SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

San Mateo County
Behavioral Health & Recovery Services

Specialty Mental Health Provider Manual

For Individual & Agency Providers

Revised 08.2021

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Welcome
SPPN Providers

Welcome to San Mateo County Behavioral Health and Recovery Services (BHRS). We are pleased that you have chosen to join the Specialty Mental Health Private Provider Network (SPPN) and look forward to working together to help consumers and their families benefit from mental health services. This manual will help you understand BHRS and the context in which we operate. It includes information such as what you can expect when you receive a new referral, responsibilities as a SPPN provider, and responsibilities of BHRS.

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 consumers' 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.

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 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
smangrum@smcgov.org

Contact Information

Access Call Center	**Phone:** (800) 686-0101 **Fax**: (650) 596-8065 310 Harbor Blvd., Bldg. E, Belmont, CA 94002
Access Call Center Manager Selma Mangrum, LCSW *Clinical Services Manager*	**Phone**: (650) 573-2615 **Email**: smangrum@smcgov.org
Utilization Management T.J. Fan, Ph.D. *U.M. Coordinator*	**Phone**: (650) 573-2722 **Email**: tjfan@smcgov.org
Provider Relations Laura Smith, LMFT *Provider Relations & QI Coordinator*	**Phone:** (650) 573-3476 **Email**: ljsmith@smcgov.org
Authorization Line *Authorization request inquiries*	**Phone:** (650) 372-6147
Learning Management System (LMS) Amber Ortiz *LMS Log in issues*	**Email:** alortiz@smcgov.org
Contracts & Credentialing Teri Whitaker *Credentialing, Updates to contact info*	**Phone:** (650) 573-2831 **Email:** twhitaker@smcgov.org
Provider Connect (PConn) Alys Herring *Password, log in issues*	**Email**: aherring@smcgov.org
Claims and Billing Jayme Berja *Claims, billing inquiries*	**Phone**: (650) 573-3645 **Email**: jaberja@smcgov.org 2000 Alameda de las Pulgas, Ste. 280 San Mateo, CA 94403
Compliance Officer Scott Gruendl, MPA, CPCO *Compliance issues, consults, reporting fraud, waste, and abuse*	**Phone**: (650) 573-2491 **Email**: sgruendl@smcgov.org

Receiving a Referral from BHRS

All BHRS clients receiving specialty mental health services at a BHRS clinic, participate in an assessment and treatment planning process with their clinical care team. When a BHRS client is referred to you, **you become a member of the client's treatment team.**

Referral Process

When a new client is referred to you for therapy, you will be contacted by the BHRS Access Call Center with the client's demographics, clinical information, and services authorized.

If a you are unable to accept a referral for any reason, we ask that you contact Access at 1-800-686-0101 within 24 hours of receiving the referral.

Your contact information will be shared with the client's BHRS Care Coordinator (CC) who will contact you to schedule the first Clinical Team Meeting and send you a copy of the client's assessment and treatment plan. The treatment plan will identify treatment goals, objectives, interventions, and frequency and duration of services. *It is expected that you return the BHRS care coordinator's call within 48 hours.*

Clinical Team Meetings

As a SPPN provider and member of the treatment team, you will be expected to participate in Clinical Team Meetings, prior to the start of therapy services with the client. Meetings between the BHRS clinic providers and the SPPN providers aim to develop a partnership between the two systems and to enhance the effectiveness of the behavioral health services for our shared clients.

a. There will be a minimum, of two team meetings in the first year of the SPPN referral, and at least one meeting annually, thereafter.

b. The first team meeting will take place within two (2) weeks of the referral, prior to the client starting therapy, the second meeting (and annual meeting) is expected to take place no later than 30 days prior to the end of the authorization.

c. Additional team meetings will be convened as clinically indicated.

Convening the Clinical Team Meetings

The client's care coordinator is responsible for reaching out to providers and other team members to schedule and convene all team meetings. Additional team meetings can be requested by any team members as needed.

What to expect during Clinical Team Meetings

Initial Clinical Team Meeting: Prior to this meeting, the care coordinator and the SPPN provider will review the client's assessment, treatment plan, and referral information. The care coordinator will facilitate the meeting to cover the following:

a. Clarification of roles of all parties involved.
b. Sharing of key clinical issues identified during assessment and course of treatment as well as current working treatment goals, especially related to therapy.
c. Sharing of clinical impressions and recommendations after review of relevant clinical documentation, including any identified risk factors such as SI/HI or assaultive behaviors.
d. Amendment, modification, and/or updating of client's treatment plan as needed, based on discussion.
e. Establishment of tentative meeting date for the following team meeting at least 30 days prior to end of authorization.

Follow-up Clinical Team Meeting (30 days prior to end of treatment plan/service authorization)

The team will meet to review progress, or lack thereof, and discuss treatment plan updates/modifications or termination.

a. If the client selects a new/updated treatment goal for which the treatment team concurs that therapy would continue to be an appropriate intervention, the care coordinator will update the treatment plan to extend authorization for continued therapy services, based on new/updated treatment plan goals and interventions.

b. If the client has achieved optimal improvement, the treatment team determines that the client will not benefit from further therapy, or if the client is no longer interested in therapy; termination plans will be discussed.

Participating as a Specialty Mental Health Provider

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

Provider Responsibilities

Availability of first appointment: The Access Call Center will refer clients according to provider geographical location, availability, specialties, and language spoken. The client must be seen within **ten (10) business days** of the request for an appointment. If you are unable to meet this standard for any reason, please contact Provider Relations. Clients should not be put on a waiting list.

Provider Availability: It is necessary to keep Provider Relations informed of your 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 your responsibility to notify Provider Relations when able to accept new clients. It is also your responsibility to arrange for coverage of current clients during planned absences.

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.

Provider Planned Absences: In the case of a planned absence, it's expected that you communicate with the client's BHRS treatment team in advance, to plan for supportive services during your absence.

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.

Scope of Practice:
Individual providers must be Licensed Practitioners of the Healing Arts (LPHA). This includes, LCSW, LMFT, LPCC, and licensed Psychologist.

Agency providers may be any of the above LPHAs, a registered or waivered professional, or a trainee with co-signer who is a licensed clinical professional. Registered staff are clinicians who are post-graduate Marriage & Family Therapist (AMFT) or Social Work (ASW) associates who are registered with the Board of Behavioral Sciences. Waivered staff are post-graduate psychologists who are waivered by the California Department of Health Care Services (DHCS) through request of BHRS.

Request for Services: Providers are to assist clients who are calling to request services with the process of contacting the Access Call Center at 1-800-686-0101.

Maintenance of clinical records: Provider records must be kept according to San Mateo County BHRS 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 client, 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 BHRS, 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.

Audits: BHRS Quality Management will conduct regular chart audits of contracted providers. You are required to provide either the original or copies of charts, including all documentation upon request. The Department of Health Care Services and other regulatory agencies conduct regular audits of the clinical

services provided by BHRS and providers, requiring submission of charts as requested. You are required to provide all necessary documentation for external audits and reviews within the stated timeline.

Compliance with HIPAA, Confidentiality Laws, and PHI Security: You must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI), including electronic PHI that it creates, receives, maintains, uses or transmits, in compliance with 45 C.F.R and to prevent use or disclosure of PHI other than as provided for by this Agreement. You shall implement reasonable and appropriate policies and procedures to comply with the standards. You are required to report any security incident or breach of confidential PHI to BHRS Quality Management within twenty–four (24) hours. The Compliance Hotline is (650) 573-2695.

Critical Incident Reporting: You are required to submit Critical Incident reports to the BHRS Clinic Supervisor when there are unusual events, accidents, errors, violence or significant injuries requiring medical treatment for clients, staff or members of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.). Incident reports are confidential; however, discussion may occur with the provider regarding future prevention efforts to reduce the likelihood of recurrence. You are required to participate in all activities related to the resolution of critical incidents.

Compliance with County policies and procedures: You will comply with County policies and procedures relating to client's rights and responsibilities. Policies and brochures are available on the county Health System internet site http://www.smchealth.org/bhrs/providers/mandpost. You are responsible for displaying 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

Equal availability and Accessibility of Service: Hours of operation should be no less than the hours of operation offered to commercial enrollees, if you also serve enrollees of a commercial plan, or that are comparable to the hours you make available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if you serve only Medi-Cal clients.

Support Survey and Data Collection: Support BHRS efforts to survey clients and collect data that informs customer service and service quality.

Referral Standards:

- Need for emergency services should be directed to 9-1-1 or to Psychiatric Emergency Services (PES) at 650-573-2662.
- All planned services to clients except initial assessments MUST BE PRE-AUTHORIZED by BHRS.
- Services provided to clients without authorization will not be reimbursed.
- BHRS reserves the final right of assignment of the client to a service provider. Client choice, history of treatment, and ability to meet special needs will be important factors in this decision.

Training Requirements

Compliance trainings must be completed on an initial and then annual basis (on or before the previous year completion date). A record of completed trainings should be maintained. Required trainings are as follows:

New BHRS Contractor Compliance Bundle, which includes the following four trainings:

- *Confidentiality and HIPAA for Mental Health and AOD*
- *Compliance Training for BHRS*
- *Fraud, Waste, and Abuse*
- *Critical Incident Reporting*

In addition to the above, the following trainings may also be required:

- *Cultural Humility* (one-time requirement)
- *Sexual Orientation Gender Identity (SOGI) Training* (one-time requirement)
- *Working Effectively with Interpreters* (if using interpretation services)

Learning Management System

Compliance and other trainings can be found on the County's Learning Management System (LMS) located at: https://sanmateocounty.csod.com/client/sanmateocounty/default.aspx. First time users can register by visiting: https://sanmateocounty.csod.com/selfreg/register.aspx?c=bhrsp01. Proof of training, such as certificate of completion, may be requested at any time during the term of the provider's agreement.

BHRS will provide consultation regarding medical necessity criteria, client rights issues, and other Quality topics referenced in this manual upon request. Online trainings in many of these areas, are available through LMS.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) established 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 submit 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 follow HIPAA. It is required that you complete a HIPAA training annually. Breaches must be reported as a critical incident.

Required Forms

Specialty Mental Health Client charts are subject to regular State audits. Clinical documentation must be typed, and charts must contain the following:

- Signed **Consent** Form
- Signed copy of Notice of Privacy Practices/**HIPAA**
- Signed **Release of Information**, if applicable
- A signed and dated **progress note** for <u>every</u> service that is billed. Please see more information on progress notes below.
- **Closing Summary**, if applicable

Progress Notes:

State law requires that each service be documented in a stand-alone progress note, that includes the following elements. We strongly encourage you to use the BHRS progress note template that includes the required information. The template is available on the BHRS provider webpage at:
https://www.smchealth.org/bhrs/contracts

- Client Name and BHRS Medical Record Number
- Date of Service
- CPT Code
- Location Code (this can be found at the bottom of the template)
- Diagnosis addressed
- Provider and Agency Name, if applicable
- Face to Face minutes (client present) – claimed minutes
- Service time (client not present)
- Language (if language services were provided)
- Service Description: Goal/behavior addressed, therapist interventions, client's response/outcome, and plan.
- Signature, printed name, credentials, and date

Closing Summary:

A closing summary is required for any of the following reasons:

- If the client has achieved optimal improvement;
- The treatment team determines that the client will not benefit from further therapy;

- The client is no longer interested in therapy, does not show for services, or has stopped engaging.

The closing summary should only be submitted after discussing decision with the BHRS care coordinator. The form can be found on the BHRS provider webpage at: https://www.smchealth.org/bhrs/contracts and should be faxed to Access at 650-596-8065.

Interpretation Services

Interpretation services for BHRS clients can be accessed by calling the number below and providing the required information. In-person, video, and American Sign Language (ASL) interpretation services require a minimum three-day advanced notice. Phone interpreters are available immediately.

For all language services, dial 650-573-3660
Press 1 for ASL, in-person, or video interpreter reservation (*require a minimum three-day advanced notice)*
Press 2 for immediate over-the-phone interpreter

Once connected, you will provide the following information:

1. You are calling from San Mateo County Health
2. The language you need
3. Your name, division (BHRS), and code: INTPR

Any feedback or questions related to your interpreter experience can be provided to the Office of Diversity and Equity, Community Health Planner, Frances Lobos flobos@smcgov.org

BHRS Responsibilities

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

- Screen all clients who request or are referred for outpatient services, for need and eligibility for services, and to assess those who meet insurance eligibility.

- Refer to BHRS Regional Clinics for assessment.

- Maintain communication with clients, providers, and referring sources so that an unbroken feedback loop concerning service need and clients' rights is established.

- Communicate any updates or changes regarding policy, administrative or financial information. All changes to the BHRS SPPN Provider Manual that are noticed in email notification and/or letters have the authority of policy and are binding, as indicated, to county and providers.

- Maintain the following standards:

    a. Notification of referral and services authorized will be communicated to providers within 24 hours.
    b. Written notification of authorization will be sent within one week of referral.

BHRS Quality Management

The BHRS Quality Management team has the responsibility of assuring that high quality services are provided to clients in a safe, cost-effective and efficient manner. (See BHRS Policy No. 98-11, Quality Improvement Compliance Review of Outpatient Provider Services at https://www.smchealth.org/bhrs-doc/quality-improvement-compliance-review-outpatient-provider-services-98-11.) 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.

Monitoring and Evaluation

BHRS will monitor clients' satisfaction regarding services using the client satisfaction surveys on an annual basis and review of client grievances.

If BHRS 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 BHRS Contract Provider https://www.smchealth.org/bhrs-doc/concernscomplaints-about-mhp-individual-and-organizational-contract-providers-98-10, will be followed. 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 BHRS.

Claims and Billing Information

Payment Policies

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

a. the services were preauthorized for payment by BHRS,
b. the services were delivered by a BHRS contracted provider; and
c. the services were within the range of pre-selected service codes allowed by scope of practice and contract agreements.

Providers shall send all claims, along with evidence of authorization, to BHRS within one hundred eighty (180) days from service date. Claims that are received 180 days or more after the date of service are late claims and will be denied by BHRS.

Payment Procedures

Claims may be submitted either electronically, via Provider Connect, or by mail.

Submitting claims electronically:

As a BHRS contracted provider, you have access to Provider Connect (PConn), an online billing portal for electronic claims submission. PConn training will be included in the onboarding process for all BHRS providers. Following the training, you will receive instructions to complete an online HIPAA training, available on BHRS' Learning Management System (LMS). Once the requirements have been completed, log-in credentials will be provided. Additional PConn training or support can be requested by contacting Provider Relations.

Submitting claims by mail:

You also have the option to request payment for services by mail. This can be done by completing and mailing a Health Insurance Claim Form (CMS 1500) to BHRS Provider Billing at the address below. Please note that in order for claims to be processed they must include the 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 providers and are not affected by material presented in this manual.

Mailing address:

San Mateo County Health System – BHRS
Attn: Provider Billing/MIS
2000 Alameda De Las Pulgas, Suite 280
San Mateo, CA 94403

Consumer Problem Resolution & Appeal System

BHRS has established a formal problem resolution process for clients. It includes preparation and distribution of materials concerning client rights and how to 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 clients and providers and observes defined timelines 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 BHRS Quality Management team and includes a designated Community Program Specialist, Grievance Coordinator, and a 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 BHRS Office of Consumer and Family Affairs (OCFA) 800-388-5189, for assistance in resolving problems.

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

Consumer Grievances

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

1. Consumer expresses a complaint about the provider or services
2. An acknowledgement letter is sent to the client within five calendar days of receipt
3. The provider is contacted by Provider Relations with a request for a formal response to the grievance
4. The Office of Consumer and Family Affairs (OCFA) mails a Resolution letter to the consumer and the provider within 30 calendar days of receipt of the grievance.
5. Quality of Care concerns are reviewed by the Quality of Care Grievance Committee.
6. Grievances regarding providers who receive reoccurring complaints from consumers are discussed at the BHRS credentialing committee and may be subject to the 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 Procedure

Good provider relations are essential to the effective delivery of mental health services. The following includes definitions and describes the process by which providers may address their complaints and appeals to BHRS for resolution.

Complaint Process:

A provider may present a complaint to the Provider Relations Coordinator by telephone, in person or in writing. The Provider Relations Coordinator will attempt to resolve the complaint. Suggested solutions will be provided within two weeks from receipt of the complaint. If the provider is not satisfied with the response, the provider may request that the issue be escalated to the BHRS Assistant Director or designee for review.

Appeals:

You may file an appeal if you have received a Notice of Adverse Benefits Determination (NOABD) for a Payment Denial Notice:

- You may file an appeal concerning the processing or payment of a claim or concerning a denied request for reimbursement of psychiatric services to BHRS. The appeal should include all supportive documentation regarding your claim. The written appeal must reach the BHRS representative within sixty (60) calendar days of the postmark or fax date of NOABD for Payment Denial.

- Oral inquires seeking to appeal an Adverse Benefits Determination are treated as appeals and confirmed in writing unless the client or the provider requests an expedited resolution. The date BHRS receives the oral appeal is considered the filing date, in order to establish the earliest possible filing date for the appeal. An oral appeal must be followed by a written and signed appeal, unless the client or the provider requests an expedited resolution. (*expedited appeals are when risk of harm to the client will result if the appeal follows the standard time line)

- For standard resolution of appeals, BHRS will send the client or parent/guardian a written Acknowledgement Letter within 5 calendar days of receiving the appeal.

- BHRS has a single level appeal process, BHRS shall convene an Appeal Review Committee which shall consist of three or more members appointed by the BHRS Director, or their designee, 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.

- BHRS has 30 days to give you an answer. At that time, you will get a "Notice of Appeal Resolution" letter. This letter will tell you what BHRS has decided.

- If you filed an appeal and received a "Notice of Appeal Resolution" letter telling you that BHRS will still not provide payment, or you never received a letter telling you of the decision and it has been past 30 days, you can ask for a "State Hearing" and a judge will review your case. You will not have to pay for a State Hearing. You must ask for a State Hearing within 120 days from the date of the "Notice of Appeal Resolution" letter. You can ask for a State Hearing by phone, electronically, or in writing.

If the BHRS Appeal Review Committee, or Medical Director, upholds the appeal, BHRS 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 Medical Director.

Provider Rights Concerning Credentialing

BHRS conducts a thorough credentialing process to validate the competency, licensure, and work history of all providers requesting to contract. This process, which occurs upon receipt of a provider's interest to contract, includes clearance of all state and federal databases that would prohibit a provider from practicing. Once a provider is under contract the review occurs monthly. Additionally, every one to three years, a detailed review is undertaken during the re-credentialing process. These processes are dictated by state and federal regulations, and the guidelines of the National Committee for Quality Assurance (NCQA). During any one of these reviews, should there be a finding that would disqualify the provider from treating BHRS clients the procedures below are followed to provide notification of the finding(s) and afford the provider due process.

Findings during Credentialing, Re-Credentialing, or Other Review:

For Continuing Providers: If any query, at any time, discovers information concerning competency, malpractice, limitations of privileges, ongoing ethical investigations, or other such factors presenting potential risk to BHRS, the information will be further reviewed and investigated. If the investigation finds continuing omissions or problems, BHRS will notify the provider of any excluded or debarred status in writing. BHRS may take immediate action, including suspension or termination of contract.

For New and Continuing Providers: Whether BHRS takes action to sanction a provider during the credentialing process or any subsequent review, once a finding is confirmed, BHRS will issue written notification to the provider within ten business days. This notification will include a detailed description of the finding(s) and instructions on how to respond.

Within 30 calendar days of receipt of this notification, the provider shall submit in writing to the BHRS Quality Manager, a response that includes identification of the provider, the specific finding that is being responded to, and no more than 800 words per finding explaining the provider's response. Any

further evidence or documentation that substantiates the response may be attached. Certificates, licenses, and other formal documents should only be attached as copies and upon request BHRS may ask to see the original documents. If the provider does not respond, or respond to all findings, then those findings with no response shall be sanctioned or the sanction upheld.

Upon receipt of the provider's response, BHRS shall decide within ten business days. The determination will be in writing and for each finding response, there will be an explanation of enough clarity as to why BHRS upholds or retracts their original sanction or other action taken. This decision shall be made by the Assistant Director upon presentation of the provider's response by the Quality Manager.

All issued notices, decisions, responses, and other documentation utilized in this process shall be filed in the provider's credentialing file and date stamped when issued or received.

Attachment A: Service Descriptions

The following are general descriptions of services that can be provided under a SPPN contract:

Assessment: Assessments are done by the BHRS clinic and are for the purposes of determining medical necessity. In rare instances, where a client is not connected to a BHRS clinic, the contracted provider may be responsible for completing the assessment and treatment plan.

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.

Collateral: 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).

Clinical Consultation: Clinical consultation services are activities that are provided by providers to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed services for eligible clients. Services may include the following:

Linkage and Coordination - the identification and pursuit of resources including, but not limited to, the following:

a) Regular communication and coordination with BHRS Clinical team that includes: treatment progress, change in client status, and if there has been 120 days of no contact with the client (no phone, no visit, etc.);

b) Plan Development – the development of client plans; monitor client progress; discuss program goals with treatment team, client or family to obtain signatures; discuss with treatment client's clinical response to client plan or to consider alternative interventions; communicating with other professionals to elicit and evaluate their impressions (e.g. probation officer, teachers, social workers) of the client's clinical progress toward achieving

their Client Plan goals, their response to interventions, or improving or maintaining client's functioning.

c) Create and provide reports when requested by BHRS (such as required reports for the courts or Child Protective Services).

Crisis Intervention: Crisis intervention should only be used in urgent situations requiring, assessment, that can't otherwise wait for a routine appointment. This is typically used in situations where a client is in crisis and requires a 5150 assessment.