received date. Both initial and continuing authorization requests will be reviewed within fourteen (14) calendar days of fax received date and the provider notified via fax and/or mail. There is no pre-authorization required for Assessments; simply claim for the service provided. Additional sessions can be requested on an ongoing basis as needed.

Please note: Providers may request an expedited authorization for outpatient services if a delay in authorization determination would seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning. Providers may request an expedited authorization by contacting the Provider Line at (800) 798-2254 option 3, then option 3 and specifically request an expedited outpatient authorization or notate the expedited authorization request on the authorization request form when submitted via fax. Please have client information available as licensed staff will be requesting specific demographic and clinical information for the authorization. Expedited authorizations are made within seventy-two (72) hours of the request.

Optum does not authorize retroactive outpatient authorizations except in extraordinary circumstances. Any exceptions must be requested within thirty (30) days of the date of service and retroactive authorizations that are approved will not go more than thirty (30) days back.

Clients may see only one (1) provider for an ongoing service. Clients may not see two (2) or more providers ongoing for the same service at the same time. It is recommended that providers screen clients for any other Behavioral Health providers that they may be seeing. Clients have the right to change providers at any time. To change providers, clients may call the San Diego County ACL to request a change in providers and receive referrals. Clients also have the right to a second opinion.

Confirming Eligibility

The provider must confirm eligibility status of clients before services are rendered. Providers must call the State-maintained Automated Eligibility Verification System (AEVS) at (800) 427-1295 or go to medi-cal.ca.gov to verify the clients' eligibility status. Authorization for services is not a guarantee that the client has Medi-Cal benefits, or that a client is eligible during a given month. Medi-Cal reimburses for medically necessary services provided during a month in which the client is eligible and has active Medi-Cal within San Diego County.

It is the FFS providers' responsibility to verify the client's Medi-Cal eligibility.

Outpatient Services – Assessment Authorization

Pre-authorization for an initial assessment is not required. Assessment authorizations for San Diego Medi-Cal eligible clients will be given in increments of one (1) assessment per year. Authorizations will be entered in to the designated database after the provider submits the claim for the initial assessment session, and an authorization letter will be sent to the provider. The authorization letter specifies each authorized service by procedure codes and cluster codes and is valid for a given time period.

Outpatient Therapy Services and Outpatient Medication Services – Initial and Continuing Sessions

After the Assessment session is complete, the provider should determine if client meets current medical necessity criteria for services for the target population of the MHP. The diagnosis, current symptoms, and level of impairment are to be recorded on the Outpatient Authorization Request Form (OAR) which must be completed and submitted to Optum when sessions are requested beyond the initial assessment. A Demographic Form must also be submitted for ongoing clients upon first submission of the OAR and as applicable when updates in the client's Demographics occur. If the client does not meet the MHP target population, the provider may refer clients to their Medi-Cal MCP for Behavioral Health Services when applicable.

For therapy services, the provider should submit a Psychotherapy OAR for up to twelve (12) additional sessions. For medication services, the provider should submit a Medication Services OAR for up to twenty-six (26) additional sessions. The OAR should be submitted to Optum Utilization Management by fax at (866) 220-4495 or mailed to the following address:

Optum Public Sector San Diego
Attn: Utilization Management
PO Box 601370
San Diego, CA 92160-1370

Please submit OARs for different clients separately.

The provider is required to include the client and the client's family (with consent, if applicable), when appropriate, in the treatment planning process. The OAR should reflect the provider's assessment of the client's diagnoses, and all required fields shall be completed. The OAR forms for both therapy and medication services are located at optumsandiego.com. The original OAR must be filed in the client's medical record. Each request for authorization of additional sessions must be accompanied by a new OAR reflecting changes in the client's symptoms and impairment. Authorization for reimbursement of services will be denied, if the information on the OAR has not been updated from previous requests

submitted. Similarly, submission of a previously submitted OAR with dates changed does not qualify as updated clinical information and will be returned with a request for an update or possibly clinically denied for further authorization. The OAR should be submitted about three (3) weeks prior to the end of the current authorization period.

Please note: If a child turns 18 years of age while in treatment and the provider has received authorizations at the child rate, the provider will continue to get paid until the authorization is completed. If the provider continues to treat the client, the provider will need to request a new authorization at the adult rate/CPT codes. A new Assessment will not be approved for that reason.

Authorization letters are sent to providers within fourteen (14) calendar days of date OAR received by Optum. If an authorization letter is not received, the provider should call the Provider Line at (800) 798-2254, option 3, then option 4 to inform a Clinical Administrative Coordinator. It is the provider's responsibility to track the authorizations and number of available sessions remaining for their clients. It is the provider's responsibility to ensure receipt of determination from Optum for all OARs submitted.

Following the assessment of a client, the provider is required to document the results of the assessment and complete a problem list. This information, along with session notes, must be placed in the client record maintained by the provider. The record may be audited by the MHP or State or Federal Regulators.

Please note: Prescribers who treat children ages 12 and under must be board certified, or eligible to be certified, in Child and Adolescent Psychiatry. Prescribers treating children ages of 13-17 may be authorized to do so without board certification or eligibility in Child and Adolescent Psychiatry, though may be required to submit documentation of their experience working with this age group.

Increased Frequency of Sessions for Emergency or Crisis Situations

Outpatient treatment sessions may be increased for any client for a brief period of time to prevent a crisis from occurring or to stabilize a person experiencing a crisis. The process for obtaining authorization in these circumstances is as follows:

- Call the Provider Line at (800) 798-2254, option 3, then option 3 again or
- Fax an OAR with the applicable start date to Optum Utilization Management at (866) 220-4495

Please explain the therapeutic rationale for the increased frequency requested, the estimated duration of the increased frequency, and the expected outcome of the intensified treatment.

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Requesting Authorizations

The following matrix describes the San Diego Medi-Cal FFS Provider Network procedures for obtaining authorization through Optum for initial assessment and continuing outpatient services.

Mild to Moderate	Severe	Request an increased frequency in authorization for current clients
No pre-authorization for Assessment required. After Assessment session is completed, provider submits claim. Providers may receive one (1) assessment session per client per year. Providers may refer mild to moderate clients to their Medi-Cal MCP Behavioral Health Services. If there is no Medi-Cal MCP, or the client presents as severe, provider is welcome to see client and work with Optum for authorization.	No pre-authorization for Assessment is required. After Assessment session is completed, provider submits claim. Providers may receive one (1) assessment session per client per year. Contracted providers may request up to twelve (12) additional psychotherapy sessions or twenty-six (26) medication management sessions at a time by submitting an OAR to Optum. Services will only be authorized up to thirty (30) days retroactively.	Fax or mail an updated OAR to Optum that includes start date for sessions, requested frequency, and the therapeutic rationale for increased visits. **Or** Call the Provider Line at (800) 798-2254, option 3 then option 3 with the above information.

Authorizing Inpatient Services

Medical Necessity for Inpatient Services

Hospitals are required to notify Optum of a client's admission to acute inpatient psychiatric services at (800) 798-2254, option 3 then option 1.

Inpatient services are reimbursed when the client has active San Diego Medi-Cal eligibility for the dates of service and the following criteria are met, as outlined in Title 9, section 1820.205:

- The client must have a diagnosis included in the Diagnostic and Statistical Manual (DSM) that is reimbursable for inpatient services as described in Title 9, section 1820.205 or Behavioral Health Information Notice 20-043: 2020 International Classification of Diseases, Tenth Revision (ICD-10), issued on 7/8/20 with an effective date of 10/1/19.

- And both of the following are true:
  - The condition cannot be safely treated at a lower level of care.

  - Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 and 2 below:
    1. The symptoms or behaviors:
       a. Represent a current danger to self or others, or significant property destruction
       b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
       c. Present a severe risk to the beneficiary's physical health
       d. Represent a recent, significant deterioration in ability to function

OR

2. The symptoms or behaviors require admission for one of the following:
   a. Further psychiatric evaluation, or
   b. Medication treatment, or
   c. Other treatment that can reasonably be provided only if the patient is hospitalized

Inpatient professional fees are authorized by Optum after the provider submits their claim for services and as long as the acute or administrative inpatient hospitalization day was not denied.

Coordination of Care

With implementation of healthcare reform, coordination of care between inpatient and outpatient services is even more critical for the mental health system to work effectively. It supports the clients' efforts to achieve and maintain the highest possible level of stability and independence. Providers are required to coordinate client's mental health services and also refer the client to other appropriate community services. The MHP monitors coordination of care in several ways:

- Chart reviews are conducted at all levels of services. Inpatient reviews include retrospective review of documentation to confirm that upon discharge clients were given referrals to community services such as drug/alcohol or domestic violence support groups, anger management groups, vocational counseling, case management services, socialization centers, or legal services.

- A Consumer Survey may be administered at discharge from an acute inpatient or crisis residential service to assess the clients' perceptions of the degree to which care was coordinated with outpatient providers.

- Individual FFS providers are expected to demonstrate a good faith effort to obtain a signed Consent for Release of Information (ROI), and to obtain relevant mental health records pertaining to any client who has recently been discharged from an inpatient or residential facility, is receiving services from a day program provider or has been transferred from a previous outpatient provider.

Coordination with Primary Care Physicians (PCP)

Coordination of care between mental health care providers and physical health care providers is necessary to optimize the overall health of a client. All providers are expected to coordinate mental health care with a client's PCP. Individual FFS providers are requested by the MHP to demonstrate a good faith effort to obtain a signed Authorization to Use or Disclose PHI Form for the client during the first visit to facilitate or enhance coordination with the client's PCP. The effort to obtain this form is reviewed during the quality chart audit, conducted by the MHP. The Coordination of Care Form and a generic Authorization to Use or Disclose PHI Form is available at optumsandiego.com > BHS Provider Resources > MHP Provider Documents > UCRM.

Please note: Providers are expected to coordinate care with the client's health care providers. Please call the San Diego ACL at 888-724-7240 to obtain information about the full range of community services available for clients.

Pharmacy Services

San Diego Medi-Cal Managed Care Plan (MCP) Beneficiaries

Most San Diego Medi-Cal beneficiaries are enrolled in one of the Medi-Cal MCPs that are apart of Healthy San Diego. Effective January 1, 2022, all pharmacy benefits for Medi-Cal beneficiaries, including those in a Medi-Cal MCP, started coverage with the DHCS state-wide pharmacy benefit called Medi-Cal Rx. Medi-Cal MCPs are not responsible to cover pharmacy benefits, including Grievance and Appeals.

Providers prescribing lab tests may refer the client back to his or her PCP for these services. The client's MCP enrollment card also may have a phone number that providers and clients can check in order to identify contracted labs.

Please note: To assist the provider in coordinating care with PCPs and/or pharmacy/lab services, a Medi-Cal Behavioral Health Quick Guide contains contact information for the San Diego MCPs and is, available at optumsandiego.com > Resources. There is also a Pharmacy Benefit Quick Guide.

Medi-Cal Beneficiaries Not Enrolled in an MCP

Medi-Cal beneficiaries who are not members of a MCP have the right to use any lab that accepts Medi-Cal reimbursement. A provider cannot require a client to use one particular lab; the client may select where to receive lab services.

Physical Health Services While in a Psychiatric Hospital

Healthy San Diego MCP Clients

The client's Healthy San Diego MCP is responsible for the initial health history and physical assessment required upon admission to a psychiatric inpatient hospital. The client's MCP is also responsible for any additional or ongoing medically necessary physical health consultations and treatments. The MCP contracted provider must perform these services unless the facility obtains prior authorization from the MCP to use another provider.

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission, and for ordering routine laboratory services. If the psychiatrist identifies a physical health problem, they contact the client's MCP to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted facility must obtain the necessary authorizations from the MCP. The client's MCP contracted providers are to provide these services, unless the contracted facility obtains prior authorization from the MCP to use a provider not contracted with the client's MCP.

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital staff must consult with appropriate MCP staff to arrange transfer from a psychiatric hospital to an MCP contracted medical hospital, if it is determined that the client requires physical health-based treatment. The Optum Medical Director and the MCP Medical Director resolve any disputes regarding transfers.

Healthy San Diego MCPs cover non-emergency medical transportation on a case-by-case basis. MCP members who call the ACL for medical transportation are referred to the Member Services Department of their MCP to arrange for such services.

Beneficiaries Not Enrolled in Healthy San Diego Health Plans

Physical health services provided in a psychiatric facility are reimbursed by the State FFS Medi-Cal program for clients who are not members of one of the Healthy San Diego Health Plans. Providers are expected to coordinate services with the client's FFS physical health care provider.

Psychiatric Consultation Services While in a Medical Hospital

Psychiatric consult services while in a medical hospital are authorized by Optum after the provider submits their claim for services.

Home Health Care

Beneficiaries who are members of one of the Healthy San Diego MCPs must request in-home mental health services from their PCP. The MCP is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of that MCP. The MCP Case Manager and the PCP coordinate ongoing in-home treatment.

Clients with No Insurance or Financial Resources

Clients without San Diego Medi-Cal eligibility or without the means or resources to pay for inpatient services are eligible for realignment funded services. Optum refers these adult clients for services to the San Diego County Psychiatric

Hospital and/or the Emergency Psychiatric Unit. Optum refers child and adolescent clients for services to the Emergency Screening Unit. The Emergency Screening Unit refers children and adolescents for inpatient services to Rady's Child and Adolescent Psychiatric Services (CAPS). These County operated and/or contracted facilities will treat unfunded clients who are experiencing psychiatric emergencies. The adult client or the family of the child/adolescent may be financially responsible for services based on a sliding scale fee.

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Claims and Billing

Optum, on behalf of the Mental Health Plan, is responsible for the reimbursement of claims for SMHS rendered by FFS network providers. The billing procedures found in this section are to be followed for all SMHS provided to:

- Medi-Cal clients with no share of cost
- Medi-Cal clients with a share of cost
- Clients with both Medicare and Medi-Cal (Medi-Medi)
- Clients with Medi-Cal and other insurance coverage
- Clients with no Medi-Cal or a restricted Medi-Cal benefit
- Out-of-County Clients

In accordance with Title 9, Section 1830.205 and Behavioral Health Information Notice 20-043, the diagnoses below are covered under Outpatient SMHS. If a client does not have one of the following diagnoses as the primary focus of treatment, medical necessity criteria are not met, and services delivered to the client cannot be reimbursed per regulations. Covered diagnoses for outpatient services include:

- Pervasive Developmental Disorders.
- Autistic Disorder/Autism Spectrum Disorder
- Premenstrual Dysphoric Disorder
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia and other Psychotic Disorders, except Psychotic Disorder due to a General Medical Condition
- Mood Disorders, except Mood Disorders due to a Medical Condition
- Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilia
- Gender Identity Disorder
- Eating Disorder
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

Please note: When requesting treatment authorization and submitting claims, providers are asked to only use the MHP approved CPT Codes included in the provider contract. Providers are asked to refer to their contract fee schedule for the official listing of the CPT Codes, the client service minutes associated with each code and the reimbursement amount for the provider's licensure.

Please note: Per Behavioral Health Information Notice 20-043: 2020 International Classification of Diseases, Tenth Revision (ICD-10), issued on 7/8/20 with an effective date of 10/1/19, Autism Spectrum Disorder is now a covered diagnosis for Outpatient SMHS.

The following diagnoses are ***not covered*** **under** Title 9 SMHS, unless they are secondary to a covered primary diagnosis:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communications Disorders
- Tic Disorders
- Delirium, Dementia, and Amnesic and other Cognitive Disorders
- Mental Disorders due to a general Medical condition
- Substance Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorders
- Other conditions that may be a focus of clinical attention, except medication induced movement disorders, which are covered

Automated Eligibility Verification System (AEVS) - Provider Access

Optum will facilitate the provider's enrollment with State Medi-Cal and the completion of the POS Agreement that will grant him/her access to the AEVS System to verify active San Diego County Medi-Cal Benefits. When these agreements are completed, the provider will be granted a PIN to access and verify benefits through the AEVS System.

Verification of Medi-Cal Eligibility

Network providers are required to verify Medi-Cal eligibility prior to the provision of services. The state eligibility system is updated on the first of each month; therefore, Medi-Cal eligibility must be verified monthly. Verifying eligibility provides critical information including:

- Medi-Cal coverage type (Aid Code)
- Share of Cost (SOC), if applicable
- County of Residence (must be 37 to bill San Diego Medi-Cal)
- Other insurance coverage
- Ineligible Aide Code

It is the responsibility of the provider rendering services to verify eligibility by calling the Automated Eligibility Verification System (AEVS) at (800) 866-AEVS (2387) or using the website medi-cal.ca.gov. Providers must have a valid PIN/User ID to access AEVS.

Providers may use the Medi-Cal Aid Code Master List link provided below to identify the types of services for which Medi-Cal and Public Health Program recipients are eligible. dhcs.ca.gov/services/MH/Pages/MedCCC-Library

Submitting Claims for Medi-Cal Services

Providers are required to use ICD-10 codes for all claims. The International Classification of Disease, 10th Revision (ICD-10) is the diagnosis and procedure coding system that replaced the ICD-9 coding system. The use of the ICD-10 Clinical Modification (CM) and Procedure Coding System (PCS) codes is expected to improve the ability to govern reimbursement, monitor a population's health, track trends in disease and treatment, and optimize health care delivery.

Providers may mail or fax ALL Medi-Cal FFS claims as follows:

Optum Public Sector Claims
P.O. Box 601340
San Diego, CA 92160-1340
Fax: 877-364-6945

The following outlines the claims submission procedures for various Medi-Cal eligible groups:

1. Claims must be submitted within sixty (60) days from the day of service.
2. All claims must be submitted using an original form CMS-1500. Form CMS-1500 may be purchased at Staples or by calling (888) 212-7219.
3. The following data elements must be included on the form CMS-1500. Claims submitted without these data elements will be denied.

Box #	Field Name
1a	Case number/HHSA CSW number/State ID number or Person number
2	Client's name
3	Client's date of birth and gender
5	Client's complete address
12	Signature of authorizing party or signature on file
13	Signature of authorizing party or signature on file
21A-L	Diagnosis using ICD-10, DSM-IV or DSM IV-TR, V Codes are acceptable
24A	Date(s) of services – one (1) date of service per line
24B	Place of service code (office = 11, home = 12)
24D	CPT Code for service rendered, including modifiers, if applicable
24F	Charge(s) for the service rendered
25	Federal Tax ID number of the billing provider or "Pay To" agency/group (Social Security Number or Employee Identification Number [EIN])
31	Signature of rendering provider (or designee) and date
32	Service facility location information
33	Pay To Provider/Agency's name, address and telephone number

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

OTHER ACCIDENT? YES

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. #

	24A	24B	24D	24F				
1								NPI
2								NPI
3								NPI
4								NPI
5								NPI
6								NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Important notes:

- The diagnosis code entered in box 21 must be a Medi-Cal covered diagnosis code and contain ALL the required digits. Optum is required to deny claims with a diagnosis code that does not contain all the required digits.
- The DHCS and Optum recognize the importance of protecting the identity and the health information of clients; therefore, providers must not include the clients' Social Security Numbers (SSN) on claims. Claims submitted with a SSN will be denied.
- Provider NPI must be on file with Optum, and if the provider is associated with a group, the group's NPI must also be on file for the claim to be processed.

List of FFS Procedure Codes Cluster List	
CPT/HCPCS Code/Group Listed on Authorization	**CPT/HCPCS Codes within the cluster you may bill**
90791	90791
90792	91792
IT, CIT	90832, 90834, 90846, 90847, 99341
MDT, CMDT	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 90846, 90847, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350
ADAT, CDAT	90833, 90836
Injections	96372
90853	90853
90870	90870, OP

CPT/HCPCS Code/Group Listed on Authorization	CPT/HCPCS Codes within the cluster you may bill
IPADM, CIADM	99221, 99222, 99223
IPFUP, CIFUP	99231, 99232, 99233, 99238, 99239, 90870 (IP)
IDAT, CIDAT	90833, 90836, (IP)
CONSU, CCONS	99252, 99253, 99254, 99255
ER Visits	90792 ET
96130, 96131, 96136, 96137	96130, 96131, 96136, 96137
99367	99366, 99367
99495	99495, 99496
CFWB/Medi-Cal Funded	H0032
CM, CCM	99366, 99368
CAN01	
CAN02	
CAN03	

Medication Services Add-On Codes

An add-on code is a CPT code that can only be used in conjunction with another code. Evaluation and Management (E/M) codes may report evaluation and management services either alone or with the addition of psychotherapy. Time determines the selection of the appropriate psychotherapy add-on code. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. Documentation should include the required key components of the selected E/M code and the additional time for the psychotherapy service.

Please note: The CPT code submitted on a claim form and the amount of time a provider spends with a client must match the amount of time associated with that CPT code in the provider's contract, fee schedule and the most current edition of the American Medical Association Procedural CPT Codebook.

Share of Cost (SOC)

Share of Cost (SOC) is a monthly client liability amount (determined by the state) that is based on a client's ability to pay. The SOC must be paid by the client each month for services received during the month, prior to the client accessing Medi-Cal benefits, and prior to the provider being reimbursed by the MHP. A client is not Medi-Cal eligible until his or her entire SOC has been paid. The MHP does not reimburse providers for any SOC. Eligibility verification via AEVS includes the SOC amount. It is the provider's responsibility to certify and clear the SOC through the AEVS by contacting (800) 866-AEVS (2387).

Medi-Cal Clients with Share of Cost (SOC)

- If the client's SOC is greater than the provider's customary charge for the service, the claim may not be filed with Optum since the client is responsible for the full amount.
- If the client's SOC has been completely cleared for that month by other services received, the claim should be submitted with the statement "Share of Cost (SOC) Cleared" in box 19 of form CMS-1500.
- If the client's remaining SOC is less than the rate in the provider contract for the service, the remaining SOC should be deducted from the contracted Medi-Cal rate, and the balance should be shown in box 24F, and the statement "SOC Balance" must be written in box 19 of form CMS-1500.

For more information on clearing Medi-Cal SOC, providers may refer to the following document: Share of Cost

Clients with Medicare and Medi-Cal (Medi-Medi)

Providers who serve clients with Medicare and Medi-Cal must bill Medicare before billing Medi-Cal.

Any Medicare deductibles and/or co-payments billed to Medi-Cal on behalf of the client are considered Medicare/Medi-Cal crossover claims and must be billed to ACS directly. These claims may crossover automatically from the Medicare Part B fiscal intermediary or the provider may be required to submit the hard copy crossover claim to ACS at the following address:

Department of Health Care Services (DHCS) Fiscal Intermediary
Attn: Crossover Unit
P.O. Box 15700
Sacramento, CA 95852-1700
Phone: (800) 541-5555

Optum is responsible for reimbursement of services provided to Medi-Medi clients whose Medicare benefits have been exhausted or denied. When a client's Medicare benefit has been exhausted/ denied, providers must attach a copy of the Medicare Explanation of Benefits (EOB), reflecting the benefits are exhausted or denied, to the Medi-Cal claim that is submitted to Optum for payment. Providers are asked to contact Optum to obtain an authorization when Medicare benefits are close to exhaustion.

Providers who are not enrolled Medicare providers will not be authorized and reimbursed for seeing clients with both Medicare and Medi-Cal.

Providers serving Medi-Medi clients are required to be Medicare providers. Optum cannot reimburse providers for serving Medi-Medi clients when the Medicare denial reason is that the provider is not a Medicare participating provider.

Medi-Cal clients who also have Medicare-contracted Health Maintenance Organization (MCP) or Medicare Advantage plan coverage must seek medical treatment through the plan; neither the plan, nor Medi-Cal/Optum pay for services rendered by non-plan providers.

To bill Optum for services not covered by the Medicare MCP or Medicare Advantage plan, providers must submit a hard copy claim to Optum, accompanied by the plan denial letter or EOB documenting that the plan does not cover the service. These claims are not considered Medicare/Medi-Cal crossover claims.

If Medicare has made a partial payment or has applied co-insurance/deductible, these claims are submitted directly to Medi-Cal State at the following address:

Department of Health Care Services (DHCS) Fiscal Intermediary
Attn: Crossover Unit
P. O. Box 15700
Sacramento, CA 95852-1700

Please note: Federal Medicaid regulations state that Medi-Cal is the payer of last resort. All other health insurance must be exhausted before Medi-Cal can reimburse a provider. Providers are required to bill Medicare and all other insurance prior to billing Medi-Cal.

Clients with Medi-Cal and Other Health Plan Coverage

When a client's primary insurance/coverage is NOT Medi-Cal the provider must be contracted with that specific Health Plan (the primary insurer) in order to render services to the client. The provider is required to obtain authorization from the client's primary Health Plan and follow that plan's policies and procedures for payment prior to submitting a claim to Optum.

Per Federal Regulations providers must bill all other insurances (Health Plans) prior to billing Medi-Cal. For Optum to pay any appropriate amount (residual) that may be due to the provider following the payment by the primary Health Plan the provider must obtain a treatment authorization for the client from Optum.

Optum will not reimburse for services when:

- A claim to the primary Health Plan has been denied because a provider did not follow the required policies for reimbursement (*The provider is responsible to know the reimbursement policies for any health plan they have a contract*).

- A claim is denied because a provider is not contracted with the primary Health Plan; this applies to all other Health Plans including Medicare.

When submitting Medi-Cal claims for clients with other Health Plan coverage, Optum must receive the claim within sixty (60) days of the provider's receipt of the primary Health Plan's EOB, but no later than six (6) months from the date of service. Claims must be submitted to the primary Health Plan in a timely manner for the provider to submit the claim to Optum within six (6) months of the date of service.

The EOB from the primary Health Plan must be attached to the form CMS-1500 when claiming a residual Medi-Cal amount.

Providers are asked to mail Medi-Cal FFS claims to the following address:

Optum Public Sector San Diego
P.O. Box 601340
San Diego, CA 92160-1340

Clients with No Medi-Cal Insurance, or Restricted Medi-Cal Benefit

At the present time, non-Medi-Cal eligible clients will not be referred to FFS providers. However, some clients may have restricted or partial Medi-Cal benefits as indicated by the Aid Codes. If those Aid Codes do not cover the services requested, then the client should be considered a non-Medi-Cal client. If a client's Medi-Cal Aid Code does not cover mental health treatment and claims are denied by the State, recoupment of paid funds will be made through the MHP.

Out-of-County Clients

Financial responsibility for a Medi-Cal client rests with the client's County of residence, as specified by the County code, except for children in the Adoption Assistance Program (AAP) & KIN GAP. Please contact Provider Services at (800) 798-2254, option 7 for information on the AAP. The county code for San Diego County is 37.

If the person requesting service is not a resident of San Diego County, it is the provider's responsibility as the provider of services to contact the appropriate County for authorization and billing information.

Out-of-State Clients

The MHP may be responsible for paying claims for out-of-State SMHS when the recipient resides in a "border community". A border community is a community located outside the State of California, which is not considered to be out-of-State, because of its proximity to California and historical usage of California providers by Medi-Cal beneficiaries of that community. Examples of border communities include, but are not limited to Ashland, Oregon; Carson City, Nevada; Yuma, and Arizona. A complete list of border communities is found in Title 9, Section 1810.205.1.

Claims Processing Procedures

All claims must be submitted within sixty (60) days from the date of service. Clean claims will be processed within thirty (30) days from the receipt of the claim. Processing means paid or denied.

A denied claim that has been corrected must be resubmitted within forty-five (45) days from the date of the EOB, but no later than four (4) months from the date of service.

All payments will be made based on the approved fee schedule in effect at the time service is delivered.

Overpayment

Overpayments may be offset against future claims payments. This includes claims reimbursed by Optum and subsequently denied by Medi-Cal. In such cases, the provider will be notified of the action and given thirty (30) days to appeal. Appeals should be submitted as described in the Issue Resolution section of this handbook.

Should a provider choose to return excess funds on his or her own check, the check must be made payable to "County of San Diego" and mailed to Optum Claims Department at the address below for processing:

Optum Public Sector San Diego Claims/Refunds
Attn: Claims Manager
P.O. Box 601340
San Diego, CA 92160-1340

How to Submit Billing Inquiries

Providers may submit specific questions regarding claims to Optum via phone or fax.

Providers may call (800) 798-2254, option 2 for all claims related inquiries.

Providers may also submit questions via fax to (619) 641-6975.

Written inquiries may be sent to:

Optum Public Sector San Diego
Claims Services
Attn: Claims Manager
P.O. Box 601340
San Diego, CA 92160-1340

Ethical, Legal and Billing Issues Hotline

The County of San Diego's MHP has created a Hotline to report concerns about a variety of ethical, legal, and billing issues. The confidential Hotline is toll-free and available 24 hours a day, 7 days a week. Callers may remain anonymous if they wish. The number of the County of San Diego's MHP Compliance Hotline is (866) 549-0004.

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Quality Management Program

The MHP provides a mental health system for clients with serious mental illness that is:

- Focused on client strengths and recovery from mental illness
- Accountable and outcomes-driven
- Client and family-centered
- Culturally competent

To implement and maintain the goals of this mandate, the County of San Diego's Behavioral Health Services Quality Management unit (BHS QM) has developed a comprehensive Quality Management Program. The BHS QM Program is responsible for assuring that all clients receive high quality and cost- effective mental health care. The BHS QM Program integrates clients, family members, clinicians, mental health advocates, and other stakeholders within its working committees and its monitoring and oversight of MHP processes.

The BHS QM Program adheres to a Quality Improvement Plan that is reviewed and updated at a minimum on an annual basis. The Quality Improvement Plan strives for continuous improvement that does not end once a specified standard or threshold is reached. The quality of the MHP care and service delivery system is evaluated by using standardized, valid, and reliable measures whenever possible.

The aspects of care and service evaluated by the MHP include, but are not limited to:

- Client satisfaction with the delivery and quality of clinical services
- Improving access to services
- Quality, effectiveness, and timeliness of clinical and administrative services
- Complaints and resolutions of complaints about provider services
- Quality of provider documentation of clinical services
- Provider satisfaction with Optum procedures
- Implementation of evidence-based practices

Questions regarding the Quality Improvement Program, may be emailed to Optum Quality Improvement at SDQI@optum.com

Questions regarding the County of San Diego Behavioral Health Services Quality Management may be emailed to QIMatters.hhsa@sdcounty.ca.gov.

Quality Management Program Compliance

Providers who contract with Optum agree to the following standards of quality that include, but are not limited to, the following items:

- Compliance with MHP standards for client access to services including distribution of literature at the first meeting with a new client. This may include, but is not limited to, Client Rights, County of San Diego Notice of Privacy Practices, Advance Directive Brochure, Grievance and Appeals brochure, etc.
- Compliance with County, State and Federal guidelines, MHP and Utilization Management guidelines
- Compliance with Credentialing, Re-Credentialing, and Peer Review Committee activities
- Cooperation and participation in the resolution of client appeals and grievances concerning the provider's services

- Cooperation with the Consumer Center for Health, Education and Advocacy (CCHEA) and Jewish Family Services (JFS) Patient Advocacy Program as they investigate and resolve appeals and grievances
- Completion of any corrective action plans that may occur as a result of an investigation by CCHEA or JFS
- Agreement to report any serious incidents on the County of San Diego Serious Incident Report Form. A Serious Incident is defined as any incident that results in a client's death, serious morbidity requiring treatment, injury inflicted on others, serious adverse drug reactions, or evidence of inappropriate or unsafe medical and/ or therapeutic practices involving MHP clients. Such incidents must be reported to the BHS Quality Management unit.
- Cooperation with and participation in the investigation of serious incidents involving a MHP client
- Cooperation with site and treatment record reviews, including the completion of any necessary corrective action plans
- Cooperation with the evaluation of potential quality of care or billing accuracy concerns
- Adherence to Title 9, Federal, State and County regulations, including cultural competence standards for the provision of mental health services
- Compliance with California DHCS and licensing board record retention procedures, whichever is longer.

Refusal to comply with the BHS Quality Management unit and/or Optum Quality Improvement procedures can result in disciplinary action up to and including termination from the network.

Client Satisfaction

The MHP is committed to assessing client satisfaction with the delivery and quality of clinical services. Title 9 requires an assessment of clients' perceptions of this care. The MHP conducts an ongoing survey of client satisfaction with inpatient services. Providers are strongly encouraged to conduct client surveys to determine client satisfaction with their services.

Provider Satisfaction

Every two (2) years, the MHP will send a survey to all contracted providers and groups measuring their satisfaction with Optum. These results are provided to Optum where they are reviewed by the leadership team to develop and implement changes aimed at improving provider satisfaction.

Quality of Care

Optum facilitates a process to address concerns related to the quality of care rendered by FFS providers. Quality of care concerns are addressed by Optum Quality Improvement, reviewed by the Optum Medical Director, and may be presented to the Optum Clinical Quality of Care Committee. In some instances, FFS providers will be requested to submit copies of treatment documentation which includes progress notes. Optum may follow up with questions regarding the information received or not received in the documentation which will be relayed via a letter. Based on the outcome of the review, providers may be required to complete a plan of correction to address quality of care concerns. In certain cases, information related to the quality of care may be referred to the Credentialing Committee for disciplinary action up to and including termination from the network.

Peer Review Committee

Optum facilitates a peer review process. This process includes Optum employees, network providers, and other professionals in the community. The peer review process reviews cases involving the suicide of a client or other serious provider issues. FFS providers may be requested to submit copies of treatment documentation, including clinical notes.

This information is reviewed internally by the Optum Quality Improvement clinicians. After development of the case history, the clinical documentation is reviewed with the Peer Review Committee. All identifying client and provider information is removed.

The Peer Review Committee may develop questions regarding treatment, which will be relayed to the provider via a letter. Based on the outcome of the review, providers may be required to complete a plan of correction to address quality of care concerns. In certain cases, information related to the quality of care may be referred to the MHP Credentialing Committee for disciplinary action up to and including termination from the network.

Outpatient Provider Reviews

The MHP requires review of providers' practice site and documentation of services to determine that County, State, and Federal guidelines and standards are met regarding the quality and effectiveness of clinical services and the accuracy of provider claims.

Monitoring is accomplished through a review of clinical records, billing practices, and an inspection of provider offices. Optum Quality Improvement employees conduct site and treatment record reviews for each provider during the three-year credentialing period.

Providers may also be selected for review in response to a complaint or quality of care issue. Providers may also be selected for review at the request of the County of San Diego or the Credentialing Committee. Reviews are scheduled in advance. Copies of the Site Review Tool and Treatment Record Review Tool are available at optumsandiego.com. Providers are required to cooperate with the review process and comply with any resulting corrective action plans.

Please review the online document: Record Keeping and Treatment Record Requirements.

Site Reviews

FFS provider sites are reviewed to ensure that providers maintain a safe office, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a Quality Improvement Clinician will review:

- Physical facility
- Health and Safety Requirements
- Licenses and Permits (as applicable)
- Required Documents and Notices
- Consumer Orientation
- Provider/staff knowledge of Client Rights, Grievance & Appeals Process and Advance Directives
- Professional Will
- Verification of the safe storage and dispensing of medications in compliance with State and Federal laws and regulations (prescribers only)
- Accessibility of the site for individuals using wheelchairs
- Availability of Guide to Medi-Cal Mental Health Services, client complaint/grievance brochures and complaint filing forms in common areas that preclude the need for a verbal or written request by the client
- Access and Crisis Line posters displayed and ACL brochures available to clients

Treatment Record Reviews

Providers are urged to review the online form Record Keeping and Treatment Record Requirements. Competent record keeping documents the client's history and treatment and protects providers against recoupment of payments or legal action. During the treatment record review, a Quality Improvement clinician will review clinical records for but not limited to:

- Assessment/Appropriateness of Treatment
- Legibility
- Administrative/Legal Compliance (therapeutic consents, office policies, description of services, etc.)
- Medical Necessity
- Clinical Quality
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Problem Lists
- Care Coordination
- Discharge Plan and Summary

Please note: The CPT code submitted on a claim form and the amount of time a provider spends with a client must match the amount of time associated with that CPT code in the provider's and/or group's contract fee schedule and the most current version of the American Medical Association Procedural Codebook.

Outcome Reports and Plans of Correction

Problems and areas of non-compliance noted during a site visit and/or treatment record review are summarized into an outcome report, which is sent to the provider. A score of 85% is required to pass. Optum may require the provider to submit a plan of correction based on the areas of non-compliance; a re-review may be incorporated into a plan of correction. Providers have thirty (30) days to submit a plan of correction in writing to Optum Quality Improvement. Quality Improvement clinicians are available to discuss problem areas and assist with developing plans of correction. Optum Quality Improvement reviews and approves plans of correction and monitors providers for compliance achievement.

The MHP is committed to working with providers to help address and correct any areas of concern that may be identified during site visits and treatment record review; however, repeated deficiencies in documentation or quality of care can result in disciplinary actions up to and including termination of the provider contract.

Recoupment and Recoupment Appeals Process

It is the policy of the MHP to disallow provider billing that does not meet the documentation standards and to recoup payment in accordance with the current County of San Diego MHP policy and procedures.

Providers are responsible for ensuring that all treatment records comply with Federal, State, and County documentation standards when billing for reimbursement of services. At the end of a treatment record review, the provider may receive a Medi-Cal FFS Recoupment Report, listing any disallowed claims.

If the provider disagrees with a recoupment, the MHP has a process for the provider to appeal the recoupment decision. Providers who disagree with the recoupment report may submit a written appeal request to Optum within fourteen (14) days from the date of the report. The written request must specify which service is being appealed, the reason why, and any supporting documentation from the medical record. The provider is informed of the decision in writing within fourteen (14) days of receipt of the appeal request. If the appeal is upheld, the provider has the option to submit a second written appeal request to Optum within fourteen (14) days. The provider is informed of the final decision in writing within fourteen (14) days of receipt of the second appeal.

Providers are required to submit their appeal in writing to Optum Quality Improvement within the required timelines. Any appeal requests received past the due date will be rejected and will not be reviewed.

Please email Optum Quality Improvement at SDQI@optum.com for information on the appeals process.

Please note: Providers are required to complete the FFS Medi-Cal Documentation Training as a pre-requisite to contracting. Instructions for creating an account can be found at optumsandiego.com. Providers are required to meet MHP documentation requirements.

Documentation Standards for Outpatient Client Records

The following information is required to be included in the client's treatment record. Documentation must be timely, legible, and support the claims information submitted to Optum for provider reimbursement. Providers are urged to review the online form Record Keeping and Treatment Record Requirements for additional information.

Client Record Documentation Requirements

- Documentation that client/guardian received the following: Client Rights, Grievance and Appeals brochure/form, Advance Directive brochure, County of San Diego Notice of Privacy Practices, right to have services provided in their primary language, etc.
- Informed Consent/Agreement for Services, telehealth specific consent for services provided via telehealth
- Problem List
- Relevant physical health conditions reported by the client must be prominently identified and updated as appropriate
- Presenting problems and relevant conditions affecting the client's physical health and mental health status must be documented; for example, living situation, daily activities, cultural issues, and social support
- Documentation must include and describe client strengths in achieving client plan goals
- Special status situations that present a risk to client or others must be prominently documented and updated as appropriate
- Documentation must include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications
- Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities must be clearly documented
- For children and adolescents, prenatal and perinatal events and a complete developmental history must be included
- Documentation must include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs
- A mental status examination
- Diagnosis consistent with the presenting problems, history, mental status evaluation, and/or other assessment data. Document the amount of time spent with the client. Time spent with the client must match CPT code and contracted rate schedule.
- Provider signature, including professional degree and licensure for each note (if applicable, an electronic signature is acceptable)

Problem List

The provider responsible for the beneficiary's care shall create and maintain a problem list. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounter or other types of service encounters.

The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary and shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice
- Problems identified by a provider acting within their scope of practice
- Problems or illnesses identified by the beneficiary and/or significant support person
- The name and title of the provider that identified, added, or removed the problem and the date the problem was identified, added or removed

Progress Notes

Progress notes are the evidence of a provider's service to the client and relate to the client's progress in treatment. The following items related to the client's progress must be entered in the client record at every service contact:

- Date that the service was provided to the beneficiary
- Location of services
- Documentation who is in attendance during each session
- Client encounters, including relevant clinical decisions and client's response to specialty mental health interventions provided
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code
- Amount of time spent with client when providing a timed service
- Documentation of the ICD-10 diagnosis for the session
- Next steps including but not limited to, planned action steps by the provider or by the beneficiary including referrals made to community resources and other agencies
- Any updates to the problem list as appropriate
- Date or timeframe of follow up appointments
- A typed or legibly printed name, signature of the service provider and date of signature

Case Management

Provider should assist with access to services. It can be done with another provider or support person. The person served does not need to be present. Case Management involves linkages, monitoring progress, advocating, brokering or ensuring access with or on behalf of the person served. When billing for case management, documentation is needed for each billed service that includes what was done, where the service was provided, date of service, length of time, and why the service was done.

Discharge

Discharge planning should be evident in the treatment records and involve documentation that communication or collaboration occurred if client transferred/discharged to another provider. The discharge summary includes reason for treatment, whether goals were met and shows appropriate follow-up efforts if client terminated prematurely. An after-care/discharge plan should highlight any safety planning and referrals for ongoing care as applicable and completed no

later than thirty (30) days following last date of service. If client does not return to services, there are documented efforts to re-engage. The following are recommended for discharge summary:

- Referral source/ reason for admission
- Outcome (were the treatment plan goals met?)
- Significant diagnostic changes
- Medications
- Safety planning
- Recommendations/referrals
- Transition Tool as applicable

Group Therapy

All progress notes for group therapy are properly apportioned to all clients present. Content of the group therapy should focus on client primary diagnosis and diminish the impairment. Therapy groups should have no more than eight (8) participants.

Inpatient Professional Service Reviews

The MHP requires annual review of providers of inpatient professional services to ensure documentation is present for claims to be substantiated. A minimum of ten percent of all paid services per provider shall be reviewed by Optum Quality Improvement employees. The MHP may require additional reviews of providers at any time if deemed necessary.

Monitoring is accomplished through a review of inpatient progress notes and paid claims. A copy of the Inpatient Review Tool is available at optumsandiego.com. An outcome report with a summary of the results including feedback on any deficiencies will be sent to the provider.

Optum may require the provider to submit a plan of correction based on the areas of deficiency. If documentation does not support claims payment, payment for the services may be recouped. Providers are required to cooperate with the review process and comply with any resulting corrective action plans.

The MHP is committed to working with providers to help address and correct any areas of concern that may be identified during inpatient professional service reviews; however, repeated deficiencies can result in disciplinary actions up to and including termination of the provider contract.

Documentation Standards for Inpatient Client Records

A progress note is required for each service rendered by a provider. Inpatient professional service progress notes must, at minimum, have the following elements:

- Client name or identifier is present in the progress note
- Provider identifier is present in the progress note
- The progress note is legible
- The diagnosis or diagnosis code is indicated
- The progress note supports the code billed

Medical Necessity Admission

- Documentation in the medical record must establish that the beneficiary has a Title 9 covered diagnosis.

- Documentation in the medical record must establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.

- Documentation in the medical record must establish that, as a result of a mental disorder the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function; or
    - Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized

Continued Stay Criteria

- Documentation in the medical record must establish the continued presence of a Title 9 covered diagnosis.

- Documentation in the medical record must establish that the beneficiary could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.

- Documentation in the medical record must establish that, as a result of a mental disorder the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction

    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter

    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health

    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function

    - Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized

    - Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization

    - Presence of new indications that meet medical necessity criteria
    - Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital

Administrative Day Requirements

- Documentation in the medical record must establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

- Documentation provided must establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements.

- The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be fewer than one (1) contact per week.

    - 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:

        - The status of the placement option
        - The date of the contact
        - Signature of the person making the contact

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Beneficiary Rights

This section summarizes the responsibilities of Medi-Cal FFS providers regarding the rights of Medi-Cal beneficiaries.

Confidentiality

Maintaining the confidentiality of client information is of vital importance, not only to meet legislative and regulatory mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

Following the HIPAA Privacy and Security Regulations is a requirement for providers. Every provider must provide a written notice of information practices known as a “Privacy Notice” to all clients. This notice must include:

- Mandated reporting requirements when a client presents as a current danger to self or others
- Mandated reporting requirements concerning the abuse or neglect of children or older adults
- The review of records by third party payers for authorization or payment purpose.
- Clients’ rights to review and obtain their medical records

Each provider is required to act in accordance with good clinical judgment, professional ethical standards, and within State and Federal law to ensure that all written and verbal communication regarding each client’s medical clinical record is kept strictly confidential. Providers are required to maintain all client records and documentation in secure, locked storage for a minimum of ten (10) years after last contact. For minors, providers are required to maintain all client records additional ten (10) years after the minor has reached 18 years of age. In addition, fax machines that receive client information must be kept in a secure location away from unauthorized viewing.

The MHP requires providers to inform clients and families, through written information, about clients’ rights, the legal limits of confidentiality, and to obtain the client's (or conservator/ legal guardian's) signature acknowledging understanding of these limits.

Providers may contact the appropriate State Licensing Board or professional association for further information regarding legal and ethical reporting mandates.

Client Rights and Protections: Code of Federal Regulations (CFR)

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children’s Health Insurance Program Managed Care Final Rule, aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. MHPs are classified as Prepaid Inpatient Health Plans, and therefore, must comply with all applicable federal managed care requirements The Final Rule stipulates new requirements for the handling of grievances and appeals that became effective July 1, 2017.

According to Title 9 and 42 CFR 438.1000, the MHP is responsible for ensuring compliance with client rights and protections. Providers, as contractors of the MHP, must comply with applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CRF, Part 80), the Age Discrimination Act of 1975 as implemented by regulations at 45 CRF, part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and other laws regarding privacy and confidentiality. These rights and protections can be summarized as follows:

- Easily understandable information. Each managed care enrollee is guaranteed the right to receive all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
- Dignity, respect, and privacy. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for their dignity and privacy.

- Receive information on the managed care plan and available treatment options. Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.

- Participate in decisions. Each managed care enrollee is guaranteed the right to participate in decisions regarding their health care, including the right to refuse treatment.

- Free from restraint or seclusion. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.

- Copy of medical records. Each managed care enrollee is guaranteed the right to request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR, 164.524 and 164.526.

- Right to health care services. Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.

- Free exercise of rights. Each managed care enrollee is guaranteed the right to free exercise of their rights in such a way that those rights do not adversely affect the way the MHP and its providers treat the enrollee.

In accordance with 42 CFR and Title 9, the MHP Quality Assurance Unit distributes the Guide to Medi-Cal Mental Health Services, which contains information on client rights, as well as a description of the services available through the MHP, and the avenues to obtain resolution of dissatisfaction with MHP services.

Please note: New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages.) Additional copies may be obtained from the MHP Behavioral Health Services Division at (619) 563-2700. To receive the materials in the audio or large print format contact QIMatters.HHSA@sdcounty.ca.gov

Process Definitions (Title 42 CFR § 438.400 (b))

- **Grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below (under appeal). Grievances may include but are not limited to the quality of care of services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect the rights of the client regardless of what remedial action is requested, including the client's right to dispute an extension of time proposed by the plan to make an authorization decision. A grievance can be filed at any time, orally or in writing. (42 CFR § 438.402)

- **Discrimination Grievance** is when a client believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the county plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. (45 CFR §§ 92.7 and 92.8; WIC§14029.91). Discrimination Grievance posters can be found in the Beneficiary Handbook and printed for posting.

- **Grievance Exemption** is when grievances are received over the telephone or in-person that are resolved to the client's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Please note: Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a complaint is received pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

- **Appeal** means a review of an adverse benefit determination or "action" which may include:

- Denial or limited 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
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to act within the timeframes regarding the standard resolution of grievances and appeals
- The failure to provide services in a timely manner
- The denial of a client's request to dispute financial liability

- **Grievance and Appeal System** are the processes the County and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

- **State Fair Hearing** is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal beneficiary may request a state fair hearing.

Additional Client Rights

- Provider Selection In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence.

- Second Opinion If the MHP or its designee determines that a client does not meet Medical Necessity Criteria for inpatient or outpatient mental health services, a client or someone on behalf of the client, may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care at no extra cost. As the MHP designee, Optum is responsible for informing the treating provider of the second opinion request and for coordinating the second opinion with a MHP contracted individual provider.

  The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor/COR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the MHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

- Right to Language, Visual, and Hearing Impairment Assistance Clients shall be routinely informed about the availability of free language assistance at the time of accessing services. The MHP prohibits the expectation that the client uses family or friends for interpreter services. However, if the client so chooses, this choice should be documented in the client record. Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and Behavioral Health Services policy.

- Right to a Patient Advocate A client pursuant to W&I Code 5325 (h) has a right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services.

The rights specified in this section may not be waived by the person's parent, guardian, or conservator.

The patient advocate does not need to have access to the entire chart, but rather, the portions that have to do with the potential denial of rights.

- Open Payments Database Physician's Notice to Clients As required by State Assembly Bill AB1278, physicians are required to provide notice to patients regarding the Open Payments Database which is managed by CMS. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adults and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. To be in full compliance with this regulation, it is necessary that all eligible clients be informed of the right to have an Advance Health Care Directive at their first contact for services, or when they become eligible (upon their 18 birthday or emancipation). An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for themselves. To comply with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new adult or emancipated clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the initial contact with a new client, and thereafter, upon request.

2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.

3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.

4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that, the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.

5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not they have an Advance Directive.

6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. All brochures are available at optumsandiego.com > Beneficiary Materials. To receive the materials in the audio or large print format contact QIMatters.HHSA@sdcounty.ca.gov, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in state law regarding Advance Directives within ninety (90) days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate employees. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Clients' Rights

In accordance with California DHCS regulations, written and oral information explaining the grievance/appeal process and the availability of a state fair hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to mental health services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected in the client's treatment record. Information on the Beneficiary and Client Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented in the client's treatment record.

Termination of Treatment

Clients have the right to be notified of a provider's termination from the network. In addition, when a provider terminates with a client, for whatever reason, the provider is obligated to manage the termination in a clinically appropriate manner. When the client continues to need treatment, the provider is expected to help the client transition to another provider either in the FFS Network or at an organizational provider or County operated clinic. Providers are also expected to assist clients in transitioning to community services such as peer support, self-help, or 12 Step programs. ACL staff are available to assist with referrals to other providers or community services.

Beneficiary Grievance and Appeal Process

The County of San Diego is committed to honoring the rights of every client to have access to a fair, impartial, effective process through which the client can seek resolution of a grievance or adverse benefit determination by the MHP. All contracted providers are required to participate fully in the beneficiary grievance and appeal process. Providers shall comply with all aspects of the process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the process. Beneficiary Packet Materials, Order Form and Grievance/Appeal Forms are available at optumsandiego.com > Beneficiary Materials.

The MHP has delegated the roles and responsibilities of managing the grievance and appeal resolution process for beneficiaries to contracted advocacy organizations. When one of the contracted advocacy organizations notifies a provider of a grievance or appeal, the provider shall cooperate with the investigation and resolution of the grievance or appeal in a timely manner.

At all times, grievance and appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place. Clients shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The client shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the client shall be assisted in preparing a written grievance/appeal, if requested.

Written materials that are critical to obtaining services including, at a minimum, appeal and grievance notices, and denial and termination notices, shall be available to beneficiaries in threshold languages and alternative formats. These materials are available at optumsandiego.com.

Grievance Resolution at Provider Sites

Clients are encouraged to direct their grievances directly to providers for the most efficient way to resolve problems. This may be done orally or in writing with the provider or office staff. In accordance with 42 CFR §438.402, a beneficiary may file a grievance at any time. The MHP shall provide to the beneficiary written acknowledgement of receipt of grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the MHP representative who the beneficiary may contact about the grievance. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. Providers shall log of all grievances containing the date of receipt of the grievance, the name of the beneficiary, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance. The log shall be secured to protect client confidentiality. Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching the provider or office staff, or the dissatisfaction has not been successfully resolved with the provider. Clients should feel equally welcomed to bring their concerns directly to the provider's attention or to seek the assistance of one of the advocacy organizations.

Complaints to Board of Behavioral Sciences (AB 630)

Effective on or after July 1, 2020, mental health professionals licensed or registered with the Board of Behavioral Sciences (BBS), prior to providing psychotherapy, must give clients a notice in at least 12- point font telling them that BBS receives and responds to complaints about licensees and tells clients how to contact BBS to file complaints. Providers should have a policy and procedure in place addressing this regulation.

Grievance Process

A “grievance” is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. There is no distinction between an informal and formal grievance. A compliant is the same as a formal grievance. A compliant shall be considered a grievance unless it meets the definition of an adverse benefit determination. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall be categorized as a grievance.

JFS Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within two (2) business days of receiving written permission from the client to represent them. Securing this permission can be difficult and time consuming. To ensure compliance with the mandated federal timeline, providers shall work closely with the advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client’s condition to review and make a decision about the case.

Grievance Resolution

Timeline: Ninety (90) days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

The MHP must resolve grievances within the established timeframes. The MHP must comply with the following requirements for resolution of grievances:

1. “Resolved” means that the MHP has reached a decision with respect to the beneficiary’s grievance and notified the beneficiary of the disposition.

2. MHP shall comply with the established timeframe of ninety (90) calendar days for resolution of grievances, except as noted below.

3. The timeframe for resolving grievances related to disputes of a MHP’s decision to extend the timeframe for making an authorization decision shall not exceed thirty (30) calendar days.

4. The MHP shall use the Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the MHP’s decision.

5. Federal regulations allow the MHP to extend the timeframe for an additional fourteen (14) calendar days if the beneficiary requests the extension or the MHP shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary’s interest. If resolution of a standard grievance is not reached within ninety (90) calendar days as required, the MHP shall provide the beneficiary with the applicable NOABD and include the status of the grievance and the estimated date of resolution, which shall not exceed fourteen (14) additional calendar days. If the Plan extends the timeframe, not at the request of the beneficiary, it must complete all of the following: (a) give the beneficiary prompt oral notice of the delay, (b) within two (2) calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with that decision, and (c) resolve the grievance no later than the date the extension expires.

Advocacy Services and Record Requests

In accordance with the CFR Title 42, Part 438, Subpart F – Grievance System, JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and appeals pursuant to state and federal law. These processes may include, but are not limited to, consulting with facility administrators, interviewing office employees, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting

employee trainings, suggesting policy changes, submitting requests for plans of correction, and preparing resolution letters.

There are mandated timelines for grievances and appeals. The quick and efficient cooperation of providers ensures compliance with these requirements. When requested, providers shall provide copies of medical records to JFS Patient Advocacy Program or CCHEA within seven (7) calendar days from the date of the medical record request. The advocacy agencies provide the provider with a signed release of information from the client with the request.

Adverse Benefit Determinations

An Adverse Benefit Determination is defined to mean any of the following actions taken by a mental health plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2. The reduction, suspension, or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service;

4. The failure to provide services in a timely manner;

5. The failure to act within the required timeframes for standard resolution of grievances and appeals (If you file a grievance with the mental health plan and the mental health plan does not get back to you with a written decision on your grievance within ninety (90) days. If you file an appeal with the mental health plan and the mental health plan does not get back to you with a written decision on your appeal within thirty (30) days, or if you filed an expedited appeal, and did not receive a response within 72 hours.); or

6. The denial of a beneficiary's request to dispute financial liability.

A Notice of Adverse Benefit Determination (NOABD) is a written letter sent to the beneficiary if a decision is made to deny, limit, reduce, delay, or end services. This includes a denial of payment for a service, a denial based on claiming the services are not covered, a denial based on claiming the services are not medically necessary, a denial that the service is for the wrong delivery system, or a denial of a request to dispute financial liability. A NOABD is also used to tell the beneficiary if their grievance, appeal, or expedited appeal was not resolved in time, or if the beneficiary did not receive services within the mental health plan's timeline standards for providing services.

The notice must be mailed to the beneficiary at least ten (10) days before the date of action for termination, suspension, or reduction of a previously authorized specialty mental health service. The notice must be mailed to the beneficiary within two (2) business days of the decision for denial of payment or decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services.

Notice of Adverse Benefit Determination – Delivery System Notice

On occasion, a client referred by the MHP is assessed, and in the provider's professional judgment, does not meet medical necessity criteria for SMHS as outlined in Behavioral Health Information Notice 20-043 and WIC Section 14059.5. Should this occur, the provider is required to give the client a Notice of Adverse Benefit Determination - Delivery System Notice. The NOABD - Delivery System Notice describes the client's Medi-Cal rights. These rights include the right to a Second Opinion, the right to file a grievance or appeal, and the right to request a State Fair Hearing after completing the County appeal process. If the client chooses to exercise any of these rights, they may contact the appropriate office, as indicated on the NOABD - Delivery System Notice and under the section "Your Hearing Rights" section of the form.

The provider must check the reason medical necessity criteria were not met on the NOABD - Delivery System Notice prior to giving it to the client. It also is important that the provider contacts Optum UM at (800) 798-2254, option 3, then option 4, to advise Optum regarding the assessment findings and the NOABD - Delivery System Notice.

Copies of the NOABD - Delivery System Notice and Your Rights may be found at optumsandiego.com > MHP Provider Documents > NOABD. Please obtain a copy for your use.

Notice of Adverse Benefit Determination – Denial Notice or Modification Notice

The NOABD - Denial Notice or NOABD - Modification Notice describes the client's right to a Second Opinion, the right to file a grievance or appeal, and the right to a State Fair Hearing. Whenever services are reduced, denied, or terminated, Medical Necessity for SMHS at WIC Section 14059.5 regulations require that the client receives a completed NOABD - Denial Notice or NOABD - Modification Notice Form from Optum. If Optum determines that treatment should be terminated or reduced in frequency, the client will receive a NOABD - Denial Notice or NOABD - Modification Notice Form.

Optum will send the provider a copy of the NOABD - Denial Notice or NOABD - Modification Notice, which was sent to the client, along with a Letter of Determination, written specifically for the provider. If a provider makes a clinical decision that a client's treatment should be terminated or reduced, no NOABD Form is needed.

If the client chooses to exercise the right to a Second Opinion, the right to file a grievance or appeal, or the right to request a State Fair Hearing, they may contact Optum, or the appropriate State or County office, at the telephone numbers indicated on the front of the NOABD - Denial Notice or NOABD - Modification Notice, and in the "Your Hearing Rights" section of the form.

Copies of the NOABD - Denial Notice or NOABD - Modification Notice, may be found at optumsandiego.com > MHP Provider Documents > NOABD. Please obtain a copy for your use.

Notice of Adverse Benefit Determination – Payment Denial Notice

The NOABD - Payment Denial Notice is the Post-Service Denial of Payment Form. Optum will send a NOABD - Payment Denial Notice to the client when the MHP denies or modifies a request for payment by a FFS provider of SMHS that were already delivered to the client. The NOABD - Payment Denial Notice informs the client that they are not responsible for reimbursing the provider for services that were denied reimbursement by the MHP.

Copies of the NOABD - Payment Denial Notice may be found at optumsandiego.com > MHP Provider Documents > NOABD. Please review a copy to become familiar with its contents.

NOABD – Notice of Adverse Benefit Determination - A standard State form given to clients when services are reduced, denied, suspended, or terminated.

NOABD – Delivery System Notice - Given when an initial assessment determines medical necessity criteria is not met for Specialty Mental Health Services.

NOABD – Denial Notice or NOABD – Modification Notice - Given when Specialty Mental Health Services are reduced, denied, or terminated by MHP.

NOABD – Payment Denial Notice - Given to a client when a provider requests approval of Specialty Mental Health Services that have already been delivered and the request is denied or modified by the MHP. The notice informs the client that they are not responsible for reimbursing the provider for the services that were denied reimbursement by the MHP.

Beneficiary Appeal Process

Timeline: Thirty (30) calendar days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

A beneficiary appeal is a review by the MHP of an adverse benefit determination regarding provision of services through an authorization process, including:

1. Denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. Reduction, suspension or termination of a previously authorized service;
3. Denial of, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner;
5. Failure to act within the required timeframes of a standard resolution of grievances and appeals; or

6. Denial of a beneficiary's request to dispute financial liability.

Federal regulations require beneficiaries to file an appeal within sixty (60) calendar days from the date on the NOABD. The MHP shall adopt the 60-calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the MHP's appeal process prior to requesting a state fair hearing. A beneficiary, or provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

In addition, an oral appeal (excluding expedited appeals) shall be followed by a written appeal signed by the beneficiary. The date of the oral appeal establishes the filing date for the appeal. The MHP shall request that the beneficiary's oral request for a standard appeal be followed by written confirmation unless the beneficiary or provider requests expedited resolution in accordance with federal regulations.

The MHP and its providers shall assist the beneficiary in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the beneficiary of the location of the forms on the Optum website or providing the form to the beneficiary upon request. The MHP shall also advise and assist the beneficiary in requesting continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations. If the MHP does not receive a written, signed appeal from the beneficiary, the MHP shall neither dismiss nor delay resolution of the appeal.

Authorized Representatives

With written consent of the beneficiary, a provider or authorized representative may file a grievance, request an appeal, or request a state fair hearing on behalf of the beneficiary. Providers and authorized representatives cannot request continuation of benefits, as specified in 42 CFR§438.420(b)(5).

Standard Resolution of Appeals

The MHP shall provide to the beneficiary written acknowledgement of receipt of the appeal. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the MHP representative who the beneficiary may contact about the appeal. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the appeal.

Extension of Timeframes

The MHP may extend the resolution timeframes for appeals by up to fourteen (14) calendar days if either of the following two conditions applies:

1. The beneficiary requests the extension.

2. The Plan demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.

For any extension not requested by the beneficiary, the MHP is required to provide the beneficiary with written notice of the reason for the delay. Federal regulations delineate the following additional requirements:

1. The MHP shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension.

2. The MHP shall provide written notice of the extension within two (2) calendar days of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension.

3. The MHP shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the 14-calendar day extension.

4. If the MHP fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a state fair hearing.

Expedited Resolution of Appeals

Timeline: 72 hours from receipt of expedited appeal request

In addition to the other logging requirements delineated in federal regulations, the MHP must log the time and date of appeal receipt when expedited resolution is requested as the specific time of receipt drives the timeframe for resolution. The MHP may extend the timeframe for expedited appeals resolution by fourteen (14) calendar days in accordance with federal regulations.

The MHP maintains an expedited review process for appeals when the MHP determines (from a beneficiary request) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking time for a standard resolution could seriously jeopardize the beneficiary's mental health of the beneficiary's ability to attain, maintain, or regain maximum function. For expedited resolution of an appeal and notice to affected parties (i.e., the beneficiary, legal representative and/or provider), the MHP shall resolve the appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, no longer than 72 hours after the MHP receives the expedited appeal request.

General Expedited Requirements

If the MHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. In addition, the MHP shall complete all the following actions:

1. The MHP shall make reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution

2. The MHP shall provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension.

3. The MHP shall resolve the appeal as expeditiously as the beneficiary's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within thirty (30) days of receipt of the appeal).

Notice of Appeal Resolution Requirements

A Notice of Appeal Resolution (NAR) is a formal letter informing a beneficiary that an adverse benefit determination has been overturned or upheld. In addition to the written NAR, the MHP is required to make reasonable efforts to provide prompt oral notice to the beneficiary of the resolution.

NAR Adverse Benefit Determination Upheld Notice

For appeals not resolved wholly in favor of the beneficiary, the MHP shall utilize the DHCS template for upheld decisions, which is comprised of two components: NAR Adverse Benefit Determination Upheld Notice, and Your Rights attachment. These documents are a packet and shall be sent together to comply with all requirements of the NAR. The MHP shall send written NARs to beneficiaries. The written NAR shall include the following:

a. The results of the resolution and the date it was completed

b. The reasons for the MHP's determination, including the criteria, clinical guidelines, or policies used in reaching the determination

c. For appeals not resolved wholly in the favor of the beneficiary, the right to request a state fair hearing and how to request it

d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request

e. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the MHP's adverse benefit determination

NAR "Your Rights" Notice

The NAR "Your Rights" attachment provides beneficiaries with the following required information pertaining to NAR:

a. The beneficiary's right to request a state fair hearing no later than 120 calendar days from the date of the MHP's written appeal resolution and instructions on how to request a state fair hearing; and,

b. The beneficiary's right to request and receive continuation of benefits while the state fair hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was postmarked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420. The MHP shall use the appropriate NAR form and "Your Rights" attachments.

NAR Adverse Benefit Determination Overturned Notice

For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. The MHP shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. The MHP shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions. MHPs must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the MHP reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. The MHP shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

Please note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

State Fair Hearing

Beneficiaries must exhaust the MHP's appeal process prior to requesting a state fair hearing. A beneficiary has the right to request a state fair hearing only after receiving notice that the MHP is upholding an adverse benefit determination. If the MHP fails to adhere to the notice and timing requirements in 42 CFR§438.408, the beneficiary is deemed to have exhausted the MHP's appeals process. The enrollee may then initiate a state fair hearing. Beneficiaries may request a state fair hearing within 120 calendar days from the date of the NAR, which informs the beneficiary that the adverse benefit decision has been upheld by the MHP.

For standard hearings, the MHP shall notify beneficiaries that the State must reach its decision on the hearing within ninety (90) calendar days of the date of the request for the hearing. For expedited hearings, the MHP shall notify beneficiaries that the State must reach its decision on the state fair hearing within three working days of the date of the request for the hearing. For overturned decisions, the MHP shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the MHP's adverse benefits determination.

Non-Discrimination and Language Assistance Notice

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination based on race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services, Office for Civil Rights issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require the MHP to post nondiscrimination and language assistance notices in significant communications to beneficiaries.

The MHP has created a "Beneficiary Non-Discrimination Notice" and "Language Assistance Notice", which shall be sent along with each of the following significant notices sent to beneficiaries:

- NOABD
- Grievance Acknowledgment Letter
- Appeal Acknowledgment Letter

- Grievance Resolution Letter
- Notice of Appeal Resolution Letter

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a plan of correction to be submitted by the provider to the Mental Health Director or designee in ten (10) days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a plan of correction, the provider may write to the Mental Health Director within ten (10) days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary and Client Problem Resolution Process for details of this portion of the process.

Considerations for Minors

If the client is a minor, unless it is a minor consent case, the original should be sent to the minor and a copy should be sent to the minor's parent(s) or legal guardian. In minor consent cases, only the minor shall receive the NOABD. The minor's parent/guardian shall not receive a copy or be otherwise notified of the adverse benefit determination.

Monitoring the Beneficiary Grievance and Appeal Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and experience of beneficiaries, monitors feedback from the grievance/appeal process to identify potential deficiencies and take actions for continuous improvement. Data is collected, analyzed and shared with the County of San Diego Behavioral Health Services system of care and stakeholders through system-wide meetings and councils.

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Issue Resolution

At times a provider may disagree with Optum regarding a clinical or administrative issue. Providers are encouraged to communicate any issues or concerns regarding clinical decisions or claims and billing procedures to Optum. Optum is committed to responding in an objective and timely manner. Optum will attempt to resolve the issue informally through direct discussion with the provider. However, if the problem is not resolved to the satisfaction of the provider, a formal appeal process is available.

All provider problem resolution and appeals processing are governed by Title 9, Chapter 11, Section 1850.305. Providers may contact Provider Services at (800) 798-2254, option 7, for any questions regarding the timelines or regulation of the process.

Provider Appeals Process

Providers who wish to pursue an appeals process regarding authorization for reimbursement of services, or processing and payment of claims, have the right to access the provider appeals process at any time.

A provider may appeal a denied or modified request for payment authorization. The written appeal shall be submitted to Optum within ninety (90) calendar days of the date of receipt of the non-approval of payment notification.

Providers are asked to submit a letter of appeal along with any relevant documents that support medical necessity of the services requested. Appeal requests must be sent to the following address:

Optum Public Sector San Diego
Attn: Appeals
P.O. Box 601340
San Diego, CA 92160-1340

A psychiatrist who was not involved in the initial denial or modification of a payment authorization request shall determine the appeal decision.

Optum shall have sixty (60) calendar days from receipt of the written appeal to inform the provider in writing of the decision.

Claims and Billing Issues

Clean claims will be processed within thirty (30) days of receipt of the claim. Processing means paid or denied. In the event of a denial, providers may appeal the decision by contacting the Claims Provider Service Representative at (800) 798-2254, option 2. The Claims Provider Services Representative will forward the information to the Senior Claims Examiner who will assist the provider in resolving the appeal informally. The provider may be asked to submit written documentation justifying the request to overturn the denial.

Should the outcome of the informal problem resolution process result in a decision that the provider feels is not satisfactory, the provider may submit a claims appeal in writing with supporting documentation to:

Optum Public Sector San Diego
Attn: Claims Provider Services
P.O. Box 601340
San Diego, CA 92160-1340

Acknowledgment of written appeals will be mailed to providers within two (2) business days of receipt. Providers are asked to make sure to have the client’s name, Medi-Cal BIC number, date(s) of service and authorization number with supporting documentation available when calling. A written response will be sent to the provider within thirty (30) days of receipt of the claims appeal.

Provider Complaints about Administrative and Contract Issues

Provider complaints about Optum administrative procedures, referral authorizations, forms, response or lack of response by an Optum employee, as well as other general questions and concerns about policies and procedures, can be discussed with any Optum staff person with whom the provider comes in contact. Optum documents the content of the complaint and is obligated to come to a resolution within thirty (30) days of receiving the complaint. The participation of providers in this process is viewed as a reflection of the providers' genuine commitment to improve the quality of care and service. Providers are protected from any form of retaliation, because of complaints about denied authorizations or claims. Optum tracks and trends the data gathered from complaints and appeals and uses this information to focus quality improvement initiatives.

Providers may present complaints, issues, or concerns to Optum by contacting the Provider Line at (800) 798-2254, option 7, or by calling the BHS Quality Management Department at (619) 563-2700.