San Mateo County Health System
Behavioral Health & Recovery Services

MENTAL HEALTH PLAN

OUTPATIENT PROVIDER MANUAL
For Individual and Agency Providers

Revised January 2013

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WELCOME

New and Returning Outpatient Providers

Welcome to the San Mateo County Health System, Behavioral Health and Recovery Services Division. We are delighted that you have chosen to join our team, and look forward to working together to help our clients and their families.

This manual will help you understand our Mental Health Plan and the context in which we operate. While these are challenging times, as stewards of precious public resources the imperative and opportunity has never been greater for us to offer the best practices for efficient and effective treatment in our field. We have a strong tradition of being both a teaching and a learning organization and that positions us well to keep pace with our changing field and environment. We see that understanding, respecting, and listening to our clients' and families' cultures and communities is a part of that continuous learning process. We welcome and value the differences among our partners; this diversity strengthens our capacity to provide effective services for San Mateo County's diverse population.

We appreciate your thoughts, suggestions, and participation; you can contact me at any time.

Brad Johnson, Provider Relations Coordinator
Behavioral Health and Recovery Services
brjohnson@smcgov.org
650-573-2893

A. INTRODUCTION

In April 1995, under a federal waiver, San Mateo County Behavioral Health and Recovery Services (BHRS) became the Mental Health Plan (MHP) charged with managing consolidated inpatient and outpatient mental health services for all county Medi-Cal beneficiaries. Subsequently, based on the success of the original pilot, BHRS assumed management of the dollars spent on psychiatric medications and any related laboratory costs. In addition, BHRS is responsible for authorizing services for eligible consumers with a variety of other insurance coverage including Care Advantage, HealthWorx, enrollees of the Medicaid Coverage Expansion (MCE) Program, and other health related services for children and families such as the new Targeted Low-Income Children's Program.

Outpatient managed mental health services should be viewed, along with inpatient and other system of care services, as components in a total continuum of care for mentally ill adults and emotionally disturbed children and youth. This manual describes the paired responsibilities of contracted outpatient providers and the MHP. It mandates a collaborative partnership in which family/client and all service providers, county and contractor, work together to achieve desired outcomes in a cost-effective, efficient manner.

B. VALUES

The county Mental Health Plan is guided by clearly stated principles, which direct implementation activities at all levels of client service. For outpatient services, the following are especially relevant:

1. Emphasis is on serving adults with serious and persistent mental illness and youth with serious emotional disturbances through a comprehensive, community-based, coordinated system of care.

2. For less serious, enduring conditions, the emphasis is on problem-focused treatment at all levels of service.

3. Services will be flexible, client and family-centered, recovery-based and culturally competent. Within the spectrum of outpatient services, there will be sufficient levels of language and cultural skills to serve the beneficiaries of the county.

4. Services will provide, to the greatest extent that is appropriate, opportunities for consumer/family preferences and choice. In order for services to be truly consumer driven and family focused, there must be consumer/family involvement in the planning and delivery of services.

5. The system will be "user friendly" with easy access for eligible consumers, a single point of responsibility for service delivery and sufficient coordination and linkage with the Health Plan of San Mateo (HPSM) that the system appears "seamless" from the consumers' point of view.

6. The system will be accountable for defined outcomes as a way of measuring effectiveness and efficiency.

7. The system will be responsive to the consumer through measurement of consumer satisfaction and a process for dealing with consumer grievances.

C. HIPAA OVERVIEW

The Health Insurance Portability and Accountability Act (HIPAA) established new requirements of health providers effective April 14, 2003. HIPAA provisions fall into three categories: protection of privacy, administrative simplification and security. HIPAA standards require that a Notice of Privacy Practices be given to every client that addresses the following issues:

- Access to medical records;
- Amendments to medical records;
- Restrictions on the use of protected health information;
- Access to an accounting of disclosures;
- Confidential communications; and
- The right to complaint about violations of privacy.

The requirements specify how health information about individuals may be used and disclosed and what rights individuals have regarding access to this information. It is essential that in your practice you develop, communicate and utilize forms, policies and procedures that are in compliance with HIPAA. We recommend that you take a HIPAA training at least every two years.

The **HIPAA for BHRS Mental Health** e-learning course is available free on the county Health System internet site http://smchealth.org. You may obtain 2 free CEUs by completing the post test. Directions are given in Resource Document 3, BHRS Internet Resources on page 20. (This training meets the requirement for 2 Law & Ethics CEUs.) To summarize, follow this path from the website → Providers → Behavioral Health Providers → Training & Workforce Development → Trainings → Online Trainings → BHRS Confidentiality & HIPAA for Mental Health & AOD.

D. DESCRIPTION OF THE BENEFICIARY

The primary beneficiary of this consolidated outpatient MHP is defined as "a person certified as eligible for Medi-Cal" in San Mateo County. Additionally, the MHP may refer beneficiaries with other insurance coverage (described in first paragraph of the Introduction on page 4) as well as uninsured clients for whom the MHP has assumed treatment responsibility.

E. DESCRIPTION OF THE BENEFIT

All beneficiaries of the MHP are eligible for an assessment to determine medical necessity for mental health services. (See Resource Document 4a, Medical Necessity for Specialty Mental Health Services on page 21 of this manual.)

The initial or subsequent assessment may find:

- medical necessity for some level of behavioral health service, or
- no medical necessity for additional behavioral health services, in which case the beneficiary may be discharged from the assessment service after:
    - referral to other county or community social welfare, protective or health agencies, and/or
    - education about the immediate non-mental health situation.

When medical necessity for some level of behavioral health service is found, benefits are limited to appropriate services and specified terms of authorization.

F. OUTPATIENT PROVIDER NETWORK

The MHP has assumed the responsibility for ensuring the provision of medically necessary outpatient behavioral health services to beneficiaries through the establishment of an outpatient

provider network. All outpatient services must be provided in a manner that is cost-effective, while maintaining and improving clinical quality, geographic access, and cultural competency. Network outpatient services must be provided in coordination with any acute services, other county behavioral health services, and physical health care services the beneficiary may require.

G. TREATMENT AUTHORIZATION

1. **Standards**
    - Requests for emergency services should be referred to Psychiatric Emergency Services (PES) at 650-573-2662.
    - All <u>planned</u> services to beneficiaries **MUST BE PRE-AUTHORIZED** by the MHP.
    - **Services provided to beneficiaries without authorization will not be reimbursed.**
    - The MHP reserves the final right of assignment of the beneficiary to a service provider. Client choice, past history of treatment, and ability to meet special needs will be important factors in this decision.

2. **Initial Authorization**
    a. Requests for pre-authorization of services for beneficiaries will be handled through the MHP's ACCESS Call Center at 1-800-686-0101, during normal working hours.
    Exception
    Youth entering the mental health system through collaborative programs as indicated in individual agency contracts.
    b. The MHP is an open access system. Requests may originate with a community agency, a primary care physician, a specialty mental health provider or with the beneficiary/family.
    c. Referrals may require a face-to-face assessment by a clinician specializing in adult or youth services.
    d. Services will be authorized in numbers of visits and calendar months based on the assessed needs of the specific client. Within this authorization limit, **providers may determine the frequency and scheduling of services as clinically appropriate.**
    e. When a referral is made to a contract provider, the ACCESS Team will consider whether:
        - the client is requesting a specific provider;
        - the client is referred by a specific provider;
        - the client is unknown to the contract provider network and should be referred to a provider from the contract list; and/or
        - special linguistic, cultural, or other service needs are present.

    f. The authorization period ends when the allowed visits have been expended or the authorization period expires, whichever comes first. No allowed visits will carry over into another authorization period. **Services which continue past the expiration of the conditions of authorization will not be reimbursed.**
    g. The **Provider Closing Summary** should be completed and returned to ACCESS under the following circumstances: a) brief treatment is concluded with a client, or b) longer term treatment is concluded with a client. If no services were provided within an authorization period, the provider should inform the Call Center by telephone.
    h. No-show Reimbursement. The MHP will generally reimburse for two (2) no-shows (at a rate indicated in the provider's contract) within the <u>initial authorization period</u> A no-show

is defined as a client failing to appear for the scheduled appointment without cancellation within 24 hours of the appointed time in which there is documentation by the provider at the time of the occurrence that can be evidenced in the client's chart for retrospective review.

3. **Reauthorization**
   - When the provider feels that additional services are medically necessary, that request must be made to the ACCESS Team or as otherwise indicated by the MHP.
   - Reauthorization for planned services must be requested a minimum of 10 working days prior to the expiration of authorized services.
   - Reauthorization for treatment beyond the initial number of sessions must be requested using the reauthorization forms provided by the ACCESS Team or by providing the necessary client/treatment information by telephone to the ACCESS Team.
   - Reauthorization requests for children and youth who are under 18 years of age should be made on the **Youth Medi-Cal Managed Care Re-Authorization Request** form. For clients 18 years of age and older, the **Adult/Older Medi-Cal Managed Care Adult Re-Authorization** form should be used to request continued treatment authorization.
   - In consultation with the provider, the MHP may obtain a second opinion with regard to the client's ongoing care.

A. PRIMARY CARE PHYSICIAN REQUESTS

A Primary Care Physician (PCP) may request a consultation with a MHP provider, in order to provide optimum care to a member. The PCP must contact the ACCESS Team and together a decision will be made about the most appropriate consultative resource.

B. MENTAL HEALTH PLAN (MHP) RESPONSIBILITIES

1. To provide a 24-hour toll-free telephone line for information and referrals: ACCESS Call Center, 1-800-686-0101.

   <u>**Standards**</u>
   - **All callers will have the opportunity to speak to a clinician whenever possible after the call is registered.**
   - **Callers in evident emergency situations will speak with a clinician immediately.**
   - **Callers with urgent situations will speak with a clinician within 30 minutes.**
   - **Callers with non-urgent conditions will have calls returned by an ACCESS Team clinician the same day.**
   - **Callers will have the option of transfer of the phone call to PES for immediate consultation.**

2. To assess all beneficiaries for need and eligibility who request or are referred for outpatient services. Assessments may be via telephone or face-to-face.

<u>Standard</u>
Face-to-face assessments will be scheduled within five working days of the ACCESS Team determination that this level of assessment is necessary.

3. To maintain written communication with beneficiaries, contract providers, and referring sources so that an unbroken feedback loop concerning service need and clients' rights is established.

   <u>Standards</u>
   - **Confirmation of authorization will be telephoned to contract providers within 24 hours of determination of need for services.**
   - **Written confirmation of authorization will be sent to the beneficiary and contract provider within one week of determination of need for services.**
   - **When psychiatric consultation is provided by the ACCESS Team or other county-provided mental health services, the PCP or other referring clinician will receive a telephone call and/or written feedback within one week of the consultative session.**
   - **Beneficiaries and providers requesting reauthorization of services will be informed in writing when no need for further services is determined.**

C. CONTRACT PROVIDER RESPONSIBILITY

1. To inform all inquiring beneficiaries of the requirement for ACCESS Team assessment and authorization prior to beginning a course of treatment.

2. To assist those beneficiaries with the process of communication with the ACCESS Team at the ACCESS Call Center at 1-800-686-0101.

3. To provide the MHP (via the ACCESS Team) with all requested information in order to expedite requests for reauthorization of services.

4. When providing an authorized consultation for a PCP, to communicate the findings back to that PCP within one week of that session.

5. To notify the MHP, by calling Provider Relations, 650-573-2893, of the provider's temporary inability to accept new clients. This suspension of referrals will exist until the provider notifies the MHP that new referrals will be accepted.

6. To provide only those services to beneficiaries that are specified and authorized by the ACCESS Team. Authorized services may include, but are not limited to, assessment, medication support, psychological assessment/testing, mental health counseling, and individual and/or group therapeutic services.

7. To schedule an initial visit with an authorized client **<u>within five working days of the client's request for an appointment</u>**. Providers who are temporarily unable to meet this standard

due to vacations, filled schedules, etc., must notify the ACCESS Call Center at 1-800-686-0101 to be placed on an inactive list. It is the provider's responsibility to notify the Call Center again when they resume the ability to accept new clients.

8. To request informal consultation with Adult Resource Management (650-372-3210) or Youth Case Management (650-573.3504) around a potential planned admission of a beneficiary into an inpatient hospital.

9. To provide services to beneficiaries in accordance with legal and ethical standards as proscribed by all relevant professional, federal, state, and/or local regulatory and statutory requirements.

10. Scope of Practice:
    a. Individual providers must be Licensed Practitioners of the Healing Arts (LPHA). This includes an MD, DO, LCSW, MFT, licensed Psychologist and Registered Nurse with a Master's Degree in Psychiatric/Mental Health.
    b. Agency providers must be any of the above LPHAs, or a registered or waivered professional. Registered or waivered staff are clinicians who are post-graduate Marriage & Family (MFTI) or Social Work (ASW) interns who are registered with the Board of Behavioral Sciences, or post-graduate psychologists who are waivered by the California Department of Health Care Services (DHCS) through request of the MHP.

11. To maintain clinical records according to San Mateo County Behavioral Health Services standards. Records must be legible and kept in detail consistent with appropriate medical and professional practice in order to:
    - permit effective internal professional review and external medical audit process; and
    - facilitate an adequate system for follow-up of treatment.

    The provider must maintain clinical records for at least seven years from the last date of service to the beneficiary, except for minors, whose records shall be kept at least one year after the minor has reached the age of 18, but in no case less than seven years. The provider must make the books and records which pertain to the services provided to beneficiaries under the contract provisions of the MHP, available for inspection, examination or copying:
    - by the MHP, the State Department of Health Care Services, and the United States Department of Health and Human Services;
    - at all reasonable times at the provider's place of business or at another mutually agreeable location; and
    - in a form maintained in accordance with the general standards applicable to such record keeping.

12. To comply with County policies and procedures relating to beneficiary's rights and responsibilities. Policies and brochures are available on the county Health System internet site http://smchealth.org. Directions are given in Resource Document 3, page 20 of this manual or, to summarize, follow this path from the website: → For Providers → Behavioral

Health Providers → Managed Care Providers → Forms → Online Trainings → BHRS Confidentiality & HIPAA for Mental Health & AOD.

- Display patients' rights posters and Consumer Rights and Problem Resolution brochures, available from the BHRS Office of Consumer and Family Affairs at 1-800-388-5189.
- Material about advance healthcare directives and lists of MHP providers are available upon request from The ACCESS Call Center 1-800-686-0101.

13. To offer equal availability and accessibility of service. Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

K. PROVIDER BULLETINS and ADMINISTRATIVE LETTERS

Provider Bulletins or Administrative Letters will be mailed in a timely manner to contract providers, to inform them of policy, administrative or financial changes. All changes to the MHP manuals that are noticed in bulletins or letters have the authority of policy and are binding, as indicated, to county and providers.

The following information, relevant to outpatient providers, was included in previously distributed bulletins. (All code and rate changes have been included in current contract exhibits.)

Insurance/Medi-Cal Clients

- The MHP has the responsibility to reimburse providers for Medi-Cal eligible services that were denied by insurance companies on the basis that those particular services were **<u>not eligible</u>** for reimbursement by the insurer.
- The MHP will not reimburse for covered services that were improperly submitted to insurance carriers.
- Requests to the MHP for reimbursement must include evidence of submission to and denial of services by the primary insurance carrier.

Medicare/Medi-Cal Crossover Claims

- The MHP must be billed for the Medi-Cal eligible portion of claims. There is no automatic tape-to-tape transmission of the denied portion of a claim.
- A complete EOB from Medicare must be submitted with claims, so that the MHP can understand the reasons for denial or reduction of the claim to Medicare. Claims missing the Medicare EOB will be pended and returned to the provider for clarification. Medicare Crossover Claims must be submitted within 180 days of the Medicare EOB issue date.

Share of Cost

- Individuals on a monthly Medi-Cal share of cost will not be referred to the outpatient provider network, but will be served, where appropriate, within county-managed resources.
- Share of cost clients in existing treatment relationships within the outpatient provider network will be able to continue so long as clients and providers are in agreement about their mutual financial responsibilities and liabilities. The MHP is not responsible for helping to meet the share of cost obligation.

Mental Health Diagnosis Coding

Mental health diagnoses should be reported using ICD-9 coding. (DSM IVR nomenclature remains acceptable.)

Services by "Covering" Provider

Providers "covering" for authorized providers must have a standard contract with the Mental Health Plan. Once a contract is in place, the covering provider must call the ACCESS Call Center (1-800-686-0101) for <u>their own authorization</u> of services prior to submitting a claim. Without such authorization, claims submitted will be pended and, in some cases, ultimately could be denied.

Telephone Consultation

The MHP recognizes that quality assessment and treatment of clients often requires considerable clinical consultation by telephone with other caregivers. Telephone consultations are reimbursed for both psychologists and psychiatrists <u>when provided under the following specific circumstances</u>:

- Unit of reimbursable time is 15 minutes
- Consultation must be <u>between the provider and another caregiver</u>
- Every claimed consultation service must be charted, giving the date, name of the caregiver, the purpose of the call, and relevant information received.
- "Caregiver" refers to such providers as:
  - Other MHP providers; inpatient providers
  - Primary Care providers
  - Social Services or Aging and Adult Services providers
  - Probation, Parole, or other legal system providers
  - Educational providers (for youth)
  - Developmental Disability or other disability caregiver
  - Operators of licensed residential care facilities (for adults)
  - Substance abuse treatment providers
- Telephone communication **<u>is not reimbursable</u>** in the following circumstances:
  - Communication with parents or other family members
  - Calls to pharmacies
  - Calls to/from clients
  - Communication with ACCESS Team or other MHP clinical staff
  - Communication with Provider Relations staff
- Four (4) telephone consultations will generally be included by the MHP in the initial treatment authorization. Subsequent telephone consultation authorizations will be determined as needed on a case-by-case basis.

- Consultation services exceeding the allowed number must be specifically authorized.
- If two MHP providers consult about a mutual case, each may claim a consultation service.

Consent to Medications

For psychiatrists, evidence of informed consent to medications must appear in the mental health chart. The preferred method is to have a specific medication(s) consent form signed by the client/parent/guardian at the onset of treatment and whenever significant changes in types of medications occur. The attached consent to medications form may be freely used, copied, or adapted to meet your needs.

Medication Prescriptions and Associated Laboratory Services

The MHP is responsible for managing psychiatric medications and associated laboratory services for our clients. Please refer questions about authorizations, formulary, etc., to Dr. Barbara Liang at (650) 599-1061. The benefit pertains to psychiatric medications, written by a psychiatrist, for an MHP beneficiary. (Physical health care medications are the responsibility of the HPSM.)

L. QUALITY MANAGEMENT

1. **THE MHP Quality Management has the responsibility of assuring that high quality services are provided to the beneficiary in a safe, cost-effective and efficient manner.** (See BHRS Policy No. 98-11, Quality Improvement Compliance Review of Outpatient Provider Services, attached.) The Quality Management Team reviews services and programs of public and private providers in order to ensure:
   - accessibility;
   - services that are meaningful and beneficial to the client;
   - services that are culturally and linguistically competent;
   - services that produce highly desirable results through the efficient use of resources;
   - services meet requirements of the Medi-Cal program for medical necessity and other documentation requirements.

2. **Training**

   BHRS will provide training in medical necessity criteria, patients' rights issues, and other quality components referenced in this manual upon request.

   Online trainings in many of these areas, most with free CEUs, are available through the County Health Services website. To explore the selection of online trainings, please follow these steps.
   - Go to the San Mateo County Health System homepage at http://smchealth.org
   - Navigate to the For Providers header
   - Hover over Behavioral Health Providers
   - Select Training and Workforce Development.
   - Scroll to Trainings
   - Select Online Trainings
   - Scroll down to select the training of your choice

Information is also provided in BHRS Internet Resources, Resource Document 3, on page 20 of this manual.

Additionally, all providers are eligible to attend bi-monthly Grand Rounds offered through the BHRS Residency Training Program. Free CEUs are available; the schedule is posted in the BHRS Newsletter "Wellness Matters" at www.smchealth.org/wm.

3. **Monitoring and Evaluation**
The MHP Quality Management will monitor beneficiaries' satisfaction with services they are receiving from providers. BHRS management staff will evaluate contract performance based on agreed upon measurable objectives.

If the MHP staff, Grievance Review staff or any other committee of the MHP makes a finding that a provider may be deficient in rendering or managing care, or if other problem areas are discovered, procedures outlined in BHRS Policy 98-10, Concerns/Complaints About MHP Contract Providers (attached), will be initiated.

If these deficiencies or problem areas are verified, corrective sanctions may be applied. These sanctions may include mandatory review of all claims, periodic review of medical records, or termination of the provider's contract with the MHP.

M. CLIENT PROBLEM RESOLUTION & PROVIDER COMPLAINT & APPEAL SYSTEM

The MHP has established a formal beneficiary problem resolution process. It includes preparation and distribution of materials concerning client rights and how clients can initiate grievances and appeals. It also will provide ongoing outreach to inform and educate clients and their families about how they can participate in that process. It includes mechanisms to monitor and take action as warranted to resolve disputes between beneficiaries and providers, and observes defined time lines and legal parameters to assure fair and equal treatment for all. Within the problem resolution process is a provider appeal module to address appeals brought by providers.

The problem resolution process is a responsibility of the MHP Quality Management, and includes a designated Provider Relations/Community Program Specialist, Grievance Coordinator, and the Consumer Affairs Coordinator (responsible for assisting clients and their families to resolve problems).

A Beneficiary Protection Manual has been written to detail the process and procedures involved when beneficiaries are not satisfied with their benefits. That manual should be viewed as a collateral reference to this Outpatient Provider Manual. Consumers may call the MHP Office of Consumer and Family Affairs-800-388-5189, for assistance in resolving problems.

The Provider Complaint and Appeal Procedure is included herein as a resource document to this manual.

N. PAYMENT POLICIES AND PROCEDURES

1. **Payment Policies (see Appendix 10 for detail)**
   - Payment will be authorized for valid claims for outpatient mental health services if:
   - the services were preauthorized by the MHP ACCESS Team; and
   - the services were delivered by a contract provider, and were within the range of pre-selected service codes allowed by scope of practice and contract agreements.

   The service authorization does not guarantee Medi-Cal eligibility; it is the provider's responsibility to assure that services are provided to eligible beneficiaries. Provider may call the MHP Provider Relations Specialist at (650) 573-2226 to assist in verification of eligibility.

2. **Payment Procedures**

   Remit payment requests using HCFA 1500 forms to:

   San Mateo County Health System
   Behavioral Health & Recovery Services
   Attention: Provider Billing/MIS
   225 37th Avenue
   San Mateo, California 94403

Financial agreements between county and individual providers including, but not limited to, rates, exclusions, and coordination of benefits will be written in agreements with independent contractors and are not affected by material presented in this manual.

San Mateo County
Mental Health Managed Care Plan

CONTACT INFORMATION

PROVIDER RELATIONS		
BRAD JOHNSON - Coordinator	PHONE	650-573-2893
To Join Network, Provider Contracts, Program Inquiries	FAX	650-573-2841
(BrJohnson@smcgov.org)		
PROVIDER BILLING		
Claims or billing inquiries:		
ELVIRA GOMEZ, *(EGomez@smcgov.org)*	PHONE	650-573-2068, or
ANALIZA SALISE, *(ASalise@smcgov.org)*	PHONE	650-573-2442
BHRS ACCESS UNIT	PHONE	1-800-686-0101
CARLOS MORALES, LCSW	PHONE	650-573-2037
Entry to Care Manager, (CMorales@smcgov.org)		
ELISEO AMEZCUA, MA	PHONE	650-573-3500
Supervisor ACCESS Call Center, (Eamezcua@smcgov.org)		
LYNDA FRATTAROLI, EdD, LCSW - *Unit Chief*	PHONE	650-573-2276
ACCESS Assessment & Treatment Unit (LFrattaroli@smcgov.org)		
PSYCHIATRIC EMERGENCY SERVICES	PHONE	650-573-2662
	FAX	650-573-2489
ADULT RESOURCE MANAGEMENT	PHONE	650-573-3571
	FAX	650-572-9347
YOUTH CASE MANAGEMENT	PHONE	650-573-3504
	FAX	650-349-0476
OFFICE OF CONSUMER & FAMILY AFFAIRS	PHONE	1-800-388-5189
LINFORD GAYLE - Director	PHONE	650-573-2534
(LGayle@smcgov.org)	FAX	650-573-2934
QUALITY MANAGEMENT		
GARY BALESTIN, PhD, LMFT, ABN	PHONE	650-573-2079
Re-Authorizations, (GBalestin@smcgov.org)	FAX	650-349-0771
KEITH CLAUSEN, PhD - QM Manager	PHONE	650-573-2331
(KClausen@smcgov.org)	FAX	650-573-2841
JEANNINE MEALEY, LMFT - QM Unit Chief	PHONE	650-573-3659
(JMealey@smcgov.org)	FAX	650-573-2841

BILLING ADDRESS
San Mateo County Health System
BHRS Attention: Provider Billing/MIS
225 37th Avenue
San Mateo, California 94403

San Mateo County
Mental Health Managed Care Plan

CPT CODE DESCRIPTIONS

There is no need to include "Add On Codes" as our system will map to them on the back end.

Major changes to Current Procedural Terminology (CPT) codes for psychiatry and psychotherapy services went into effect on January 1, 2013. Please note:

- **Changes to the CPT code sets are made by the American Medical Association (AMA) on an annual basis, but this year will have a much higher-than-usual impact on psychiatry and psychotherapy services.**
- **Several commonly used psychiatric CPT codes have been deleted or modified.**
- **In most cases, the current CPT code will simply be replaced with a new five digit Evaluation and Management (E&M) Code.**
- **There is absolutely no change to rates of service.**
- **Over the next two months we will be working to re-program our billing and claims system (AVATAR) to accept the new codes as well as amending each of the our provider network contracts (by executive letter).**
- **Please be on the look out for your amended contract detailing the exact CPT code changes.**

The new codes are listed here (the previous code in parentheses) and a brief description.

For LCSWs, MFTs and PhDs:

90791 Assessment (90801) Assessment services include clinical analysis of the history and current status of the client's mental, emotional or behavioral condition.

90832 (40 min) Individual Therapy (90804) Individual Therapy services are those therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments. Individual Therapy is usually delivered to an individual but may include family or significant support persons when the individual is present, but the focus of work is on the client and not the family system.

90834 (60 min) Individual Therapy (90806) Individual Therapy services are those therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments. Individual Therapy is usually delivered to an individual but may include family or significant support persons when the individual is present, but the focus of work is on the client and not the family system.

For MDs and Dos:

90791 (no medical services) and 90792 (with medical services) Assessment (90801) Assessment services include clinical analysis of the history and current status of the client's mental, emotional or behavioral condition.

99213 (20-30 minutes) Outpatient Psychotherapy with E&M (90805)

90834 (45-50 minutes) Outpatient Psychotherapy (90806)

99214 (45-50 minutes) Outpatient Psychotherapy with E&M (90807)

90837 (75-80 minutes) Outpatient Psychotherapy (90808)

99215 (75-80 minutes) Outpatient Psychotherapy with E&M (90809)

90832 (20-30 minutes) Inpatient Psychotherapy (90816)

90232 (20-30 minutes) Inpatient Psychotherapy with E & M (90816)

90834 (45-50 minutes) Inpatient Psychotherapy (90818)

99233 (45-50 minutes) Inpatient Psychotherapy with E & M (90819)

90837 (75-80 minutes) Inpatient Psychotherapy (90821)

99212 Pharmacologic Management (90862) Medication support services shall consist of at least one (1) face-to-face visit conducted by a licensed physician (psychiatrist) for the purpose of prescribing, administering, dispensing and monitoring of psychiatric medications, or biologicals, necessary to alleviate the symptoms of mental illness. Medication group services may be provided by a MD or RN and can include such topics as (but are not limited to): medication education and symptom management.

BHRS continues to accept these CPT Codes using their original number and definition.

90847 Family Therapy: Family Therapy consists of contact with the client and one or more family members and/or significant support persons. Services shall focus on the care and management of the client's mental health conditions within the family system.

90853 Group Therapy: Group Therapy consists of therapy in the presence of a therapist in which several patients discuss and share their personal problems. Services shall focus on the care and management of the client's mental health conditions within a group setting.

90887 Collateral Services: Collateral Services consists of contact with one or more family members and/or significant support persons (when the client is not present) which may include consultation and training to assist in better utilization of services and understanding mental

illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the client's condition and involving them in service planning and implementation of service plan(s).

99205 Medication Assessment Service: A medication assessment shall consist of at least one (1) face-to-face visit conducted by a licensed physician (psychiatrist).

N0000 No Show: Failure of client to appear for or cancel an appointment within 24 hours of the scheduled time, documented in chart at time of appointment, verifiable in retrospective audit. Limit 2 per client within the first authorization period.

X8255 Phone Conversation: 15 minute clinical consultation (telephone).

Here for You 24/7

BHRS Internet Resources

http://smchealth.org

This website, designed for BHRS staff members, contract providers & agencies, clients, families and the public is available to anyone with web access. We hope you add it to your online "Favorites".

When you go to the San Mateo County Health System homepage **http://smchealth.org,** navigate to the ***For Providers*** header, then hover over ***Behavioral Health Providers*** to see, hover and select an area of interest.

When you select **Managed Care Providers** you will find

- ► The first resource is this Manual - click to open the Managed Care Provider Manual.
- ► The second resource is Forms - click to open the Adult or Youth Re-Authorization Requests, or any of the other forms you need.
- ► Most of the Appendices to this manual are listed as forms, freestanding making them easier to save and/or print.

When you select **Training & Workforce Development** you can

- ► scroll down to Trainings
- ► select Online Trainings
- ► scroll down to find several online training options

  The most relevant for individual outpatient providers are

  - BHRS Confidentiality & HIPAA for Mental Health & AOD
  - Basic Documentation Training for Non-Avatar Users

  You might also be interested in

  - Critical Incident Management & Mandated Reports Training for BHRS
  - 5150 Certification Training

<u>Medical Necessity Criteria for Specialty Mental Health Services</u>

California Code of Regulations Title 9. Division 1—Department of Mental Health 1830.205

To be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, clients must meet <u>all 3 criteria</u> (diagnostic, impairment, & intervention related)

A. DIAGNOSTIC CRITERIA **Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:**

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

B. IMPAIRMENT CRITERIA **Must have** one of the following **as a result of the mental disorder(s) identified in the diagnostic (A) criteria; must have one, either 1, 2, or 3:**

1. A significant impairment in an important area of life functioning, <u>or</u>
2. A probability of significant deterioration in an important area of life functioning, <u>or</u>
3. Children also qualify if there is a probability the child will not progress developmentally as individual appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

C. INTERVENTION RELATED CRITERIA **Must have** all, 1, 2, and 3 below**:**

1. The focus of the proposed intervention is to address the condition identified in impairment criteria “B” above, <u>and</u>

2. It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare-based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance abuse component. The intervention must be consistent with, and necessary to, the attainment of the specialty MH treatment goals.

EXCLUDED DIAGNOSES

- Mental Retardation
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical condition
- Substance-Related Disorders
- Sexual Disorders
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions that May Be a Focus of Clinical Attention

A consumer may receive services for an included diagnosis when an excluded diagnosis is also present.

 San Mateo County Behavioral Health and Recovery Services

Criteria for Entry to Child/Youth Services

This document describes the diagnostic, level of impairment, focus of intervention, and risk factors that are taken into consideration by San Mateo County BHRS clinicians when determining whether behavioral health services, provided within the Division or by its subcontractors, are appropriate for and should be made available to a child or youth. The criteria vary for different insurance categories due to limited resources within public behavioral health and its primary role as a mental health plan for Medi-Cal beneficiaries and as a safety net for those who have no resources. These criteria are not meant to replace individual clinical judgment, which always guides decisions about entry to the behavioral health system. Cases that do not meet these criteria but appear to present overriding clinical concerns should be reviewed with the Medical Director and the Deputy Director of Child and Youth Services to determine appropriate disposition.

Eligible Categories of Children/Youth

- Children/Youth with Medi-Cal, Healthy Families or Healthy Kids insurance who meet State-defined medical necessity criteria for specialty mental health services, including services to child/youth with SED.
- San Mateo County wards and dependents.
- Child/Youth determined to be 26.5 eligible.
- Child/Youth in psychiatric crisis (generally eligible for services).

The following information summarizes factors that must be taken into consideration when determining an individual's eligibility for County Behavioral Health Services. The same material is then presented in greater detail and specificity in grid form (Resource Document 3c).

- Included Diagnosis, typically one or more of the following:

    - Pervasive Developmental Disorder (except Autistic Disorder)
    - Attention Deficit and Disruptive Behavior Disorders
    - Schizophrenia and other Psychotic Disorders
    - Mood Disorders
    - Anxiety Disorders
    - Eating Disorders
    - Impulse-control Disorders not classified elsewhere
    - Adjustment Disorders
    - Personality Disorders, excluding Antisocial Personality Disorder
    - Other Disorders of Infancy, Childhood or Adolescence

- Current Degree of Impairment (at least one of the following)

    - Either a significant impairment in an important area of life functioning, or

  - A probability of significant deterioration in an important area of life functioning, <u>or</u>
  - There is a probability that the child will not progress developmentally as individually appropriate.

- Degree of risk as demonstrated by at least one of the following factors:

  - Significant risk of out of home placement (including inpatient) or failed school placement.
  - Past/present psychiatric emergency visits and hospitalizations that indicate a high probability of current risk, unrelated to substance abuse, medical conditions, or cognitive impairment.
  - Significant degree of current risk for self-injurious behavior or injury to others as a result of an included diagnosis, as demonstrated by:
    - Recent serious thoughts off harming self/others, or
    - Recent significant injurious behaviors.

Must meet both Diagnostic **and** Intervention Focus **criteria below and at least one of either** Impairment **or** Risk **criteria.**		**Beneficiaries, Health Families, Healthy Kids**	**Residents of San Mateo County**	**of San Mateo County**
I DIAGNOSIS				
Diagnostic Criteria Services may be provided for an Included Diagnosis when an Excluded Diagnosis is also present. Medi-Cal list of included diagnoses): Typically one or more of the following diagnoses: • Pervasive Developmental Disorder (except Autism) • Attention Deficit and Disruptive Behavior Disorders • Schizophrenia and other Psychotic Disorders • Mood Disorders • Anxiety Disorders • Eating Disorders • Impulse Control disorders not classified elsewhere • Adjustment Disorders • Personality Disorders, excluding Antisocial • Other Disorders of Infancy, Childhood and Adolescence	Yes, but also must have Impairment or Risk and Intervention Focus (see following pages)	Yes, but also must have Impairment or Risk and Intervention Focus (see following pages)	Yes, if a ward or dependent is in custody or placement (children in foster care are Medi-Cal eligible) and there is Impairment or Risk and Intervention Focus. If a ward or dependent is no longer in custody or placement, services may be provided but will be specific and limited.	Yes, if a ward or dependent is in custody or placement and there is Impairment or Risk and Intervention Focus. If a ward or dependent is no longer in custody or placement, services meeting criteria may be continued with insurance billing approval.
II IMPAIRMENT				
Degree of Impairment: • Either a significant impairment in an important area of life functioning • **Or** a probability of significant deterioration in an important area of life functioning **Or** there is a probability the child will not progress developmentally as individually	Yes if accompanied by Diagnosis and Intervention Focus.	Yes if accompanied by Diagnosis and Intervention Focus. Under EPSDT, children qualify if they have a mental disorder that can be	Yes if accompanied by Diagnosis and Intervention Focus.	Yes if accompanied by Diagnosis and Intervention Focus.

III INTERVENTION FOCUS				
• The condition would not be responsive to physical health care based treatment. • The focus of the proposed intervention is to address the included diagnosis. • **And** there is an expectation that the proposed intervention will significantly diminish the impairment or prevent deterioration in a significant area of life functioning, or it is probable the child will be enabled to progress developmentally as individually appropriate.	Yes if accompanied by Diagnosis and Impairment or Risk.	Yes if accompanied by Diagnosis and Impairment or Risk.	Yes, if a ward or dependent is in custody or placement (children in foster care are Medi-Cal eligible) and accompanied by Diagnosis and Impairment or Risk. Yes, if previously a ward or dependent and accompanied by Diagnosis and Impairment or Risk.	Yes, if a ward or dependent is in custody or placement and accompanied by Diagnosis and Impairment or Risk. If a ward or dependent is no longer in custody or placement, services meeting criteria may be continued with insurance billing approval.
IV RISK				
• The condition would not be responsive to physical health care based treatment. • The focus of the proposed intervention is to address the included diagnosis. **And** there is an expectation that the proposed intervention will significantly diminish the impairment or prevent deterioration in a significant area of life functioning, or it is probable the child will be enabled to progress developmentally as individually appropriate.	Yes if accompanied by Diagnosis and Impairment or Risk.	Yes if accompanied by Diagnosis and Impairment or Risk.	Yes, if a ward or dependent is in custody or placement (children in foster care are Medi-Cal eligible) and accompanied by Diagnosis and Impairment or Risk. Yes, if previously a ward or dependent and accompanied by Diagnosis and Impairment or Risk.	Yes, if a ward or dependent is in custody or placement and accompanied by Diagnosis and Impairment or Risk. If a ward or dependent is no longer in custody or placement, services meeting criteria may be continued with insurance billing approval.
• Significant risk of out of home placement (including inpatient) or failed school placement • Past/present psychiatric	Yes if accompanied by Diagnosis and Intervention Focus.	Yes if accompanied by Diagnosis and Intervention Focus.	Yes, if a ward or dependent is in custody or placement (children in foster	Yes, if a ward or dependent is in custody or placement and accompanied by

• Significant degree of current risk for self-injurious behavior or injury to others as a result of Diagnosis I as demonstrated by: – Recent serious thoughts of harming self/others, or – Recent significant injurious behaviors.			Yes if previously a ward or dependent and accompanied by Diagnosis and Intervention Focus.	or placement, services meeting criteria may be continued with insurance billing approval.

- Specific services provided to eligible Child/Youth will be based on clinical assessment of appropriate level of care and in some cases may be only a brief intervention.

- Emergency psychiatric services are provided regardless of eligibility through the Psychiatric Emergency Services Department located at San Mateo County Medical Center but ongoing treatment will be provided only if above criteria are met for entry to mental health services.

- A Child/Youth may be served by a special, grant funded program that receives no Medi-Cal or county safety net funding, and may not meet these criteria but may have other specific, target population criteria.

- Behavioral Health can provide psychiatric consultation for some conditions including developmental disability, substance abuse, and medical conditions. Generally, individuals whose behavioral health conditions are secondary to medical conditions (such as cognitive impairment due to Mental Retardation or Autism) would not receive San Mateo County Behavioral Health services.

San Mateo County
Behavioral Health and Recovery Services

"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

Resource Document 5a

VERIFICATION OF CONSENT TO MEDICATION

Client Name ______________________________________ **MH Number** _________________________

This is to acknowledge that I have had a discussion with my/my child's physician, __________________M.D., concerning his/her prescription of the following checked medication(s,) some of which may not have U.S. FDA approval for the use(s) discussed.

We discussed side effects, some of which are listed below, for different medications. Not all known or potential side effects are listed. Please be also aware that you should not drive or use heavy machinery until you know how the medications below affect you.

☐ **Antipsychotic** ____

Some possible side effects: nausea, vomiting, dizziness, weight gain, increased blood sugar/lipids, diabetes, sedation, restlessness, tremor, stiff muscles, tardive dyskinesia (involuntary movements of the head, neck, arms,) seizures, sexual problems, neuroleptic malignant syndrome (rare medical emergency marked by high fever, rigidity, delerium, circulatory and respiratory collapse.) Increased risk of stroke and death in elderly patients with dementia. Additionally for Clozapine: seizures; lowered white blood cell count leading to infections; and, rarely, damage to the heart.

☐ **Antidepressant** ____

Some possible side effects: nausea, vomiting, appetite/weight changes, headaches, dizziness, sedation, sleep disturbances, dry mouth, sexual/erectile problems, seizures, abnormal internal bleeding.

Especially in youth: suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outbursts, hostility, violence.

☐ **Anti-Extrapyramidal (EPS) Medications** ____

Some possible side effects: dry mouth, blurred vision, tiredness, dizziness, mental dulling, constipation, trouble urinating.

☐ **Antianxiety/Hypnotic** ____

Some possible side effects: drowsiness, trouble concentrating, confusion, clumsiness, dizziness, weakness, decreased reflexes, difficulty driving, loss of inhibition. I understand that I/my child should avoid alcohol.

☐ **Mood Stabilizer** ____

Some possible side effects: nausea, vomiting, skin rash, weight gain, dizziness, confusion, tiredness, **birth defects**. Additionally for Depakote: liver/pancreas problems, ovarian problems; for Carbamazepine: lowered blood count leading to infections; for Trileptal: possible serious rash, potentially life-threatening. Mood stabilizers have also been associated with increases in suicidal thoughts and behaviors.

☐ **Lithium** ____

Some possible side effects: nausea, vomiting, diarrhea, tiredness, mental dulling, confusion, weight gain, thirst, increased urination, tremors, acne, thyroid disorder, birth defects.

☐ **ADHD Medications** ____

Some possible side effects: loss of appetite, decreased growth, trouble sleeping, restlessness, nausea, change in blood pressure/heartbeat.

Additionally for Strattera: rare liver injury with possible jaundice (yellow skin and eyes,) abdominal pain, itchy skin, flu, dark urine.Additionally for Adderall/Amphetamine salts: risk of sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities. Additionally for Concerta/methylphenidate: psychotic behavior including visual hallucinations, suicidal ideation, aggression or violent behavior.

☐ **Others** ____

Please read reverse side/next page acknowledgement and agreement and initial.

I understand that I have the right to refuse this/these medication(s) and that it/they cannot be administered to me/my child until I have spoken with my/my child's physician and have given my consent to treatment with this/these medications. I may seek further information at any time that I wish, and I may withdraw my consent to treatment with the above medication(s) at any time by stating my intention to my/my child's physician.

I have read and initialed the reverse side.

I certify with my signature that I have legal authority to sign this consent and that the relationship listed is valid and legal.

______________________________	______________________	______________________
Client/Parent or Guardian/Conservator Signatures	*Legal Relationship*	*Date*

______________________________	______________________	______________________
Youth Signature (Optional)	*Physician Signature*	*Date*

☐ ***Client concurs, but chooses NOT to sign***

Acknowledgement and Agreement

In our discussion, my/my child's physician and I also spoke about the following subjects:

1. The nature of my/my child's mental condition.

2. The reasons that my physician has for prescribing the above medication(s), including the likelihood of improving or of not improving without such medication(s), the risks of treatment, and risks of no treatment.

3. Any reasonable alternative treatment available for my/my child's condition.

4. The type of medications that I/my child will be receiving, the frequency and amounts of dosages, the method by which I/my child will take the medication(s) (*injection or by mouth*), and the possible duration of such treatment. Medication information brochures are available upon request.

5. Possible drug interactions that may occur with other medications and drugs. I agree to notify my/my child's physician(s) regarding any medications, or changes in medications, prescribed by other physicians, and regarding use, or changes in use, of over-the-counter drugs or natural/herbal supplements.

I am aware that by signing this form I am acknowledging that I have held a discussion with my/my child's physician in which the above topics were covered to my satisfaction, and that I accept the risks of, and have consented to, treatment with the above medication(s). I understand/my child understands and agree(s) to the following:

1. I agree/my child agrees to take/administer the medication(s) as prescribed, and, especially when starting meds, in the first several months, and/or during changing doses, to watch for and contact my/my child's physician about any adverse effects. Emergency/911 will be contacted if adverse effects are serious.

2. Because they alter the mind, alcohol and/or recreational/street/illicit drugs should be avoided. They can also cause dangerous interactions and can adversely affect the intended actions of prescribed medications. Medications and/or drugs can impair the ability to drive or operate equipment, and I take responsibility for maintaining the safety of myself/my child, and the safety of others.

3. Discontinuing medications, especially abruptly, can cause serious adverse effects. I agree to discuss stopping medications with my/my child's doctor before doing so, and to follow medical advice about safely tapering medications if intending to discontinue medications.

4. Medications can damage an unborn baby. I am not/my child is not currently pregnant. I agree to inform my doctor if there is any possibility or intention of my becoming pregnant. I will inform my child's doctor if thee is a possibility that my child is now pregnant or possibly may become pregnant while on psychiatric medications.

I have read and acknowledged the above, and agree to the above conditions.

Client/parent or guardian/conservator initials ________

San Mateo County
Behavioral Health & Recovery Services

"INFORMACIÓN CONFIDENCIAL DEL PACIENTE: Véase la fracción 5328 del Código del Bienestar Social e Instituciones de California "

Resource Document 5b **VERIFICACIÓN DEL CONSENTIMIENTO PARA MEDICAMENTOS**

Nombre del cliente ______________________ **Número MH** ______________________

Esta forma es para dar a conocer que tuve una conversación con mi médico/el médico de mi hijo(a), ______________________ M.D., sobre su receta para el(los) siguiente(s) medicamentos que se indican y es posible que algunos de ellos no cuenten con la aprobación de *U.S. FDA* (Administración Federal de Alimentos y Medicamentos) para el(los) uso(s) del cual nosotros conversamos.

Por favor, tome en cuenta que no se debe conducir o utilizar maquinaria pesada hasta que sepa como la medicina mencionada a continuación lo afecta.

☐ **Antipsicóticos** ______________________

Alguno de los posibles efectos secundarios: nausea, vómito, mareos, aumento de peso, aumento de azúcar/lípidos en la sangre, diabetes, sedación, intranquilidad, temblores, entumecimiento de músculos, disquinesia tardada (movimientos involuntarios de la cabeza, cuello, brazos), ataques epilecticos, problemas sexuales, síndrome neuroléptico maligno (una emergencia médica rara que se caracteriza por fiebre alta, rigidez, delirios, colapso circulatorio y respiratorio) Además con Clozapina (*Clozapine*): ataques, disminución de glóbulos blancos, lo que podría ocasionar infecciones y, en raras ocasiones, daños al corazón.

☐ **Antidepresivos** ______________________

Algunos posibles efectos secundarios: nausea, vómito, cambios en el apetito/peso, dolores de cabeza, mareos, sedación, trastornos del sueño, resequedad en la boca, problemas sexuales/de erección, ataques, sangrado interno anormal.

Especialmente entre los jóvenes **Los estabilizadores de ánimo también han sido asociados con un aumento en pensamientos y conductas suicidas.**

☐ **Medicamentos Anti-Extrapiramidales (*EPS*)** ______________________

Algunos posibles efectos secundarios: resequedad de la boca, vista borrosa, cansancio, mareos, deficiencia mental, estreñimiento, dificultad al orinar.

☐ **Anti-ansiedad/Hipnóticos** ______________________

Algunos posibles efectos secundarios: sueño, dificultad para concentrarse, confusión, torpeza, mareos, debilidad, disminución en los reflejos, dificultad para manejar, pérdida de la inhibición. Entiendo que yo/mi hijo(a) deberé (deberá) evitar el alcohol.

☐ **Estabilizantes del Animo (*Mood Stabilizer*)** ______________________

Algunos posibles efectos secundarios: náusea, vómito, salpullido, aumento de peso, mareos, confusión, cansancio, **defectos de nacimiento**. Además, con Depakote: problemas del hígado/páncreas, problemas de los ovarios; con Carbamazepina (*Carbamazepine*): disminución de glóbulos sanguíneos, lo que podría ocasionar infecciones.

☐ **Litio** ______________________

Algunos posibles efectos secundarios: náusea, vómito, diarrea, cansancio, deficiencia mental, confusión, aumento de peso, sed, continuos deseos de orinar, temblores, acné, trastornos de la tiroides, defectos de nacimiento.

☐ **Medicamentos DHD** ______________________

Algunos posibles efectos secundarios: pérdida de apetito, deficiencia en el crecimiento, dificultad para dormir, intranquilidad, náusea, cambios en la presión arterial/latidos del corazón. Además con *Strattera*: lesiones raras del hígado con ictericia (coloración amarilla en la piel y ojos), dolor abdominal, comezón en la piel, gripe, orina de color obscuro. Además con Adderall/sales de anfetamina: riesgo de muerte repentina e inexplicable, principalmente con anormalidades (indetectables) de las estructuras cardíacas.

☐ **Otros** ______________________

Favor de leer y poner sus iniciales en la constancia de reconocimiento y acuerdo que aparece al reverso.

Entiendo que tengo derecho a negarme a tomar este/estos medicamento(s) y que no se le(s) podrá(n) administrar a mi/mi hijo(a) hasta que yo haya platicado con mi médico/el médico de mi hijo(a) y haya otorgado mi consentimiento para el tratamiento con este/estos medicamentos. Puedo buscar mayor información en cualquier momento que yo le desée, y puedo retirar mi consentimiento para el tratamiento con el/los medicamento(s) anteriormente mencionados en cualquier momento con solo mencionar a mi médico/el médico de mi hijo mi intención.

He leído y colocado mis iniciales al reverso de esta forma.

Con mi firma certifico que tengo la autoridad legal para firmar este consentimiento y que la relación que aquí se indica es válida y legal.

______________________ ______________________ ______________________

Firma del Cliente/Padre de Familia o Tutor/Guardián nombrado judicialmente	*Relación Legal*	*Fecha*
Firma del(la) Joven (Opcional`)	**Firma del Médico**	**Fecha**

☐ ***El(la) cliente concuerda, pero decidió NO firmar***

Constancia de Reconocimiento y de Acuerdo

En nuestra conversacion mi médico/el médico de mi hijo(a) y yo también hablamos de los siguientes temas:

1. La naturaleza de la condición mental/la de mi hijo(a).

2. Los motivos que tiene mi médico para haber recetado el(los) medicamento(s) anteriormente mencionado(s), inclusive la posibilidad de tener una mejoría o no sin dicho(s) medicamento(s), los riesgos del tratamiento, y los riesgos de no recibir tratamiento.

3. Cualquier tratamiento razonable alterno que exista para mi condición/la condición de mi hijo(a).

4. El tipo de medicamento(s) que voy a recibir/mi hijo(a) va a recibir, la frecuencia y cantidades de las dosis, el método por el que yo/mi hijo(a) deberé/deberá tomarse el(los) medicamento(s) (*inyección o por la vía oral*) y la duración posible de dicho tratamiento. Se pueden conseguir folletos de información sobre los medicamentos si usted así lo solicita.

5. Posibles interacciones entre medicamentos que pudieran ocurrir con otros medicamentos y drogas. Estoy de acuerdo en notificar a mi(s) médico(s)/el(los) médico(s) de mi hijo(a) sobre cualquier medicamento, o cambios de medicamento recetado por otros médicos y sobre el uso o cambios en el uso de drogas o suplementos naturales/de plantas medicinales sin receta médica.

Estoy consciente que al firmar esta forma estoy reconociendo que tuve una plática con mi médico/el médico de mi hijo(a) en la cual se abordaron los temas anteriormente mencionados a mi satisfacción, y acepto los riesgos de, Y otorgo mi consentimiento para el tratamiento con el(los) medicamento(s) anteriormente mencionado(s). Yo entiendo, mi hijo(a) entiende y estoy de acuerdo en lo siguiente:

1. Estoy de acuerdo que mi hijo(a) se le tiene que administrar el(los) medicamento(s) de la manera en que se han recetado, especialmente al comenzar a tomarse los medicamentos, en los primeros meses, y/o durante cambios en las dosis, a vigilar y ponerse en contacto con mi médico/el médico de mi hijo(a) acerca de cualquier efecto adverso. Si los efectos adversos son de gravedad, se llamará a la sala de emergencia al numero 911.

2. Se deberá evitar el alcohol y/o las drogas recreativas/callejeras/ilícitas, pues alteran la mente. También podrían ocasionar interacciones peligrosas y podrían afectar adversamente los efectos que se intentan con los medicamentos recetados. Los medicamentos y/o las drogas podrían disminuir la capacidad para manejar automóviles o maquinaria, y me hago responsable de mantener mi propia seguridad/la seguridad de mi hijo(a) y la seguridad de los demás.

3. No se puede parar de tomar los medicamentos de manera repentina, esto podría ocasionar efectos graves y adversos. Antes de hacerlo, yo estoy de acuerdo en hablar con mi médico/el médico de mi hijo(a) sobre el tema de dejar de tomar medicamentos y seguir la asesoría médica acerca de cómo dejar de tomarlos gradualmente si existe la intención de descontinuar dichos medicamentos.

4. **Las medicinas pueden dañar a su bebe durante el embarazo. No estoy/Mi hija no esta actualmente embarazada. Me comprometo a informar a mi medico si hay alguna posibilidad o tengo la intención de quedarme embarazada. Informare al medico de mi hija si es posible que ella este actualmente embarazada o si hay la posibilidad de que quede embarazada mientras este tomando medicación siquiátrica.**

He leído y reconozco lo anterior y estoy de acuerdo con las condiciones anteriormente mencionadas.

Iniciales del(la) cliente/padre de familia o tutor/guardián nombrado judicialmente ________

"Kompidensiyal Na Impormasyon Tungkol Sa Pasyente: Tignan ang California Welfare and Institutions Code Section 5328"

PAGPAPATOTOO NG PAGSANG-AYON SA GAMOT

Pangalan ng Kliyente ______________________________ **Numero sa MH** ______________________

Pinatutunayan nito na pinag-usapan namin ng doktor ko/ng aking anak na si, ________________________M.D., ang tungkol sa kanyang pagreseta ng (mga) sumusunod na tsinekang gamot, na ang ilan sa mga ito ay maaaring hindi inaprobahan ng U.S. FDA para sa (mga) paggamit ng gamot na pinag-usapan namin. **Pinag-usapan namin ang mga iba pang epekto ng gamot na nakalista sa ibaba ang ilan sa mga ito. Hindi nakalista ang lahat o mga posibleng magiging mga iba pang epekto.** Dapat mong malaman na hindi ka dapat magmaneho o gumamit ng mga mabibigat na makina hanggang malaman mo ang epekto sa iyo ng mga gamot na nakalista sa ibaba.

☐ **Antipsychotic** ____

Ang mga ilang posibleng iba pang epekto: napapaduwal, nagsusuka, nahihilo, tumataba, tumataas ang blood sugar/lipids, diabetes, nagpapakalma, di-mapalagay, nanginginig, naninigas ang mga kalamnan, tardive dyskinesia (hindi kinukusang mga paggalaw ng ulo, leeg, mga bisig), mga seizure, mga problemang sekswal, neuroleptic malignant syndrome (di-karaniwang medical emergency na ang palatandaan ay mataas na lagnat, paninigas, delerium, circulatory at respiratory collapse). At para sa Clozapine: mga seizure, bumababa ang white blood cell count na nagreresulta sa mga impeksiyon; at, kung minsan, napipinsala ang puso.

☐ **Antidepressant** ____

Ang mga ilang posibleng iba pang epekto: napapaduwal, nagsusuka, mga pagbabago sa pagkakagana sa pagkain/timbang, sumasakit ang ulo, nahihilo, nagpapakalma, naiistorbo ang pagtulog, nanunuyo ang bibig, mga problemang sekswal/pagtigas na titi, mga seizure, abnormal na pagdurugo sa loob ng katawan.

Lalo na sa kabataan: mga pag-isip at kaasalan na magpapakamatay, sinusumpong, naiistorbo ang pagtulog, magalitin, biglang nagagalit o nagtatatawa, palaaway, marahas.

☐ **Mga Gamot na Anti-Extrapyramidal (EPS)** ______________________________

Ang mga ilang posibleng iba pang epekto: nanunuyo ang bibig, malabo ang paningin, napapagod, nahihilo, nabobobo, hindi makatae, nahihirapang umihi.

☐ **Antianxiety/Hypnotic** ____

Ang mga ilang posibleng iba pang epekto: inaantok, nahihirapang mag-concentrate, naguguluhan, walang-ingat, nahihilo, nanghihina, humihina ang reflexes, nahihirapang magmaneho, nawawalan ng inhibition. Naiintindihan ko na ako/ang aking anak ay hindi puwedeng uminom ng mga inuming may alkohol.

☐ **Mood Stabilizer** ____

Ang mga ilang posibleng iba pang epekto: napapaduwal, nagsusuka, mga singaw sa balat, tumataba, nahihilo,naguguluhan, napapagod, **nagkakaroon ng mga diperensiya ang ipapanganak na sanggol.**

At para sa Depakote: mga diperensiya sa atay/lapay, mga diperensiya sa obaryo; para sa Carbamazepine: bumababa ang blood count na nagreresulta sa mga impeksiyon.

☐ **Lithium** ____

Ang mga ilang posibleng iba pang epekto: napapaduwal, nagsusuka, nagtatae, napapagod, nabobobo, naguguluhan, tumataba, nauuhaw, malimit umihi, nanginginig, tinitighiyawat, diperensiya sa thyroid, nagkakaroon ng mga diperensiya ang ipapanganak na sanggol.

☐ **Mga Gamot para sa ADHD** ____

Ang mga ilang posibleng iba pang epekto: walang ganang kumain, hindi tumatangkad, nahihirapang matulog, di-mapalagay, napapaduwal, nagbabago ang presyon sa dugo/pagtibok ng puso.

At para sa Strattera: kung minsang ay pinsala sa atay na may posibleng jaundice (paninilaw ng balat at mga mata), sakit sa tiyan, pangangati ng balat, trangkaso, madilim ang ihi.

At para sa Adderall/Amphetamine salts: ang panganib ng biglang pagkamatay na hindi maipaliwanag ang dahilan, lalong-lalo na kapag may mga (hindi natuklasang) nauunang diperensiya sa puso.

☐ **Mga iba pa** ____

Mangyaring basahin at inisyalan ang pagpapatibay at pagsang-ayon sa likod nito.

Naiintindihan ko na ako ay may karapatang tanggihan itong (mga)gamot at hindi ito puwedeng ibigay sa akin/aking anak hanggang sa makausap ko ang doktor ko/ng aking anak at pumayag ako sa paggamit nitong mga gamot. Puwede akong humiling ng karagdagang impormasyon sa anumang oras na gustuhin ko, at puwede kong bawiin ang aking pagpayag sa paggamit ng (mga) gamot na binabanggit sa itaas sa anumang oras sa pamamagitan ng aking pagsabi sa doktor ko/ng aking anak.

Binasa at ininisyalan ko ang likod nito.

Pinatototohanan ko sa aking pagpirma nito na ako ay may legal na kapangyarihang pumirma sa pagpayag na ito at balido at legal ang kaugnayan.

Pirma ng Kliyente/Magulang o Tagapag-alaga/Conservator	*Legal na Kaugnayan*	*Petsa*
Pirma ng Batang Wala Pa Sa Hustong Gulang (Opsiyonal)	**Pirma ng Doktor**	**Petsa**

☐ ***Pumapayag ang kliyenente, pero ayaw pumirma***

Pagpapatibay at Pagsang-ayon

Sa aming pag-uusap, pinag-usapan rin namin ng doktor ko/ng aking anak ang tungkol sa mga sumusunod na paksa:

1. Anong klase ang mental condition ko/ng aking anak.

2. Ang mga dahilan ng aking doktor sa pagrereseta ng (mga) gamot na binabanggit sa itaas, kabilang ang posibilidad na gumaling o hindi gumaling kapag hindi gagamitin ang ganitong (mga) gamot, ang mga panganib ng paggamot, at ang mga panganib ng hindi paggamot.

3. Anumang makatwirang mapagpipiliang paggamot sa kondisyon ko/ng aking anak.

4. Ang klase ng mga gamot na ibibigay sa akin/aking anak, ilang beses, at gaaano karami ang mga dosis, ang paraan kung paano ibibigay sa akin/aking anak ang (mga) gamot (*iniksiyon o iinumin*) at ang malamang na tagal ng gayong paggamot. Makakakuha ng mga brochure na nauukol sa impormasyong tungkol sa (mga) gamot kapag hiniling.

5. Posibleng drug interactions na maaaring mangyari sa mga ibang gamot at drugs. Sumasang-ayon akong ipaalam sa (mga) doktor ko/ng aking anak ang tungkol sa anumang mga gamot, o mga pagbabago sa mga gamot, na inireseta ng mga ibang doktor, at tungkol sa paggamit, o mga pagbabago sa paggamit, ng drugs o natural/herbal supplements na hindi inirereseta ng doktor.

Alam ko na sa pagpirma ko sa form na ito ay pinagtitibay ko na nag-usap kami ng doktor ko/ng aking anak at pinag-usapan namin ang mga paksang binabanggit sa itaas sa abot ng aking kasiyahan, at tinatanggap ko ang mga panganib sa paggamit ng (mga) gamot na binabanggit sa itaas, at pumapayag akong ibigay sa akin/aking anak itong (mga) gamot. Naiintindihan ko/ng aking anak at sumasang-ayon ako/ang aking anak sa mga sumusunod:

1. Ako/ang aking anak ay sumasang-ayon na gamitin/ibigay ang (mga) gamot tulad ng inireseta ng doktor, at, lalong lalo na kapag nag-uumpisa ng mga gamot, sa unang mga ilang buwan, at/o sa mga panahon ng pagbabago ng dosis, bantayan ang anumang mga masamang epekto ng (mga) gamot at ipaalam ito sa doktor ko/ng aking anak. Tatawagan ang Emergency/911 kung malubha ang mga masamang epekto ng (mga) gamot.

2. Dahil iniiba ng mga ito ang pag-iisip, kailangang iwasan ang pag-inom ng mga inuming may alkohol at/o ang paggamit ng mga ipinagbabawal na drugs. Ang mga ito ay maaari ring magsanhi ng mapanganib na interactions at maaaring magkaroon ng masamang epekto sa mga balak na mga iniresetang gamot. Ang mga gamot at/o drugs ay maaaring magpahina sa aking kakayahang magmaneho o magpatakbo ng makinarya, at pananagutan kong panatilihing ligtas sa panganib ako/ang aking anak, at ang ibang tao.

3. Ang paghinto ng mga gamot, lalo na kung biglang hininto, ay maaaring magsanhi ng mga malubhang iba pang epekto. Sumasang-ayon akong pag-uusapan muna namin ng doktor ko/ng aking anak ang paghinto ng paggamit ng mga gamot bago ko ihinto ito, at sundin ang medical advice tungkol sa maingat na unti-unting pagbawas sa paggamit ng mga gamot kung balak ihinto ang paggamit ng mga gamot.

4. Maaring makasama sa sanggol sa sinapupunan ang mga gamot. Ako/ang aking anak ay hindi buntis sa kasalukuyan. Sasabihin ko sa aking duktor kung may posibilidad o balak akong mabuntis. Sasabihin ko sa duktor ng aking anak kung may posibilidad na ang aking anak ay buntis sa ngayon o posibleng mabuntis habang umiinom siya ng mga gamot na saykayatriko (psychiatric medications).

Binasa ko at pinagtitibay ko ang mga nakasulat sa itaas, at sumasang-ayon ako sa mga kondisyong binabanggit sa itaas.

Inisyal ng kliyente o tagapag-alaga/conservator ________

Resource Document 6 **MD Behavioral Health Outpatient Client Assessment/Plan/Re-Authorization Form**

San Mateo County Behavioral Health Services, ACCESS Team, 1950 Alameda de las Pulgas, San Mateo CA 94403

Phone or fax this information to ACCESS.

Phone: 1-800-686-0101 **Fax: (650) 349-0771**

DIRECTIONS – Submit after the final authorized visit or, if on-going treatment is being requested, prior to expiration of initial authorization (four months or the 10th session). If approved, re-authorization will begin from the date this request is received by the ACCESS Team. Incomplete information may result in delay of authorization for services. **Please complete all information requested on this form.**

PROVIDER (Print)____________________________PIN#________Phone_____________Fax_______________

CLIENT NAME_________________________SS#_______________DOB_______________Date_______________

Current Clinical Issues

____

____

____

____

Substance Abuse ☐Current ☐Past ☐None Describe type, amount, frequency (incl Nicotine, Caffiene, and OTC)

____

____

____

History, Relevant Clinical or Other Information (Include present &/or previous physical &/or sexual abuse – victim &/or perpetrator)

Medications (for Medical and Psychiatric Conditions)

Diagnosis Use **"P"** and **"S"** to specify one **Primary** and one **Secondary** Mental Health Diagnosis on Axis I and/or Axis II. You may report up to three additional diagnoses. Do not enter the Code for a "Rule Out" Diagnosis.

AXIS I	DSM-IV	ICD-9	P/S	AXIS II	DSM-IV	ICD-9	P/S

AXIS III

Other Factors Significantly Affecting Mental Health **Circle** Yes, No, or Unknown.

Substance Abuse (If yes, specify in an Axis I Diagnosis.)	Yes	No	Unknown
Developmental Disabilities	Yes	No	Unknown
Physical Health Disorders	Yes	No	Unknown

AXIS IV **Check** any problem(s) making a significant contribution to the client's current disorder.

- ☐ Problems with Primary Support Group
- ☐ Economic Problems with Access to Health Care
- ☐ Problems Related to the Social Environment
- ☐ Problems Related with the Legal System/Crime
- ☐ Educational Problems
- ☐ Other Psychosocial and Environmental Problems
- ☐ Occupational Problems
- ☐ Housing Problems
- ☐ Unknown

AXIS V/GAF **Enter Current** Level of Functioning: ________

Treatment Goals

1)____Target Date_________

2)____Target Date_________

These goals have been formulated in conference with, and have the approval of, the Mental Health Plan member/parent or guardian.

Provider/Date ______________________________ Client/Parent (if feasible) ___________________________

PROVIDER REQUEST for Treatment Authorization (Provider must complete.)	**CODE(S)**	**# of Visits Requested**	**Authorization Period Requested**	
			From:	To:
			From:	To:
AUTHORIZED (Completed by Mental Health Plan staff only.)	**CODE(S)**	**# of Visits Authorized**	**Authorized Period**	
			From:	To:
			From:	To:

Run Date: 1/17/2012 01:11 PM

Page 1 of 1

BEHAVIORAL HEALTH AND RECOVERY SERVICES
225 W 37TH Avenue
San Mateo, CA 94403

Authorization Report

Authorization Number: 9999
Type Of Authorization: Outpatient
Current Authorization: Status: Approved
Initial Or Continued Auth.: No Entry

Start: 8/3/2011 **End:** 12/3/2011
Next Review Date:
Auth. Status Reason: APPROVED AS ROUTINE
Auth. Level Care: DEF - Default Rate

Contracting Provider Information

Provider: TEST, THERAPIST - 99999

Phone: 111-222-1212
Fax: 111-222-1234
Email:
Address: 12324 77TH AVE., SAN MATEO, CA. 94501
Performing Provider:
Performing Provider Type:
Level Of Care: Outpatient

Member Information

Member: TEST, CLIENT (999999)
DOB: 01 / 01 / 2012
Home Phone: 999-000-1234
Cell Phone:
Work Phone:
Address: 12890 53RD ST., SAN MATEO, CA., 94501
Letter Type: No Entry
Primary Diagnosis:

Secondary Diagnosis:

Auth. Fields	1	2	3	4	5	6	7	8	9	10
Codes *	C-90807	C-99205	C-N0000	C-X8255						
Units	9	1	2	4						

Authorization for code P8266 allows claiming of 90804, 90806, 90847 or 90853.

Internal Comments:

Comments On Authorization:

Financial

Case Manager: TEST,MANAGER

Entered By: TEST ENTRY - 1 / 2 / 2012 - 01:34 PM

SAN MATEO COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES

DATE: January 13, 1998

BHRS POLICY .: 98-11

SUBJECT: Quality Improvement Compliance Review of Outpatient Provider Services

AUTHORITY: Divisional

SUPERSEDES: Renumbering of Mental Health Plan Policy No. 97-01

ATTACHMENTS:
A. Review of Private Provider Office Site
B. Review of Private Provider Client Treatment Record

PURPOSE

In order to assure that the Mental Health Plan provides high quality outpatient services through its network of private providers, this policy describes a review process for office sites and client treatment records.

PROCEDURE

The Mental Health Plan will perform compliance reviews of outpatient private providers which shall include a site visit and a review of selected charts by a Quality Improvement professional staff member. For group practices one site review is sufficient. A minimum of three Medi-Cal charts, or charts for a 20% random sample of each provider's Medi-Cal clients (whichever is greater), will be evaluated. Following a satisfactory initial or subsequent review, preferred providers will be reviewed every two years; other providers will be reviewed every three years.

The priority for scheduling initial compliance reviews shall be:

- providers serving the largest number of clients;
- providers serving clients with charts open for longer than one year; and
- other criteria a developed by the Mental Health Plan.

The Mental Health Plan will notify each provider by mail of the impending review and will then contact each provider by phone to establish a mutually agreeable time and date for the review (within six weeks of the phone call). Site and chart review criteria (attached) will be mailed to

providers with the notice of pending review. At least two weeks prior to the review, the Mental Health Plan will confirm the schedule, and identify the charts to be examined, by faxing and/or mailing a written letter to the provider.

Within two weeks following the quality review, the Quality Improvement professional staff member will send a written report of findings to the provider. If any deficiencies are noted, the report will include a request for a written plan of corrective action. The provider is expected to submit the plan of correction within 60 days from the date of the request. If chart records for one or more visits do not meet service documentation requirements, authorization of payment of those visits shall be disallowed.

The Quality Improvement professional staff member and/or the Medical Director shall be available for consultation to address provider concerns and questions, as well as for clarification of the review findings. If the plan of correction submitted is incomplete or not appropriate, the provider will be further contacted by the Mental Health Plan. If compliance problems persist and are unable to be resolved, the issue will be forwarded to the Mental Health Plan's Credentialing Committee.

Approved: ________________________________

Beverly Abbott, Director
Mental Health Services Division

Quality Improvement

Private Provider Office Visit

Provider ______________________________ **#** ____________________ **Phone**________________

Address ______________________________ **City** _________________ **Fax** _________________

Area	Standards and Recommendations	Yes	No	Notes
Environment	Sufficient space for clients/staff, clean & well maintained.			
	Consumer Rights & Problem Resolution brochures available			
	Drinking water is available, including for wheelchair clients.			
Safety	Fire extinguisher is accessible, charged w/in 365 days.			
	Smoke detectors and/or sprinklers are installed.			
	Provides clients w info to get emergency care dur. off-hours.			
ADA	Office is wheelchair accessible.			
	Handicapped accessible restroom is available.			
	Designated handicapped parking is available.			
	Braille indicators in elevator if building > than 1 story.			
Medical	Secure storage system for active & inactive medical records.			
Records	Access is limited to medical or legal purposes.			
	Client records are retained for a minimum of 7 years, except for minors, whose records are kept at least 1 year after the minor has reached 18 years, but in no case less than 7 years.			
Medications	Prescription pads are inaccessible to clients.			
(MDs only)	All drugs stored securely manner with access limited to MD.			
	Routine procedure to check the expiration date of drugs.			
	All drugs in office are within expiration date.			

Comments

Reviewer __________________________________ **Date** _________________________

Resource Document 8c San Mateo County Behavioral Health and Recovery Services

Quality Improvement

Managed Care Chart Review – Individual and Agency Providers

Provider __________________ **Client** _________________________ **MH#** _______________

Date Episode Opened ____________ **Date Reauthorization, if applicable** ________________

Documentation	Standards	Yes	No	Notes
Assessment	Completed & in chart; reflects minimum 1 face-face visit.			
Dx. __________	Notes symptoms with impaired functioning/development.			
Progress Notes	Client name or ID is on every page of clinical record.			
(Required for all)	Dated progress note for every service claimed (attached).			
Quality	Every note is signed with provider's name and license.			
Indicators	Interventions relate to diagnosis and treatment plan goals.			
	Notes describe client strengths to reach treatment goals.			
	Notes document any high risk SI/HI/other with updates.			
	As needed, notes show coordination with PCP/others.			
	Chart includes hospital DC summaries, other reports prn.			
	Notes document progress toward goals and/or discharge.			
	If applicable, client signed authorization to release PHI.			
Assessment/Dx	Notes developmental history for children and adolescents.			
for Reauth'ization	Includes past medical & psychiatric history.			
Date _________	Notes use of alcohol, illicit, prescribed & OTC drugs.			
Dx. __________	DSM-IV/ICD-9 dx consistent with symptoms, behaviors.			
Treatment Plan	Goals consistent with symptoms, impairments &diagnosis.			
for Reauth'ization	Evidence client aware and agrees w treatment plan.			
Med Consent	Signed w license and dated w/in 12 months by physician.			
(Recommended,	Signed and dated by client/parent.			
if applicable)	Includes all medications ordered for client.			

Comments

Reviewer ____ **Date** _________________________

SAN MATEO COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES

DATE: July 16, 1998

BHRS Policy: 98-10

SUBJECT: Concerns/Complaints about MHP Individual and Organizational Contract Providers

AUTHORITY: Divisional; CFR Title 42, 438.10 (f)(5)

AMENDED: October 14, 2009

PURPOSE

To establish a procedure for review of concerns/complaints about MHP contract providers;
To assure timely notification of beneficiaries whose contract provider has been terminated by the MHP.

Concerns about financial/legal performance of contract obligations:

- Per individual contract language, a meeting may be called at any time by the MHP to review concerns about failure to meet specific contract obligations. Contract language specifies MHP recourse for negative findings including retrieval of dollars paid, termination of contract, and/or legal action.

- The provider has a similar opportunity to call a meeting with the MHP to discuss these or other issues; the individual (but not the organizational) provider also has the full process of the Provider Grievance Procedure to seek redress for any perceived fault of the MHP in meeting contract obligations. The Provider Grievance Procedure is in no way curtailed or abridged by any of the following discussion, nor are any specific contractual obligations incumbent upon the provider or the county:

Concerns about failure of the contracted provider to meet MHP clinical/administrative standards:

- The MHP shall review all concerns/complaints and shall document where the practice described appears to deviate from objective standards as defined in BHRS Policy 98-07 Provider Selection and Performance Criteria.

    a. Consumer Relations Specialist will investigate and record consumer and/or family concerns or complaints.

b. Provider Relations Specialist will investigate and record concerns/complaints about failure to maintain administrative standards.

c. Access Team Members, Adult Resource Management (ARM) or Youth Case Management, and BHRS managers will document, using the Provider Concern Form, incidences where the provider failed to meet contract standards concerning referrals, prior authorization, or other clinical and administrative standards.

Efforts will be made to resolve concerns/complaints at the lowest level of MHP involvement. For example, an ARM staff member may ask that team's manager to communicate with a provider around a performance concern. Such efforts shall be documented in the appropriate MHP file (Example: Complaint/Grievance Files, Provider Credentialing or Contract Files).

When documented efforts to resolve concerns/complaints at an informal level have failed to achieve resolution of an issue, MHP staff must refer the situation to MHP Management which will recommend further efforts at complaint resolution. Further, if a concern/complaint that appeared to have been resolved recurs at some later date, this will similarly mandate referral to the MHP Management, for its review and recommendations.

Concern/Complaint Resolution Process

- The BHRS Medical Director or her designee will review documented material to verify that significant variation from standard clinical performance criteria has occurred. The Assistant Director of Mental Health will review documented material to verify that significant variations from standard administrative performance criteria has occurred.

- In a situation where a significant variation from standard performance criteria has occurred, above referenced director(s) or their designee(s) will schedule a meeting with the provider to discuss the concern/complaint; this meeting is intended to convey MHP concern and to allow the provider an opportunity to present his/her perspective about the situation.

- A written communication presenting the findings of the meeting will be sent to the provider and maintained in the provider files.

- If a Plan of Correction is found necessary and is mutually agreed upon, the Provider Relations Specialist will track its progress and will report the findings back to MHP Managers at the appropriate interval(s).

- If a necessary Plan of Correction is not agreed upon, or if the provider refused to attend this meeting, the provider will be notified that the issue under concern must be resolved within a time specified by the MHP. This also shall be tracked by the Provider Relations Specialist.

- o If the situation continues past the time periods referenced above, a written report will be prepared by the BHRS Medical Director or her designee or by the Assistant Director of Mental Health or his designee, recommending suspension or withdrawal of credentialing/contracting.

- o In the case of an individual provider, this report shall be forwarded to the Credentialing Committee for its review. A profession specific subcommittee of the Credentialing Committee shall invite the provider to participate in a face-to-face discussion of the complaint. Whether or not such a meeting occurs, the Credentialing Committee will provide the BHRS Director with a written statement of its findings.

- o The final decision about suspension or withdrawal of credentialing/contracting will be that of the BHRS Director, who will review all recommendations. The provider will be notified in writing about this final decision.

- The MHP Management may recommend an abbreviation of the above described process in situations where the practice under concern represents significant clinical or administrative risk. In such situations, the Assistant Director of BHRS may immediately suspend the provider's credentialing privileges, pending further review and final resolution by the BHRS Director.

Notification of Clients

The MHP will make a good faith effort to give affected beneficiaries written notice of the termination of a contracted provider within 15 days after receipt or issuance of the termination notice.

Approved: ______________________________
Louise Rogers, Director
Behavioral Health and recovery Services

Reviewed: ________________________
____
____
____

PROVIDER COMPLAINT AND APPEAL PROCEDURES

Good provider relations are essential to the effective delivery of mental health services. The following describes the process by which providers may address their complaints and appeals to the Medi-Cal Managed Care Mental Health Plan (MHP) for resolution.

I. DEFINITIONS

A. Services means inpatient or outpatient Medi-Cal mental health services.

B. Complaint is a statement registered by a provider regarding a problem that can be resolved informally.

C. Appeal concerns issues regarding the processing or payment of provider claims for psychiatric services, which cannot be resolved informally.

D. Non-Contracting Provider is a mental health provider who does not have a contract with the Medi-Cal Managed Care MHP, but may do business with the Medi-Cal MHP for specific reasons, e.g., provision of emergency, out-of-area or one-time client care.

E. Provider is a mental health provider who has a contract with the Medi-Cal Managed Care MHP to provide services to Medi-Cal beneficiaries.

F. Provider Relations Specialist or Community Program Specialist is the Medi-Cal Managed Care MHP staff member responsible for responding to and attempting to resolve provider complaints.

G. Medi-Cal Managed Care Mental Health Plan (MHP) is responsible for the administration of Medi-Cal mental health services in San Mateo County.

II. COMPLAINT PROCESS

A. Provider complaints may address one or more of the following:

1. Lack or level of payment for an unauthorized or emergency claim.
2. Delay of payments.
3. Lack of information or cooperation by MHP staff.
4. Disagreement by the provider with utilization review decisions made by the MHP staff.

5. A dispute with MHP regarding interpretations of provider action, which are reasons for contract terminations.

6. A dispute between a contracting hospital and the MHP arising from the interpretation and/or implementation of the terms and conditions of the services contract.

7. Other issues as determined by the provider.

B. A provider may present a complaint to the Provider Relations Specialist/ Community Program Specialist by telephone, in person or in writing.

1. The Provider Relations Specialist/Community Program Specialist will attempt to resolve the complaint. Suggested solutions will be provided to the complainant within two weeks from receipt of the complaint.

2. If the provider is not satisfied with the response, the provider may file an appeal under the circumstances listed in III below.

III. APPEALS

Providers may file an appeal in lieu of, or in addition to, a complaint a follows:

A. A provider may file an appeal concerning the processing or payment of a claim, or concerning a denied request for reimbursement of psychiatric services to the MHP. The appeal should include all supportive documentation regarding the provider's claim. The written appeal must reach the MHP representative within three (3) calendar months of the postmark or fax date of notification of the non-approval of payment.

B. The first level of appeal within the MHP shall be to the MHP Appeal Review Committee which shall consist of three or more members appointed by the MHP Director, none of whom were involved in the referral or authorization of services for any client for whom professional services are being contested; neither shall any member of this committee have been involved in efforts to mediate the complaint at an informal level. The Committee will review and consider all materials submitted by the provider.

C. The MHP shall have two (2) calendar months from the postmark or fax date of the receipt of the appeal to inform the provider in writing of its decision concerning the appeal, and shall cite the basis for that decision.

D. If the appeal is denied, the provider shall be notified of his/her further right (second level appeal) to review by the MHP Medical Director.

a. The provider must request a second level appeal within one (1) calendar month of the date of the Appeal Review Committee's written decision.

b. The provider shall be notified in writing, within two (2) calendar months of the provider's appeal to the Medical Director, of his/her decision; the decision of the MHP Medical Director shall be final.

E. If the MHP Appeal Review Committee, or the MHP Medical Director, upholds the provider's appeal, the MHP shall have two (2) calendar weeks to approve the payment authorization or to take any other corrective action described within the decision. The provider may be requested to submit a revised payment request under the circumstances of specific decisions by the Appeals Committee or the MHP Medical Director.

Resource Document 11

OUTPATIENT SERVICES
CLAIMS PROCESSING PROCEDURES

I. GENERAL INFORMATION

Claim Form: HCFA 1500.

Authorization: All services require pre-authorization by the Mental Health ACCESS Team at 1-800-686-0101.

Diagnosis Codes: ICD-9 codes. (NOTE: Most DSM IV codes cross-walk directly to ICD-9 codes. Where they are different, provider must specify ICD-9 code).

Eligibility: Service authorization does not guarantee Medi-Cal eligibility; it is the provider's responsibility to assure that services are provided to eligible beneficiaries. Providers may call the Managed Care Mental Health Plan (MHP) claims processing unit at 650-573-2068 for assistance.

Authorization: ALL NON-EMERGENCY SERVICES MUST BE PRE-AUTHORIZED. CLAIMS FOR UNAUTHORIZED SERVICES WILL BE DENIED.

Time Limits: 180 days from the date of service. Claims must be received within 180 days from the date of service. Claims received past the 180-day time limit will be denied.

II. CLAIMS PROCEDURE FOR OUTPATIENT SERVICES

Box 21: Record the patient diagnosis code(s).

Box 23: Record the authorization number. Providers will receive an authorization letter from the ACCESS Team within one week after authorization request. This letter includes the authorization number, authorized procedure code(s), and the effective dates of authorization.

Box 24: Record the date of service provided and the procedure code. Providers may bill only for the authorized CPT/HCPC codes listed in the authorization letter sent by the ACCESS Team. Any claim submitted with a code other than the codes authorized in writing by the ACCESS Team will result in the claim being pended and/or may result in denial of payment.

Box 31: Sign claim and record date.

Box 32: Record the location at which services were rendered.

Box 33: Record the San Mateo County PIN. This Provider Identification Number is issued at the time of contract agreement.

Mail Claims to:

San Mateo County
Mental Health Services
Attn: Provider Billing
225 37th Avenue
San Mateo, California 94403

III. INSURANCE/MEDI-CAL CROSSOVER CLAIMS

A. Obtain pre-authorization as necessary from primary provider.

B. Submit claim(s) to primary insurance carrier for payment.

C. After receipt of insurance payment/denial, submit claim with complete primary insurance Explanation of Payment (EOP) for payment liability determination by Managed Care MHP. Mail claim and EOP to above address.

D. Crossover claims must be submitted to MHP within 180 days of the insurance EOP issue date.

FOR ADDITIONAL ASSISTANCE IN PROVIDER BILLING
CALL THE MHP CLAIMS PROCESSING UNIT AT
650-573-2068

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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 | YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 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-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

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

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG AND FECA CLAIMS

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

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

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

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

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

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

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

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

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

SAMPLE

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

San Mateo County Behavioral Health and Recovery Services
ACCESS Team, 1950 Alameda de Las Pulgas, San Mateo, CA 94403
Phone: 1-800-686-0101 **FAX: (650) 349-0771**

PROVIDER CLOSING SUMMARY
Submit to enable payment for Initial Assessment and Services.

Provider ____________________ Therapist # __________ or Agency # ____________________

Phone __________________ FAX ________________ Check if requesting bilingual pay differential ☐

Client Name ____________________________________ Authorization # ____________________

MH # _________________________ DOB ______________ SS# ________-________-________

Current Clinical Issues ____

____

____

Substance Abuse ☐ none ☐ yes Specify ____

History of symptoms/relevant clinical information ____

____

____

Medications ____

____

Diagnosis: Use P and S to indicate Primary & Secondary; Axis III – list relevant medical issues.

Axis I	**P/S**	**Axis II**	**P/S**
Axis III		**Axis IV**	
		Axis V/GAF Score	

Treatment goals addressed

1. ____

2. ____

Treatment modality ☐ DBT ☐ RET ☐ CBT ☐ Other [specify] ______________________

Is client stable at end of treatment? ☐ yes ☐ no Comment ______________________

Is client improved? ☐ yes ☐ no Comment ____________________________________

Client Strengths ____

Are you recommending other services? ☐ no ☐yes [If yes, please identify needs.] ____________

____

____

_________________________ _________________________ _________________
Clinician Signature, License Agency Name, if applicable Date

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

Resource Document 14 **San Mateo County Behavioral Health & Recovery Services**

ACCESS Team, 1950 Alameda de Las Pulgas, San Mateo, CA 94403

Phone: 1-800-686-0101 **FAX: (650) 349-0771**

Client Name ____________________ DOB _______________ SS# _________ - _________ - _________

YOUTH Medi-Cal Managed Care Re-Authorization Request
Complete & submit after initial ten sessions to request authorization to provide ongoing MH Services.
If no changes after subsequent sessions, submit pages 7, 8, 9 & 10 to request additional authorization.

Provider ____________________ Therapist # ____________ or Agency # ____________________

Phone __________________ FAX ___________________ Check if requesting bilingual pay differential ☐

Date __________________ Date Initial ACCESS Referral ____________ MH # _______________

Client's current address ____

Phone-Home/message _____________ Cell ____________ Email ___________________________

Lives with [name and relationship] ____

Contact person ______________________ Contact's phone _________________________________

Client's School [name & grade] ______________________________________ Special Ed ☐ yes ☐ no

Primary Language ☐ English ☐ Spanish ☐ Tagalog ☐ Chinese ☐ Russian ☐ Other __________

Are cultural issues involved? ☐ yes ☐ no If yes, identify __________________________________

Does client have? Shadow ☐ yes ☐ no Case Manager ☐ yes ☐ no

IEP in place ☐ yes ☐ no GGRC Services ☐ yes ☐ no

If yes, provide name and phone number ____

Support: ☐ family involved ☐ family not involved/supportive ☐ other resources

Explain: ____

Presenting Problem(s)

____

____

____

____

____

____

____

____

____

Client Name ____________________ DOB ______________ SS# ________-________-________

Previous Medications

Medication	Symptoms Addressed/focus of Medication regimen	Name and telephone number of physician prescribing this medication	Indicate if PCP or Psychiatrist

Current Medications

Medication	Symptoms Addressed/focus of Medication regimen	Name and telephone number of physician prescribing this medication	Indicate if PCP or Psychiatrist

Are you coordinating your mental health services with the client's PCP? ☐ yes ☐ no

Are you coordinating your mental health services with the client's psychiatrist? ☐ yes ☐ no

If no coordination or contact, please explain why: ________________________________

____

____

Psychiatric History

	Name & Location of Hospital or Provider including discipline	Dates	Reason for Service
Psychiatric Hospitalization			
Outpatient Treatment including current services			

Client Name ____________________ DOB _______________ SS# ________-________-________

Psychiatric History (continued)

	Name & Location of Hospital or Provider including discipline	Dates	Reason for Service
Day Program			
Substance Abuse Treatment including current services			

Medical History

Any report of:

Surgery (when & for what)	☐ yes	☐ no
Chronic Illness (includes seizures, thyroid disorder, cancer, anemia)	☐ yes	☐ no
Hospitalizations	☐ yes	☐ no
Head Trauma	☐ yes	☐ no
Major Accidents	☐ yes	☐ no
Allergies	☐ yes	☐ no
Somatic issues or complaints	☐ yes	☐ no

Provide information for each category in which 'yes' was checked ____

____

____

____

____

____

____

Primary Care Physician ______________________________ Date of last physical exam ____________________

Client Name ____________________ DOB _______________ SS# ________-________-________

Legal History

Is client currently on probation? ☐ yes ☐ no

If yes, provide information regarding arrest & conviction ____

____

____

Suicide Assessment

Suicide/Self-Harm	Assessed Risk Level				
Factors	None	Low	Moderate	High	Uncertain
Current ideation	☐	☐	☐	☐	☐
Expressed intent	☐	☐	☐	☐	☐
Specific plan	☐	☐	☐	☐	☐
Ease & means availability	☐	☐	☐	☐	☐
Access to firearms/weapons in the home	☐	☐	☐	☐	☐
Degree of perceived hopeless/helplessness	☐	☐	☐	☐	☐
Reliability of impulse control	☐	☐	☐	☐	☐
Level of detail of plans to dispense of personal belongings, after death (e.g., preparation of Last Will & Testament)	☐	☐	☐	☐	☐
Amount of and ability to use supportive resources	☐	☐	☐	☐	☐

Lethality of Prior Suicide/Self-Harm Attempts	Assessed Risk Level				
Describe attempt (e.g. Overdose, Accident . . .)	None	Low	Moderate	High	Uncertain
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐

Client Name ____________________ DOB ______________ SS# _______ - _______ - _______

Current Psychosocial Stressors (Briefly identify or describe stressor in appropriate area)

	None/Mild	Moderate	Severe	Undetermined
Family Problems	☐	☐	☐	☐
Social/Interpersonal	☐	☐	☐	☐
Financial	☐	☐	☐	☐
Exposure to Trauma	☐	☐	☐	☐
Housing	☐	☐	☐	☐
School	☐	☐	☐	☐
Work	☐	☐	☐	☐

Additional Information About Psychosocial Stressors

Have you reviewed all available school records, including psychological examinations?	☐ yes	☐ no
Have you had on-going, regular contact with client's teacher/s?	☐ yes	☐ no
Have you had on-going and regular contact with the client's school psychologist?	☐ yes	☐ no
Is the client being considered for EC 26.5/AB 3632 referral?	☐ yes	☐ no
Have you completed a detailed developmental history of the child and made referrals for necessary diagnostic evaluations (e.g., hearing, speech, vision, genetic, D&A)	☐ yes	☐ no

Explain all areas checked 'no' above

Client Name ______________________ DOB ________________ SS# ________-________-________

Child or Youth's Strengths and Family/Support System Resources

Client Name ____________________ DOB ______________ SS# _______-_______-_______

Specific Symptoms & Behaviors

		Status of Symptoms				
Symptom	Date of Onset	None Resolved	Mild Seldom	Moderate Sporadic	Severe Frequent	Check if focus of treatment during this authorization period & if medication utilized
Sleep Disturbance		☐	☐	☐	☐	☐ Focus ☐ Medication
Appetite Disturbance		☐	☐	☐	☐	☐ Focus ☐ Medication
Irritability		☐	☐	☐	☐	☐ Focus ☐ Medication
Anxiety or Panic		☐	☐	☐	☐	☐ Focus ☐ Medication
Depression		☐	☐	☐	☐	☐ Focus ☐ Medication
Bizarre Behavior		☐	☐	☐	☐	☐ Focus ☐ Medication
Compulsions/Obsessions		☐	☐	☐	☐	☐ Focus ☐ Medication
A/V Hallucinations		☐	☐	☐	☐	☐ Focus ☐ Medication
Delusions		☐	☐	☐	☐	☐ Focus ☐ Medication
Suicidal Ideation		☐	☐	☐	☐	☐ Focus ☐ Medication
Homicidal/Assault Ideas		☐	☐	☐	☐	☐ Focus ☐ Medication
Violence Towards Self/Others		☐	☐	☐	☐	☐ Focus ☐ Medication
Destruction of Property		☐	☐	☐	☐	☐ Focus ☐ Medication
Other		☐	☐	☐	☐	☐ Focus ☐ Medication

If Other is check, please describe symptoms: ______________________________

____

Client Name ____________________ DOB _______________ SS# ________-________-________

Substance Abuse Use

			Status of Current Usage				
Substance	Age when Use Began	Check if Family History	None or Resolved	Mild Seldom	Moderate Sporadic	Severe Frequent	Focus of Treatment
Alcohol		☐	☐	☐	☐	☐	☐
Amphetamines		☐	☐	☐	☐	☐	☐
Cocaine		☐	☐	☐	☐	☐	☐
Opiates		☐	☐	☐	☐	☐	☐
Sedatives		☐	☐	☐	☐	☐	☐
PCP		☐	☐	☐	☐	☐	☐
Hallucinogens		☐	☐	☐	☐	☐	☐
Inhalants		☐	☐	☐	☐	☐	☐
Marijuana		☐	☐	☐	☐	☐	☐
Prescription Abuse		☐	☐	☐	☐	☐	☐
Tobacco		☐	☐	☐	☐	☐	☐

DSM IV Diagnosis and Treatment Related Issues

Use **P&S** to specify one **P**rimary and one **S**econdary Mental Health Diagnosis, on Axis I and/or Axis II

AXIS I	Code	P/S
AXIS II	**Code**	**P/S**

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

Client Name ____________________ DOB ______________ SS# ________-________-________

AXIS III			
Other Factors Significantly Affecting Mental Health			
Substance Abuse (if yes, specify in an Axis I Diagnosis)	☐ yes	☐ no	☐ unknown
Developmental Disabilities	☐ yes	☐ no	☐ unknown
Physical Health Disorders (specify below)	☐ yes	☐ no	☐ unknown

AXIS IV
List problem/s making a significant contribution to the client's current disorder

AXIS V
GAF
Enter current level of functioning__________

Treatment Plan to reduce impairment and risks – targets must coordinate with diagnosis

Target Behavior	Intervention	Target Date	New or Continuing Goal
1.			
2.			
3.			
4.			
5.			
6.			

Current medication regimen ____

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

Client Name ____________________ DOB ______________ SS# ________ - ________ - ________

Parent/Guardian Acknowledgement of Treatment Plan

I have read this treatment plan document and understand its contents. I consent to the services recommended.

Parent's Signature	Date	Legal Guardian's Signature	Date

Treatment Authorization Requested Check box if requesting bilingual pay differential ☐

CPT Code	Frequency Requested (e.g., weekly, 2x month, etc.)	Sessions (<13)	Start Date	End Date

Provider Name, typed or printed	Discipline	License #	Signature

Provider Agency, if applicable	Provider Office Phone	Provider Fax Number

---

FOR ACCESS USE ONLY – DO NOT WRITE BELOW THIS LINE

ACCESS Authorization Decision

Add bilingual pay differential ☐

CPT Code	Frequency state	Sessions (<13)	Start Date	End Date

Date of Auth __________ Initials __________ NOA Sent ☐ yes ☐ no Chart Located ☐ yes ☐ no

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

 San Mateo County Behavioral Health & Recovery Services

ACCESS Team, 1950 Alameda de Las Pulgas, San Mateo, CA 94403

Phone: 1-800-686-0101 **FAX: (650) 349-0771**

Client Name ____________ DOB ____________ SS# ______ - ______ - ______

ADULT/OLDER ADULT Medi-Cal Managed Care Re-Authorization Request
Complete & submit after initial ten sessions to request authorization to provide ongoing MH Services.
If no changes after subsequent sessions, submit pages 7, 8, 9 & 10 to request additional authorization.

Provider ____________ Therapist # ____________ or Agency # ____________

Phone ____________ FAX ____________ Check if requesting bilingual pay differential ☐

Date ____________ Date Initial ACCESS Referral ____________ MH # ____________

Client's current address ____________

Phone-Home/message ____________ Cell ____________ Email ____________

Lives with [name and relationship] ____________

Contact person ____________ Contact's phone ____________

Client's Educational Level ____________ Special Ed ☐ yes ☐ no

Primary Language ☐ English ☐ Spanish ☐ Tagalog ☐ Chinese ☐ Russian ☐ Other ____________

Does client have? Rep Payee ☐ yes ☐ no Conservator ☐ yes ☐ no

Case Manager ☐ yes ☐ no GGRC Services ☐ yes ☐ no

If yes, provide name and phone number ____________

Support: ☐ family involved ☐ family not involved/supportive ☐ other resources

Explain: ____________

Presenting Problem(s)

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

Client Name ____________________ DOB ______________ SS# ________ - ________ - ________

Previous Medications

Medication	Symptoms Addressed/focus of Medication regimen	Name and telephone number of physician prescribing this medication	Indicate if PCP or Psychiatrist

Current Medications

Medication	Symptoms Addressed/focus of Medication regimen	Name and telephone number of physician prescribing this medication	Indicate if PCP or Psychiatrist

Are you coordinating your mental health services with the client's PCP? ☐ yes ☐ no

Are you coordinating your mental health services with the client's psychiatrist? ☐ yes ☐ no

If no coordination or contact, please explain why: ________________________________

____

____

Psychiatric History

	Name & Location of Hospital or Provider including discipline	Dates	Reason for Service
Psychiatric Hospitalization			
Outpatient Treatment including current services			

Client Name ______________________ DOB ________________ SS# ________-________-________

Psychiatric History (continued)

	Name & Location of Hospital or Provider including discipline	Dates	Reason for Service
Day Program			
Substance Abuse Treatment including current services			

Medical History

Any report of:

Surgery (when & for what)	☐ yes	☐ no
Chronic Illness (includes seizures, thyroid disorder, cancer, anemia)	☐ yes	☐ no
Hospitalizations	☐ yes	☐ no
Head Trauma	☐ yes	☐ no
Major Accidents	☐ yes	☐ no
Allergies	☐ yes	☐ no
Somatic issues or complaints	☐ yes	☐ no

Provide information for each category in which 'yes' was checked ______________________________

____

____

____

____

____

____

Primary Care Physician ______________________________ **Date of last physical exam** ______________________

Client Name ____________________ DOB ______________ SS# ______ - ______ - ______

Legal History

Is client currently on probation? ☐ yes ☐ no

If yes, provide information regarding arrest & conviction ____

____

____

Suicide Assessment

Suicide/Self-Harm	**Assessed Risk Level**				
Factors	None	Low	Moderate	High	Uncertain
Current ideation	☐	☐	☐	☐	☐
Expressed intent	☐	☐	☐	☐	☐
Specific plan	☐	☐	☐	☐	☐
Ease & means availability	☐	☐	☐	☐	☐
Access to firearms/weapons in the home	☐	☐	☐	☐	☐
Degree of perceived hopeless/helplessness	☐	☐	☐	☐	☐
Reliability of impulse control	☐	☐	☐	☐	☐
Level of detail of plans to dispense of personal belongings, after death (e.g., preparation of Last Will & Testament)	☐	☐	☐	☐	☐
Amount of and ability to use supportive resources	☐	☐	☐	☐	☐

Lethality of Prior Suicide/Self-Harm Attempts	**Assessed Risk Level**				
Describe attempt (e.g. Overdose, Accident . . .)	None	Low	Moderate	High	Uncertain
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐

Client Name ______________________ DOB ________________ SS# ________-_________-________

Current Psychosocial Stressors (Briefly identify or describe stressor in appropriate area)

	None/Mild	Moderate	Severe	Undetermined
Family Problems	☐	☐	☐	☐
Social/Interpersonal	☐	☐	☐	☐
Financial	☐	☐	☐	☐
Exposure to Trauma	☐	☐	☐	☐
Housing	☐	☐	☐	☐
School	☐	☐	☐	☐
Work	☐	☐	☐	☐

Additional Information About Psychosocial Stressors

____

____

____

____

____

____

Client Name ______________________ DOB ________________ SS# _________-_________-_________

Client Strengths

Client Name ____________________ DOB ______________ SS# ________-________-________

Specific Symptoms & Behaviors

		Status of Symptoms				
Symptom	Date of Onset	None Resolved	Mild Seldom	Moderate Sporadic	Severe Frequent	Check if focus of treatment during this authorization period & if medication utilized
Sleep Disturbance		☐	☐	☐	☐	☐ Focus ☐ Medication
Appetite Disturbance		☐	☐	☐	☐	☐ Focus ☐ Medication
Irritability		☐	☐	☐	☐	☐ Focus ☐ Medication
Anxiety or Panic		☐	☐	☐	☐	☐ Focus ☐ Medication
Depression		☐	☐	☐	☐	☐ Focus ☐ Medication
Bizarre Behavior		☐	☐	☐	☐	☐ Focus ☐ Medication
Compulsions/Obsessions		☐	☐	☐	☐	☐ Focus ☐ Medication
A/V Hallucinations		☐	☐	☐	☐	☐ Focus ☐ Medication
Delusions		☐	☐	☐	☐	☐ Focus ☐ Medication
Suicidal Ideation		☐	☐	☐	☐	☐ Focus ☐ Medication
Homicidal/Assault Ideas		☐	☐	☐	☐	☐ Focus ☐ Medication
Violence Towards Self/Others		☐	☐	☐	☐	☐ Focus ☐ Medication
Destruction of Property		☐	☐	☐	☐	☐ Focus ☐ Medication
Other		☐	☐	☐	☐	☐ Focus ☐ Medication

If Other is check, please describe symptoms: ____

____

Client Name ______________________ DOB ________________ SS# ________-_________-________

Substance Abuse Use

			Status of Current Usage				
Substance	Age when Use Began	Check if Family History	None or Resolved	Mild Seldom	Moderate Sporadic	Severe Frequent	Focus of Treatment
Alcohol		☐	☐	☐	☐	☐	☐
Amphetamines		☐	☐	☐	☐	☐	☐
Cocaine		☐	☐	☐	☐	☐	☐
Opiates		☐	☐	☐	☐	☐	☐
Sedatives		☐	☐	☐	☐	☐	☐
PCP		☐	☐	☐	☐	☐	☐
Hallucinogens		☐	☐	☐	☐	☐	☐
Inhalants		☐	☐	☐	☐	☐	☐
Marijuana		☐	☐	☐	☐	☐	☐
Prescription Abuse		☐	☐	☐	☐	☐	☐
Tobacco		☐	☐	☐	☐	☐	☐

DSM IV Diagnosis and Treatment Related Issues

Use **P&S** to specify one **P**rimary and one **S**econdary Mental Health Diagnosis, on Axis I and/or Axis II

AXIS I	Code	P/S
AXIS II	**Code**	**P/S**

Client Name ____________________ DOB ______________ SS# _______-_______-_______

AXIS III			
Other Factors Significantly Affecting Mental Health			
Substance Abuse (if yes, specify in an Axis I Diagnosis)	☐ yes	☐ no	☐ unknown
Developmental Disabilities	☐ yes	☐ no	☐ unknown
Physical Health Disorders (specify below)	☐ yes	☐ no	☐ unknown

AXIS IV
List problem/s making a significant contribution to the client's current disorder

AXIS V
GAF
Enter current level of functioning____________

<u>Treatment Plan to reduce impairment and risks</u> – targets must coordinate with diagnosis

Target Behavior	Intervention	Target Date	New or Continuing Goal
1.			
2.			
3.			
4.			
5.			
6.			

Current medication regimen ____

Client Name ____________________ DOB _______________ SS# _________-_________-_________

Consumer Acknowledgement of Treatment Plan

I have read this treatment plan document and understand its contents. I consent to the services recommended.

______________________	__________	______________________	__________
Consumer's Signature	Date	Legal Guardian's Signature	Date

Treatment Authorization Requested Check box if requesting bilingual pay differential ☐

CPT Code	Frequency Requested (e.g., weekly, 2x month)	Sessions (<13)	Start Date	End Date

______________________	__________	__________	______________________
Provider Name, typed or printed	Discipline	License #	Signature

______________________	__________	__________
Provider Agency, if applicable	Provider Office Phone	Provider Fax Number

FOR ACCESS USE ONLY – DO NOT WRITE BELOW THIS LINE

ACCESS Authorization Decision

Add bilingual pay differential ☐

CPT Code	Frequency state	Sessions (<13)	Start Date	End Date

Date of Auth __________ Initials __________ NOA Sent ☐ yes ☐ no Chart Located ☐ yes ☐ no

Resource Document 16 **San Mateo County Behavioral Health & Recovery Services**

ACCESS Team, 1950 Alameda de Las Pulgas, San Mateo, CA 94403

Phone: 1-800-686-0101 **FAX: (650) 349-0771**

Request for ACCESS Psychiatric Medication Referral

The primary care physician (PCP) is usually the initial contact to request medications for your client. Please consult with your client's PCP as the first step in a medication request. If your client's PCP is unable to provide medication, please complete the following referral form and return it to ACCESS by postal mail to the address above or by fax to the number at above right.

Mental Health # ______________

Client Name ______________________ DOB ______________ SS# - - ______________

DIAGNOSTIC IMPRESSIONS

I ____

II ____

III ____

Name of PCP __________________________ PCP Office Phone ______________

Reason PCP is unavailable to provide medications: ______________________________

____

____

Please list your specific concerns and/or questions for the psychiatrist to address, including a brief history of your treatment and prior medications. (e.g., reason for evaluation for medication, change of meds, consultation with PCP.)

____

____

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____

Clinician Name Clinician Telephone

______________________________ ______________________________

Resource Document 16

San Mateo County Health System

Behavioral Health and Recovery Services

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

REFERRAL for PSYCHOLOGICAL EVALUATION

SECTION I: COMPLETED BY CLINICIAN

Date ________________________

Name of Person Referred for Evaluation ____

Phone # ______________________ DOB ________________ BHRS Record # ______________________

Referring Clinician ____ Phone # ____________________________

REQUIRED DOCUMENTATION

- ☐ Client's *Social History* updated within the past 30 days.
- ☐ Additional records, such as previous *psychological evaluations, treatment, court or educational records*.
- ☐ If the client is in mental health treatment, a *treatment summary* updated within the past 90 days.

CLINCIAL REASONS FOR REQUESTING EVALUATION (Please check all that apply.)

- ☐ Diagnosis unclear
- ☐ Parenting ability uncertain
- ☐ Not progressing in mental health treatment
- ☐ Change in daily functioning
- ☐ Question about social/interpersonal, emotional or cognitive functioning at home, school or community
- ☐ Recommend from prior assessment or current mental health services
- ☐ Other ____

Do you believe the individual is actively using alcohol or drugs? ☐ Yes ☐ No ☐ Don't Know

Has the client ever participated in mental health or substance abuse services? ☐ Yes ☐ No

Has the client had a previous psychological evaluation? ☐ Yes ☐ No

List the client's current medications. ____

____

____

CLIENT PRESENTS WITH SPECIAL NEEDS THAT MUST BE ACCOMMODATED DURING THE EVALUATION

- ☐ Primary language other than English (specify)
- ☐ Hearing-impaired
- ☐ Physically-disabled
- ☐ Vision impaired
- ☐ Out-of-Office testing needed (e.g., client in hospital, DOC)
- ☐ Other

Please describe what event/s in the case or in the individual's behaviors lead to referral for a psychological evaluation at this time. ____

____

____

____

____

Signature of Clinician ______________________ Date ______________

Signature of Supervisor ______________________ Date ______________

Name of Supervisor ______________________ Phone ______________

SECTION II: COMPLETED BY CONSULTING PSYCHOLOGIST

The BHRS Consulting Psychologist may discuss with the clinician to complete the following information. An in-person or telephone consultation will be requested if needed.

This request for psychological evaluation is (check one):

☐ ***APPROVED***. In the space below, list and number referral questions to be addressed by BHRS Approved Psychological Testing Provider. Include any recommendations for specific types of testing needed (e.g. adaptive functioning, achievement). Provider will copy verbatim these questions in the Referral Question section of Provider's Psychological Evaluation report.

Check type of evaluation required:

☐ **Intelligence** ☐ **Neuropsychological** ☐ **Personality**

☐ **Memory** ☐ **Developmental** ☐ **Academic/Learning**

☐ ***REJECTED/DEFERRED***. Use space below to explain reasons for doing so. If deferred, specify what additional information is needed before rendering a decision.

____

____

____

____

____

____

____

Identify additional documentation from previous psychological evaluation, if provided.________________

____

Homebound or out-of-office testing is needed: ☐ Yes ☐ No

Person/s being evaluated ____

____

Signature of Consulting Psychologist _____________________________ Date _______________

Printed Name of Consulting Psychologist __________________________ Phone ______________