



San Mateo County ~ Behavioral Health & Recovery Services

Managed Care Provider Manual

For Individual & Agency Providers

Revised 09/2018

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WELCOME

New and Returning Outpatient Providers

Welcome to the San Mateo County Mental Health Plan (MHP), Behavioral Health and Recovery Services Division. We are pleased that you have chosen to join our provider network and look forward to working together to help our clients and their families benefit from mental health and substance use disorder services.

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 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 which positions us well to keep pace with our changing field and environment. We believe 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 populations. We appreciate your thoughts, suggestions, and participation.

Our goal is to do all we can to support you in serving the children, families and adults of San Mateo County who need mental health and/or drug and alcohol services. Thank you for your participation. Please feel free to contact us at any time with any questions, feedback or suggestions.

Selma Mangrum, LCSW
BHRS Access Call Center Manager
650-573-2615
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Mental Health Managed Care Plan

CONTACT INFORMATION

ACCESS CALL CENTER	PHONE: 1-800-686-0101 FAX: (650) 596-8065
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<u>UTILIZATION MANAGEMENT</u> T.J. FAN, PhD <i>U.M. Coordinator & Clinical Consultant</i>	PHONE: (650) 573-2722 EMAIL: tjfan@smcgov.org
<u>PROVIDER RELATIONS</u> LAURA SMITH, LMFT <i>Provider Relations & QI Coordinator</i>	PHONE: (650) 573-3476 EMAIL: lsmith@smcgov.org
<u>CONTINUED AUTHORIZATION LINE</u> OFFICER OF THE DAY <i>Continued Authorizations, Medication referrals</i>	PHONE: (650) 372-6147
<u>PROVIDER CONTRACTS</u> HELEN RODRIGUEZ <i>Contracts</i>	PHONE: (650) 573-2242 FAX: (650) 573-2110 EMAIL: hrodriguez@smcgov.org
<u>PROVIDER BILLING</u> ELVIRA GOMEZ <i>Claims, Billing Inquiries</i>	PHONE: (650) 573-2068 EMAIL: egomez2@smcgov.org

MANAGED CARE PROVIDERS WEBSITE: <http://www.smchealth.org/bhrs/contracts>

ACCESS CALL CENTER: 310 Harbor Blvd. Bldg. E, Belmont, CA 94002

BILLING ADDRESS: BHRS - Provider Billing 2000 Alameda de Las Pulgas, Suite 280 San Mateo, CA 94403

Client/Beneficiary Eligibility

San Mateo County residents who are covered by Medi-Cal, Care Advantage, Cal Medi-Connect, Healthy Kids, and Healthworx insurance are eligible for mental health services. Beneficiaries and their providers are notified in writing at any point that it is discovered that the beneficiary's insurance status has changed, rendering the beneficiary ineligible for services. Notification is provided by the Claims and Billing department and beneficiaries are given a minimum of 30 days to re-establish eligibility or to terminate services.

Covered mental health benefits include:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Psychological testing when clinically indicated to evaluate a mental health condition
3. Medication
4. Psychiatric Consultation
5. Outpatient Laboratory, drugs, supplies and supplements

Utilization Management

All beneficiaries are eligible for an initial assessment to determine medical necessity for mental health services.

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 service after:
 - referral to other county or community social welfare, protective or health agencies, and/or
 - education about the immediate non-mental health situation.

Your completed assessment will be reviewed for diagnosis, treatment goals, and number of sessions requested. All or part of the number of sessions requested may be approved, denied or partially denied based on medical necessity as supported by industry standards found in Milliman Care Guidelines. You will be notified if the approval will be different from the request and you will have the opportunity to provide further documentation to justify the original request.

Participating as a Managed Care Private Provider

Providing high quality care for behavioral health clients is a top priority of the MHP. To assure quality care and services, the following is expected from all BHRS and contracted providers.

Provider Responsibilities:

1. ***Availability of first appointment:*** New clients must be offered a first available appointment within FIVE (5) working days from the date of authorization. The Access Call Center will authorize new clients according to provider geographical location and availability. It is expected that once authorized to a new client, calls are returned to the client within 24 hours. If a client is unable to accept the first available appointment, it is acceptable to offer another day and time. If you are unable to meet this standard for any reason, contact Provider Relations to be placed on the Inactive List. Clients should not be put on a waiting list.
2. ***Provider Availability:*** It is necessary to keep Provider Relations informed of provider availability; including number of vacancies, planned unavailability, vacation coverage, and filled schedules in order to be placed on an inactive list and avoid referrals which cannot be accommodated. It is the provider's responsibility to notify Provider Relations when able to accept new clients. It is also the provider's responsibility to arrange for coverage of current clients during planned absences
3. ***Returning calls:*** Calls left by clients must be returned within 24 hours. While we respect the fact that schedules may make this difficult at times, it is expected that every effort be made to meet this requirement.
4. ***Transition of Care:*** In the event that a provider determines that he/she is no longer able to provide services to an authorized client and the client continues to need ongoing care, a higher level of care, or to be temporarily reassigned; the provider must contact the Access Call Center to request assistance with assuring appropriate transition of care.
5. ***Compliance with legal and ethical standards:*** Services are to be provided in accordance with legal and ethical standards: as required by all relevant professional, federal, state, and/or local regulatory and statutory requirements.
6. ***Scope of Practice:***
 - a. Individual providers must be Licensed Practitioners of the Healing Arts (LPHA). This includes MD, DO, NP, LCSW, MFT, LPCC, 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 waived professional. Registered or waived staff are clinicians who are post-graduate Marriage & Family Therapist (MFTi) or Social Work (ASW) interns who are registered with the Board of Behavioral Sciences, or post-graduate psychologists who are waived by the California Department of Health Care Services (DHCS) through request of the MHP.
- 7. **Notification of Authorization:** Providers are to inform all inquiring beneficiaries of the requirement for authorization prior to beginning a course of treatment. **Communication:** Providers are to assist beneficiaries with the process of communication with the ACCESS Team at the ACCESS Call Center at 1-800-686-0101.
- 8. **Maintenance of clinical records:** Provider records must be kept according to San Mateo County Behavioral Health and Recovery 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.

Clinical records must be maintained **for at least ten 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 ten years and must be made 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.
- 9. **Compliance with County policies and procedures:** The provider will 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>. Providers are responsible to do the following
 - a. 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.
 - b. Provide material about advance healthcare directives and lists of MHP providers upon request. MHP Provider Lists are available from The ACCESS Call Center 1-800-686-0101.
- 10. **Equal availability and Accessibility of Service:** Hours of operation should be 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.

MENTAL HEALTH PLAN RESPONSIBILITIES

RESPONSIBILITIES

The MHP will do the following:

1. Provide a 24-hour toll-free telephone line for information and referrals: ACCESS Call Center, 1-800-686-0101.
2. Screen all beneficiaries who request or are referred for outpatient services, for need and eligibility for services and to assess those who meet insurance eligibility.
3. Authorize face-to-face assessments that can be scheduled within 5 working days from the point that it has been determined that the beneficiary qualifies for an assessment.
4. Maintain written communication with beneficiaries, contract providers, and referring sources so that an unbroken feedback loop concerning service need and clients' rights is established.
5. Maintain the following standards:

Standards

- a. Confirmation of authorization will be telephoned to contract providers within 24 hours of authorization of services.
- b. Written confirmation of authorization will be sent to the beneficiary and contract provider within one week of determination of need for services.
- c. Beneficiaries and providers requesting continued authorization of services will be informed verbally and in writing when no need for further services is determined.

PROVIDER BULLETINS and ADMINISTRATIVE LETTERS

Provider Bulletins or Administrative Letters are e-mailed or mailed to contract providers, to inform 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.

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:

- a. Access to medical records;
- b. Amendments to medical records;
- c. Restrictions on the use of protected health information;
- d. Access to an accounting of disclosures;
- e. Confidential communications; and
- f. 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: <https://www.smchealth.org/bhrs/providers/ontrain>. You may obtain 2 free CEUs by completing the post test. (This training meets the requirement for 2 Law & Ethics CEUs.)

MENTAL HEALTH DIAGNOSIS CODING

Mental health diagnoses should be reported using DSM5 description and ICD-10 code.

SERVICES BY “COVERING” PROVIDER

Providers providing coverage 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 their own authorization of services prior to submitting a claim. Without such authorization, claims submitted will be pended and, in some cases, ultimately could be denied.

CONSENT TO MEDICATIONS

For psychiatrists and nurse practitioners, 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.

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 or nurse practitioner, for an MHP beneficiary. (Physical health care medications are the responsibility of the HPSM.)

MHP 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:
 - a. accessibility;
 - b. services that are meaningful and beneficial to the client;
 - c. services that are culturally and linguistically competent;
 - d. services that produce highly desirable results through the efficient use of resources;
 - e. 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, are available through the County Health Services website. To explore the selection of online trainings, please go to:
<https://www.smchealth.org/bhrs/providers/ontrain>

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 will monitor clients' satisfaction regarding services using the client satisfaction surveys received from providers on an annual basis.

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, will be initiated.

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

Treatment Authorization

1. Standards:

- Requests for emergency services should be referred to Psychiatric Emergency Services (PES) at 650-573-2662.
- All planned services to beneficiaries except initial assessments **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:

When you have been authorized to provide mental health services to a health plan member, you will be contacted by the Access Call Center with the client's name, phone number, and authorization number. You will also receive a copy of the authorization by fax and/or mail. The client has also been given your name and phone number and should be calling you to set up an appointment. It is expected that you will return the client's call within 24 hours, and be able to offer the client a first appointment within five business days.

For LMFT, MFTi, LCSW, ASW, PhD, PsyD, LPCC:

Authorized services for assessment:

For Adult Clients: Your initial authorization provides you with authorization for two assessments, one 15-minute phone consultation, and two no-shows. (2) 90791 (1) 99442 (2) N0000.

For Youth Clients: Your initial authorization provides you with authorization for two assessments, one family session, one 15 minute phone consultation, and two no-shows. (2) 90791 (1) 90847 (1) 99442 (2) N0000.

MD or Nurse Practitioner:

Authorized services for a medication evaluation:

For Adult & Youth Clients: Your initial authorization provides you with authorization for **one assessment session** and provides for two no shows. Choose either 90792 (Psychiatric Evaluation with Medical Services), or one of the Evaluation and Management (E&M) codes -whichever is most appropriate for the session. If you choose an E&M code, follow the Evaluation and Management Services Guide, published by the

American Psychiatric Association and American Academy of Child & Adolescent Psychiatry, (which can be found on P. 20 of this manual or the Managed Care Provider website.) The following is an example regarding choice of CPT code:

CPT code 99205 supports a service where comprehensive history and examination are performed, and the client's condition demands high complexity of medical decision making. Please note that a comprehensive history includes a complete Review of System which covers at least 10 body systems, and a comprehensive examination includes recording vital signs. A high complexity of medical decision-making is for situations in which serious problems or multiple problems occur, many additional data are required, and/or the risk of the presenting condition is high. E&M Codes in the 9920x series, including 99205 and 99204, can only be used once, and if you haven't seen this client in the last three years. The initial authorization that you receive will include the series of assessment CPT codes. You may choose only one CPT code--that which best reflects the service provided.

3. **Authorization for Treatment:**

Once you have met with and assessed your new client you must complete the Managed Care Assessment and Client Plan, and the Assignment of Benefits (AOB) form. The treatment plan which is part of the assessment, must be completed with, and signed by the client/guardian. The last page of the Managed Care Assessment contains the treatment authorization request for requesting additional services. Fax the Managed Care Assessment and Client Plan to the Access Call Center at 650-596-8065 or mail to 310 Harbor Blvd. Bldg. E, Belmont, CA 94002.

Mail the Assignment of Benefits (AOB) form to the Claims Department: 2000 Alameda de las Pulgas Suite 280, San Mateo, CA 94403.

Your completed assessment will be reviewed for diagnosis, treatment goals, and number of sessions requested. All or part of the number of sessions requested may be approved, denied or partially denied based on medical necessity as supported by industry standards found in Milliman Care Guidelines. You will be notified if the approval will be different from the request and you will have the opportunity to provide further documentation to justify the original request.

Once you have received your authorization report, it is important to make note of the authorization expiration date. The expiration date is the last date on which the service authorization can be used. After this date, the authorization will be invalid even if all authorized services have not been utilized.

4. **Requests for Continued Authorizations:** At the conclusion of an authorized period, if you determine that your client continues to need additional services, a **Continued Authorization Request form** must be completed along with a new Client Treatment Plan that includes updated goals, interventions, and provider and client signatures. Be sure to submit the request well in advance of the expiration of your current authorization to avoid denial of payment of unauthorized services. The initial assessment is good for up to three years but may be updated with new information at any time. For continued services beyond three years, a new full assessment must be completed and submitted with the treatment plan.
5. **Progress notes:** It is a state requirement that you include all of the following elements in your progress notes. You must sign each progress note and include degree/license # and date the note was written. You may use your own progress notes and include the elements below or the progress notes template found at <http://www.smchealth.org/bhrs/contracts>
 - Client Name, MR#
 - Provider/Agency name
 - Date & Year of Service
 - Face-Face Minutes (Client Present) – billed min.
 - CPT Code
 - Service Time (Client not present)
 - Location Code
 - Language (if language svcs. provided)
 - Diagnosis Addressed
 - Service Description: Goal/behavior addressed, interventions, client's response/outcome, and plan
6. **Requests for Medication Evaluation:**

Please consult with your client's Primary Care provider as the first step in a medication request. If your client's PCP is unable to provide psychiatric medication, you may complete a **Psychiatric Medication Referral** and fax it to 650-596-8065. You will be notified when your client has been authorized to a provider who can assess for medication.
7. **Termination of Treatment:** The **Closing Summary** is filled out and submitted when the provider and beneficiary agree that treatment has concluded; when an authorization expires and no further services will be requested or when a client fails to show for services. Fax to 650-596-8065.

All required forms can be found at: <http://www.smchealth.org/bhrs/contracts>

CLAIMS AND BILLING INFORMATION

1. Payment Policies

Authorized, valid claims for services will be processed for payment if:

- a. the services were preauthorized by the MHP ACCESS Team;
- b. the services were delivered by a contract provider; and
- c. the services 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. Providers may call Human Services Agency (HSA) at 1-800-223 8383 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
2000 Alameda De Las Pulgas, Suite 280
San Mateo, California 94403

Health Insurance Claim Form (HCFA 1500) – Complete this form and mail to Provider Billing at the address above to request payment for services. Remember to include the Procedure/CPT code and duration of service in minutes in the modifier column in section 24D. The minutes of the service must match the minutes of service on the progress note.

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.

SERVICE DESCRIPTIONS

The following are general descriptions for most commonly provided services:

Assessment: Assessment services include clinical analysis of the history and status of the client's mental, emotional or behavioral condition.

Individual Therapy Individual Therapy services are those therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction 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.

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.

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

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.

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

Pharmacologic Management 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

Clinical Consultation (Inter-professional): Clinical consultation refers to collaboration with other providers who are important in client's treatment such as PCP, psychiatrist, previous therapist, teacher, social worker etc. This is not to be used to talk to parents or family members or for supervision or consultation about clients.

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.

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 beneficiaries can initiate grievances and appeals. It also provides ongoing outreach to inform and educate clients and their families about how they can participate in that process. It includes mechanisms to monitor and act 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 Family and Consumer Protection Manual has been written to detail the process and procedures involved when beneficiaries are not satisfied with their benefits or services which can be found at <http://www.smchealth.org/support-clients-family>. 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.

What happens if a beneficiary files a grievance about a provider?

Grievances or complaints filed by beneficiaries regarding private providers are investigated as follows:

1. Beneficiary expresses a complaint about the provider or services
2. An acknowledgement letter is sent to the beneficiary within five calendar days of receipt
3. The provider is contacted by Access staff with a request for a formal response to the grievance
4. A Resolution letter is mailed to the beneficiary and the provider within 30 calendar days of receipt of the grievance.
 - i) Quality of Care concerns are reviewed by the Quality of Care Grievance Committee
 - ii) Grievances regarding providers who receive reoccurring complaints from beneficiaries are discussed at the BHRS credentialing committee and may be subject to the procedures outlined in procedures outlined in BHRS Policy 98-10, which can be found at: <https://www.smchealth.org/bhrs-doc/concernscomplaints-about-mhp-individual-and-organizational-contract-providers-98-10>

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. Other issues as determined by the provider.
- B.** A provider may present a complaint to the Provider Relations Coordinator by telephone, in person or in writing.
1. The Provider Relations Coordinator 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 below.

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

III. APPEALS

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 Health Plan of San Mateo. The appeal should include all supportive documentation regarding the provider's claim. The written appeal must reach the Health Plan of San Mateo Grievance and Appeals team within 60 days of the postmark or fax date of notification of the non-approval of payment for Medi-Cal claims, and 90 days for Care Advantage/Cal Medi-Connect, Healthworx or healthy Kids claims.

- **HOW TO FILE AN APPEAL**
- You can file an appeal by phone, in writing, or electronically:
- **By phone:** Contact the Health Plan of San Mateo (HPSM) Grievance and Appeals team, Monday – Friday between 8:00 a.m. – 5:00 p.m. by calling **1-888-576-7227** (toll-free) or **650-616-2850**. Or, if you cannot hear or speak well, please call **1-800-735-2929** or dial **7-1-1**.
- **Electronically:** Visit the HPSM website at www.hpsm.org.
- **In writing:** Fill out an appeal form or write a letter and send it to:

Health Plan of San Mateo
Attn: Grievance and Appeals
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

ATTACHMENT A

CLIENT TREATMENT & RECOVERY PLAN

CLIENT TREATMENT & RECOVERY PLAN

The Client Treatment & Recovery Plan is a primary way of involving clients in their own care. The development of the Client Plan is an interactive process between the client and the treatment team. It is designed to establish the client's treatment goals, develop a set of objectives to help realize these goals, and reach agreement on the services we will provide. Program goals should be consistent with the client's/family's goals as well as the diagnosis and assessment. The client plan must include documentation of the client's participation in the development of, and agreement with the client plan.

CLIENT PARTICIPATION

Client participation in the formulation of the treatment plan is documented by obtaining the signature of the client/parent/guardian, providing a copy of the plan to the client/family member, OR by documenting in a progress note how the client/parent/guardian participated in developing and approving the treatment plan.

It is not sufficient to write on the plan or in a progress note that the client missed the Plan Development appointment or could not be reached; this does not describe the client's participation.

It must be documented that a copy of the plan was offered to the client and if the client accepted or declined the copy. Offering a copy of the plan to the client/family member is an important acknowledgment of the client's involvement in the development of the client plan, and demonstrates the clinician's commitment to involving clients/families as full participants in their own recovery process.

Treatment Plans must be written in the client's preferred language. If the preferred language is not English, the treatment plan must be translated into English as well.

The 10 elements required by the current MHP & SUD/ODS Contract with DHCS:

1. Statement of the problem to be addressed;
 2. An expected frequency for each proposed intervention;
 3. An expected duration for each proposed intervention and target dates;
 4. Adequate documentation that the beneficiary was offered a copy of the Plan;
 5. Observable and measurable goals and objectives; SMART (*See pg. 15)
 6. Provider's signature with Degree/License or job title on the Plan;
 7. Specific behavioral interventions (description) for each proposed service;
 8. All interventions that were actually delivered to the beneficiary;
 9. Timely completion according to the MHP's or SUD provider's own documentation standards;
 10. Documentation that the beneficiary participated in and agreed to the Plan;
- Date of the Provider's signature on the Plan (i.e., date completed).

ATTACHMENT B

CLIENT TREATMENT & RECOVERY PLAN ELEMENTS:

CLIENT'S OVERALL GOAL/DESIRED OUTCOME - The client's desired outcome from successful treatment.

This is the reason the client is seeking treatment. Overall goals are broad life goals, such as returning to work or graduating from high school, that reflect the client's intent and interests. The overall goal should be clear to the client and the treatment team, and it should reflect the client's preferences and strengths. These goals have a special place in a system committed to recovery – they should speak to the client's ability to manage or recover from his/her illness and to achieve major developmental milestones.

DIAGNOSIS/RECOVERY BARRIER/PROBLEM – *Primary Diagnosis'* signs/symptoms/impairments, and other barriers/challenges/problems. Describes the behavioral health symptoms and impairments that are the focus of treatment.

GOAL –The removal or reduction of the problem.

The goal addresses the problem. The goal is the development of new skills/behaviors and the reduction, stabilization or removal of the barrier/problem. Individual goals address the barriers that prevent clients from reaching overall goals. They are generally related to important areas of functioning - affected by the client's mental health condition - such as living situation, daily activities, school, work, social support, legal issues, safety, physical health, substance abuse and psychiatric symptoms. The treatment plan must clearly document how a particular goal reflects the client's mental health condition. Goals must relate to the diagnosis and case formulation and be specific and observable.

OBJECTIVE(S) – What the client will do.

This is a breakdown of the goal. It may include specific skills the client will master and/or steps or tasks the client will complete to accomplish the goal. Objectives should be specific, observable or quantifiable, and related to the assessment and diagnosis. A simple mnemonic that may be helpful when working with the client to develop program objectives is SMART (Simple, Measurable, Accurate, Realistic, Time-bound).

INTERVENTION(S) – The specific services that staff will provide.

These are all of the service types that will be utilized in treatment (e.g., Medication Support, Family Therapy, Individual Therapy, Group Therapy...etc.) List all that apply. Interventions describe actions to be taken by the provider (i.e. services or service modality) to assist clients in achieving their goals. Every planned intervention (such as individual therapy, family therapy) must be listed. An intervention added in the course of treatment must be written and dated on the plan.

DURATION OF INTERVENTION - This time frame is a prediction of how long the intervention will be needed; it is the total expected timespan of the service.

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Evaluation and Management Services Guide

Coding by Key Components

AMERICAN ACADEMY OF
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PSYCHIATRY
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History	Chief Complaint (CC)		History of present illness (HPI)		Past, family, social history (PFSH)		Review of systems (ROS)				
	Reason for the visit		Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms		Past medical; Family medical; Social		Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic				
	CC		HPI		PFSH		ROS		History Type		
	Yes	Brief (1-3 elements or 1-2 chronic conditions)		N/A		N/A		N/A		Problem focused (PF)	
		Extended (4 elements or 3 chronic conditions)		Pertinent (1 element)		Extended (2-9 systems)		Problem pertinent (1 system)		Expanded problem focused (EPF)	
Complete (2 elements (est) or 3 elements (new/initial))				Complete (10-14 systems)		Detailed (DET)		Comprehensive (COMP)			

Examination	System/body area		Examination	
	Constitutional		<ul style="list-style-type: none">3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weightGeneral appearance	
	Musculoskeletal		<ul style="list-style-type: none">Muscle strength and toneGait and station	
	Psychiatric		<ul style="list-style-type: none">SpeechThought processAssociationsAbnormal/psychotic thoughtsJudgment and insightOrientationRecent and remote memoryAttention and concentrationLanguageFund of knowledgeMood and affect	
	Examination Elements		Examination type	
	1-5 bullets		Problem focused (PF)	
	At least 6 bullets		Expanded problem focused (EPF)	
	At least 9 bullets		Detailed (DET)	
	All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box		Comprehensive (COMP)	

Med Dec Making	Medical Decision Making Element		Determined by	
	Number of diagnoses or management options		Problem points chart	
	Amount and/or complexity of data to be reviewed		Data points chart	
	Risk of significant complications, morbidity, and/or mortality		Table of risk	
	Problem Points			
	Category of Problems/Major New symptoms		Points per problem	
	Self-limiting or minor (stable, improved, or worsening) (max=2)		1	
	Established problem (to examining physician); stable or improved		1	
	Established problem (to examining physician); worsening		2	
	New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)		3	
New problem (to examining physician); additional workup planned*		4		
*Additional workup does not include referring patient to another physician for future care				

MANAGED CARE PROVIDER MANUAL SAN MATEO COUNTY HPSM/BHRS

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