Sonoma County
Department of Health Services
Mental Health Provider Manual

sonoma county
DEPARTMENT OF HEALTH SERVICES

August 2021

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Introduction

Thank you for being a Sonoma County Department of Health Services Behavioral Health Division (DHS-BHD) contracted provider. As a contracted provider, you play a very important role in the delivery of specialty mental health services (SMHS) to Medi-Cal beneficiaries in Sonoma County. This manual is intended to provide further guidance and instruction to specialty mental health contractors to support the many requirements of being a Medi-Cal provider. It contains helpful information for day-to-day operations, and is also to be used in conjunction with Exhibit F of the DHS-BHD contract. Please defer to your DHS-BHD contract for all required activities. Please note that not all parts of this manual apply to all contracted providers. Should you have questions about information contained in this manual, please feel free to contact our QA staff at BHQA@sonoma-county.org.

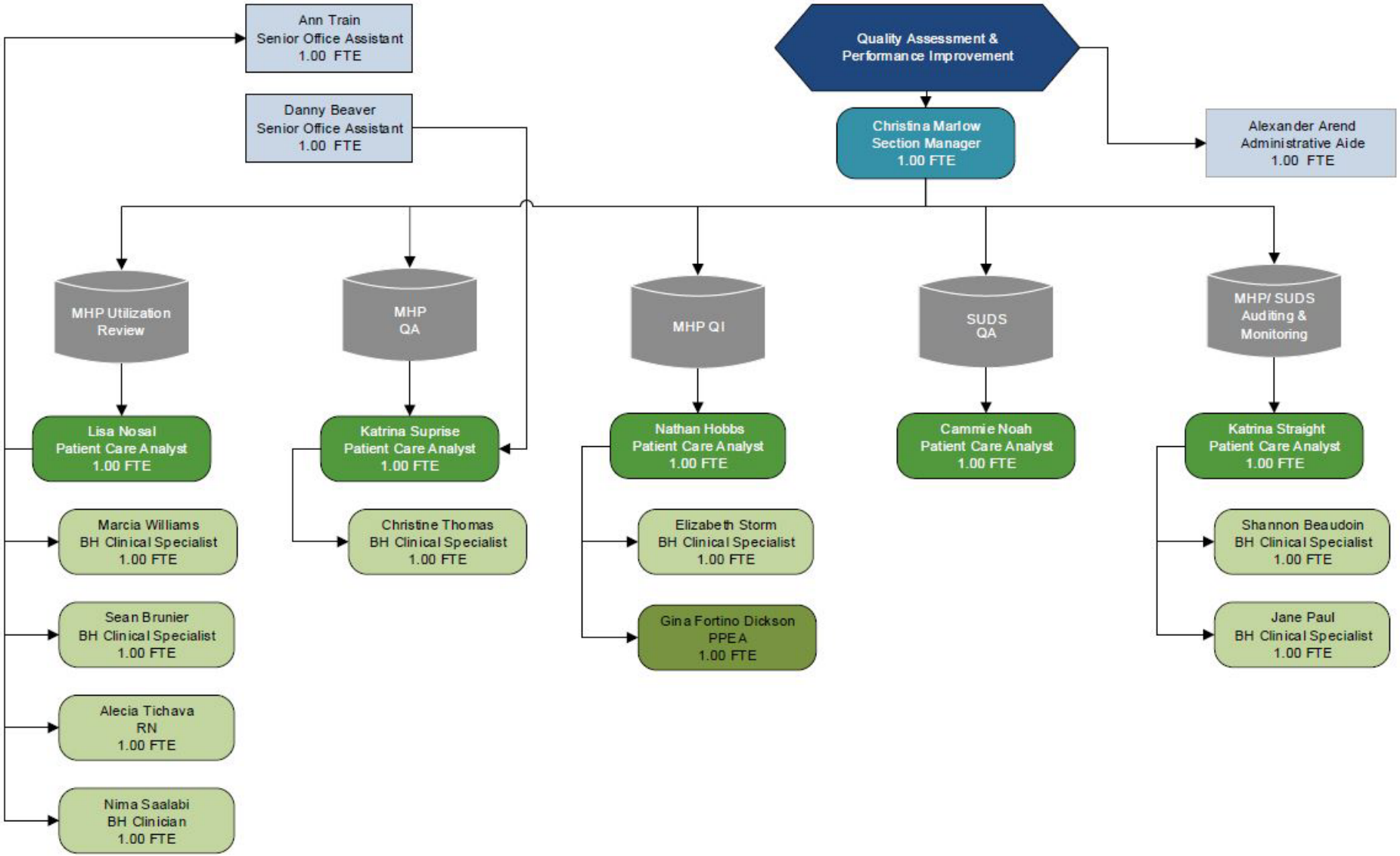
We look forward to working with you to provide quality healthcare services to Medi-Cal beneficiaries of Sonoma County.

Mission Statement

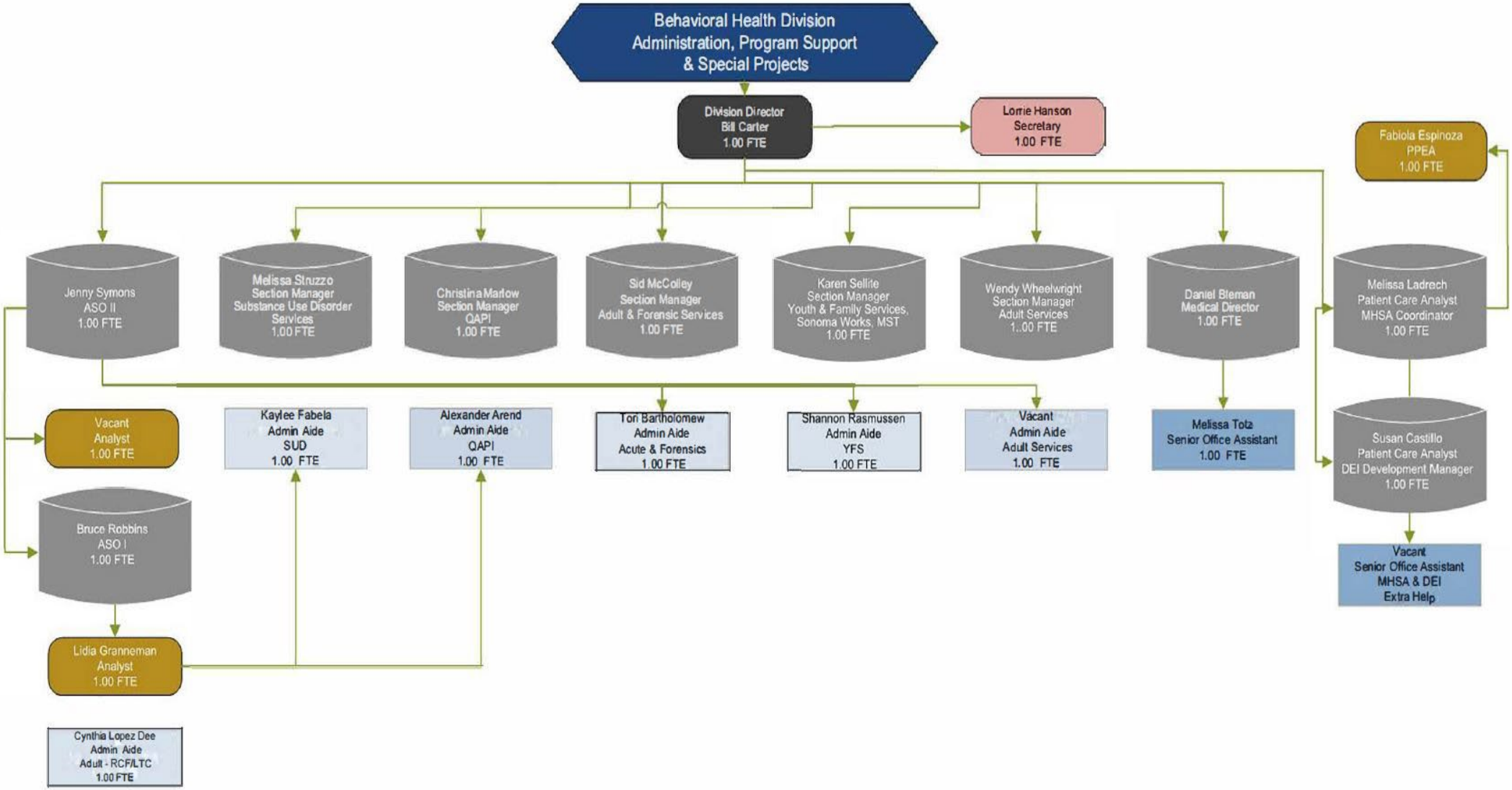
The mission of DHS-BHD is to promote recovery and wellness to Sonoma County residents.

Organizational Charts

Quality Assessment & Performance Improvement (QAPI)



Behavioral Health Management and Program Support



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PAVE

The Department of Health Care Services Provider Enrollment Division (DHCS PED) defines PAVE as Provider Application and Validation for Enrollment. The Federal Cures Act [42 CFR 438.602(b)] requires PAVE registration for Certified Nurse Practitioners, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Physicians (MD and DO), Psychologists and Registered Pharmacists, who provide specialty mental health services (SMHS) to Medi-Cal beneficiaries. Interns, trainees, and associates are *not* eligible for PAVE enrollment.

PAVE's Ordering, Referring and Prescribing (ORP) application will fulfill the minimum federal enrollment requirement and, as such, DHCS PED recommends using the **PAVE ORP no-cost application** for eligible licensed individual practitioners listed above. Additionally, ORP providers are not required to meet Medi-Cal's established place of business requirements. Therefore, enrolling as an ORP provider allows licensed individuals to meet the enrollment requirement without submitting a complete billing application. Proof of professional liability insurance is not required for an ORP application. DHCS PED does not limit who can assist with the application process. However, the ORP provider is responsible for their enrollment including signing their application and attesting that all information provided in the application is true and accurate.

- Licensed practitioners described above who are required to enroll must enroll, regardless of whether they are billing the Medi-Cal program directly. DHCS PED will check to ensure enrollment status via DHCS' Provider Information Management System (PIMS).
- **Exception**: Licensed individuals who are not providing direct treatment services to SMHS beneficiaries (i.e. administrative or office staff) are not required to enroll in PAVE at this time.
- PAVE ORP application step-by-step tutorial and "how-to" instructions are available starting from slide 23 of the DHCS webinar slide deck: https://www.dhcs.ca.gov/Documents/Provider-Webinar-9-11-20.pdf

PAVE Enrollment Tips and Frequently Asked Questions

1. Are there any tips or suggestions on how to make enrolling in PAVE a smoother process for individual practitioners (as described above)?

Have the following information on hand prior to enrolling in PAVE ORP application, as practitioners will be asked to enter this information [PAVE Help Desk at (866) 252-1949 can also assist with Technical Support]:

- NPI number (Depending on when and where an NPI was created for you, the address on the NPPES system may not be your current place of employment and may need to get updated. It might be helpful to review and update information on NPPES first: https://nppes.cms.hhs.gov/#/)

In addition, have the following documents ready to scan into PAVE:

- Copy of Current Driver's License or State-issued ID (cannot be expired)
- Professional License (this must be the issued license, not a print-out from the licensing board's website)

2. When enrolling in PAVE, is there a preferred web browser or email address type that practitioners should use?

Using Google Chrome as your web browser is recommended, as there have been reports of problems with the website when practitioners use Internet Explorer. PAVE also recommends that staff use a personal computer when initially enrolling in PAVE as some work and county computers may have firewalls and other security measures that may interfere with completing the PAVE online enrollment. Practitioners have the option of using either their personal or work email address when enrolling in PAVE. Practitioners should use the email address where they want to receive information about PAVE and their application status.

3. What help features are available in PAVE?
Call the PAVE Help Desk at (866) 252-1949, and one of the PAVE friendly experts will be happy to assist you with PAVE enrollment. The Help Desk is available Monday - Friday, 08:00 am - 06:00 pm Pacific time, excluding state holidays. PAVE has been specifically designed for ease of use, and also includes embedded in-context tutorial videos found in PAVE applications, as well as hover-help functionality. PAVE features secure login, document uploading, electronic signature, application progress tracking, intuitive guidance, social collaboration and much more. For additional detailed DHCS training materials, view the following:

- PAVE 101 Training Slides at https://www.dhcs.ca.gov/provgovpart/Pages/PAVE-101-Training-Slides.aspx; or
- PAVE Training Videos and other tutorials at https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

4. If I cannot complete the application in one sitting, will I have to start over?
No. You can stop and save your work at any time. Your application will be securely stored in PAVE until you are ready to resume completion.

5. Are individual licensed practitioners who work for county-operated facilities required to enroll via PAVE?
Yes, if they are included in the comprehensive list of providers who are eligible to enroll in the FFS Medi-Cal program on the PED website and are providing services to SMHS beneficiaries, then they are required to enroll. A comprehensive list of individual practitioner and entity types that are eligible and required to register in PAVE can be found on the DHCS PED website: https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx.

6. Are DHS-BHD-contracted agencies required to enroll?
Contracted organizational entities are not required to enroll as they are not directly providing services to SMHS beneficiaries. However, while DHS-BHD-contracted organizational entities are not required to enroll, *eligible licensed individuals who provide SMHS on behalf of that entity* **are** required to enroll as individual ORP providers in PAVE, as described in paragraph above, under "PAVE Enrollment Requirements for Individual Practitioners".

DHCS issued a list of Frequently Asked Questions (FAQ) on February 4, 2021 which can be accessed at:
https://www.dhcs.ca.gov/provgovpart/Documents/PAVE_Project_for_Provider_Enrollment_Division/SMHSEnrollmentFAQFinal.pdf

Sentinel Events

Types of Sentinel Events

A Sentinel Event is an unexpected occurrence that results in or has the potential for death or serious physical and/or psychological injury (including the permanent loss of function) to a client. The following list of occurrences would be reported as a Sentinel Event if they resulted in or had the potential to result in death or serious harm:

- Adverse medication reactions, excluding common side effects
- Medication Errors: Order / Transcription / Administration
- Abuse of a client: physical or sexual
- Assault by a client: physical or sexual
- Community Care Licensing reportable events
- Death of a client (other than suicide or homicide)
- Elopements of clients from a 24-hour facility who are on Conservatorship or who are otherwise at risk of danger to self or others
- Homicides or homicide attempts
- Seclusion/Restraint resulting in client injury or death
- Serious threats of harm to others, including Tarasoff-reportable events
- Suicides or suicide attempts
- Significant delays in treatment resulting in harm or exacerbation of condition.

Adverse Medication Reactions

This category only applies if Medication Support Services is part of your contract, or if Medication Monitoring is part of your program (for example, in a residential program). Adverse Medication Reaction is a broad term referring to unwanted, uncomfortable, or harmful effects that a medication may have. Most Adverse Medication Reactions are dose-related; others are allergic or idiosyncratic. Consult with appropriate medical practitioners if you suspect or if a client reports an Adverse Medication Reaction.

Medication Errors

This category only applies if Medication Support Services is part of your contract, or if Medication Monitoring is part of your program (for example, in a residential program). The pathway connecting a clinician's decision to prescribe a medication and the client actually receiving the medication consists of several steps:

- ***Ordering:*** the clinician must select the appropriate medication and the dose, frequency, and duration.
- ***Transcribing:*** in a paper-based system, an intermediary (such as a clerk or technician) must read and interpret the prescription correctly.
- ***Dispensing:*** the pharmacists must check for drug-drug interactions and allergies, then release the appropriate quantity of the medication in the correct form.
- ***Administration:*** the correct medication must be supplied to the correct client with the correct dose by the correct route at the correct time. In residential settings, this is generally the responsibility of nurses or other trained staff; in outpatient care the responsibility falls to clients or caregivers.

Medication Errors can occur at each stage of the pathway outlined above. To implement a prevention program to ensure safe medication management process, consider the following best practices:

Stage	*Safety Strategy*
Ordering	• Established practice guidelines and prescribing principles • Computerized provider order entry • Medication reconciliation at times of transitions in care
Transcribing	• Computerized provider order entry to eliminate handwriting errors • Medication charting review schedule
Dispensing	• Medication reconciliation between printed orders and program medication log
Administration	• Adherence to the "Five Rights" of medication safety (administer the Right Medication, in the Right Dose, at the Right Time, by the Right Route, to the Right Patient) • Minimize interruptions to allow nurses/staff to administer/monitor medications safely • Multicompartment medication devices (medisets/bubblepacks) for clients taking multiple medications • Medication education to improve client comprehension of administration instructions

Abuse of a Client

Client Abuse is any action which causes unreasonable suffering, misery, or harm to the client. Abuse includes physically striking or sexually assaulting a client. It also includes the intentional withholding of necessary food, physical care, and medical attention.

Assault by a Client

This category includes any Assault (physical or sexual) that is committed by a client against another client, a family member, a staff member, or a member of the public.

Community Care Licensing Reportable Event

This category only applies to programs licensed through the California Community Care Licensing (CCL) Division. Any unusual incident/injury reported to CCL on form LIC 624 would qualify as a Sentinel Event reported to DHS-BHD as the Placement Agency.

Death of a Client

Any client death, including from natural causes, is reportable as a Sentinel Event.

Elopements

This category only applies to 24-hour facilities. Elopement occurs when a client who is incapable of adequately protecting themselves departs from a program facility unsupervised and undetected. Elopements are reported for clients in the following two circumstances:

- Clients on conservatorship
- Clients who are at risk of danger to self or others

Serious Threats of Harm to Others

This category includes, but is not limited to, Tarasoff-reportable threats. Threat of harm is defined as all actions, statements, written or non-verbal messages conveying threats of physical or mental injury which are serious enough for a person to reasonably perceive a threat of injury. Threats of harm might be made against a specific individual, or a reasonably identifiable group.

Homicides/Attempts

Any death caused by a client is reportable as a Sentinel Event. Attempted homicide is reported when a client tries but fails to kill another person.

Seclusion/Restraint resulting in Injury/Death

Restraint and Seclusion are behavioral management interventions used as a last resort to control a behavioral emergency. Restraints include the use of physical force, mechanical devices, or chemicals to immobilize a person. Seclusion, a type of restraint, involves confining a person in a room from which the person cannot exit freely. Any injury or death caused by the use of Seclusion/Restraint is reportable as a Sentinel Event.

Suicides/Attempts

Suicide is death caused by injuring oneself with the intent to die. A suicide attempt occurs when someone harms themselves with any intent to end their life, but they do not die as a result of their actions. Non-suicidal self-injurious behavior would not qualify as a sentinel event, unless it results in injury requiring medical care.

Significant Delay in Treatment

A Delay in Treatment is when a client does not get a treatment – whether it be a medication, lab test, physical therapy treatment, or any kind of treatment – that had been ordered/authorized for them in the time frame in which it was supposed to be delivered. A delay in treatment is reportable as a Sentinel Event when the failure to respond to a treatment need causes harm to the client, or exacerbates an existing condition.

Reporting Sentinel Events

Sentinel events must be reported immediately by phone to the Quality Improvement Manager (707-565-4868), followed by a written Incident Report within 5 business days of knowledge of the occurrence. Sentinel Event reports may be submitted by secure email, by FAX (707-565-2202) or by mail to: 2227 Capricorn Way, Suite 210, Santa Rosa, CA, 95407.

Reporting Forms

It is not required to utilize a specific County form for reporting Sentinel events. Programs may use their own internal incident reporting forms for this purpose. For programs licensed through CCL, a copy of form LIC 624 is sufficient written notification of a Sentinel Event. This form can be located at the following link:

https://www.cdss.ca.gov/cdssweb/entres/forms/English/LIC624.PDF

Alternatively, a narrative report of the incident is acceptable, so long as it includes the following elements:

- Name of Program
- Names of Clients/Staff Involved
- Type of Incident
- Description of Incident
- Actions Taken to Address Incident

Reporting Past Sentinel Events

Sentinel Events are only reported for events that occur after a program begins a treating relationship with a client. Thus, if a client reports something on intake that occurred prior to engaging in treatment with the program (for example, a history of suicide attempts), that would not be reported as a Sentinel Event. This is true for all types of Sentinel Events, ***EXCEPT*** Abuse of a Client. If a client reports abuse that occurred in a prior program, it should be reported as a Sentinel Event. Also, please note that Sentinel Event reporting does not satisfy any Mandated Reporting requirements triggered during the course of intake/treatment.

Reviewing Sentinel Events

It is required that all treatment providing programs implement an incident review process to analyze unusual occurrences in order to institute prevention strategies. It is recommended that such reviews include fact finding, analysis, and action steps. The following guidelines may be helpful in developing a review process.

Fact Finding

Check the facts provided by your staff/clients.

- They may have misperceived a fact.
- They may have misreported a fact.
- They may have overlooked a fact.

Construct a timeline of events.

- What's missing from the timeline of events?
- Who would have/know the missing information?
- Are releases in place to obtain that information?
- Investigate further to fill in the holes

Review the Clinical Record.

- Is there documentation relevant to the event?
- Is any important documentation missing?
- How often was the client seen? Any missing appointments? Gaps in service?
- Are there risk assessments in the record? Safety planning in the record?
- Any clinically indicated services that weren't being provided?

Analysis

Examine any Indicators & Risk-Factors.

- Are there any chronic risk factors in play?
- Are there any emergent or acute risk factors in play?
- Did providers respond to these factors in a timely and appropriate manner?

Review the Impacts of the Event.

- Were there any consequences (medically, emotionally, etc.) to the client from this event?
- Were the consequences addressed in a timely and appropriate manner?

Review the Evidence of Response.

- Is there evidence of a response on the part of the provider?
- Is there documentation to support the response?

Conduct a System Analysis.

- Communication
    - Did problems in communication lines contribute to the event?
- Training
    - Is there a training issue revealed by the event?
    - Have training opportunities been given on this topic?
- Organizational
    - Are there issues regarding organizational procedures or workflow which contributed to this event?
- Forms
    - Are there any confusing/misleading elements on program forms which contributed to this event?

Action Steps

Identify Problem-Solution Steps.

- What has the program already done to address the identified problems?
- What is the program planning to do to prevent future occurrences?
- Are program staff waiting on someone else for needed information to address or identify problems?
    - What is the plan once the information is obtained?

Identify Notification Steps.

- Are any legal notifications required to address the event?
    - Tarasoff
    - Mandated Reporting
    - Other
- Are any internal notifications required to address the event?
    - Procedural/protocol changes

Conduct Debriefing, as applicable

- Was the client debriefed? (if appropriate)
- Were any other clients near who witnessed or were impacted by the event?
    - Were these clients debriefed? (if appropriate)
- Did staff get an opportunity to debrief?
    - Were staff directed to appropriate resources for self-care?

Network Adequacy

Definition

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network providers and services included under the terms of the contract. This includes ensuring consumers have access to needed care without unreasonable delay. In order to strengthen access to services in a managed care network, the Final Rule requires states to establish network adequacy standards in Medicaid managed care for key types of providers, including behavioral health providers.

Annual certification of the provider network involves review of compliance in the following areas:

- Network Capacity and Composition
- Time and Distance Standards
- Timely Access to Services
- Language Assistance Capabilities
- Mandatory Provider Types
- Transition of Care/Continuity of Care
- System Infrastructure

See DHCS Behavioral Health Information Notice 21-023.

https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf

Network Capacity and Composition

Sonoma Mental Health Plan (MHP)/ Sonoma County Department of Health Services Behavioral Health Division (DHS-BHD) must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to SMHS for all beneficiaries within Sonoma County, including those with limited English proficiency or physical or mental disabilities. To assist with this process, participating provider agencies should track and update monthly the following information about their organization, program sites, and individual providers.

Organizational Level Information

The term "Organization" refers to the parent organization and/or legal entity designation. The following elements are required to certify the Organizational Provider participation in the Provider Network.

- Organizational Provider Name
- Legal Entity Number assigned to the organization
- National Provider Identification Number (NPI –Type 2) assigned to the organization
- Tax ID number
- Provider Group Name/Affiliation (if applicable)
- Contract Effective and Expiration Dates
- Full Address

- Maximum number of Medi-Cal beneficiaries the Organizational Provider will accept
- Current number of Medi-Cal beneficiaries assigned to the Organizational Provider
- Ownership Type
- Name of CEO (or equivalent)
- Name of CFO (or equivalent)

Site Level Information

The term "site" refers to the physical location (i.e., clinic sites or satellite sites) where services are rendered to Medi-Cal beneficiaries. The following elements are required to certify the Program Site participation in the Provider Network.

- Site Name
- NPI Number Type 2 assigned to the site
- DEA Number (if applicable)
- Full address
- Site Provider Number
- Service Types offered at the Site
- Hours of operation
- ADA Compliance for Physical Plant
- TDD/TTY Equipment availability
- Distance between site and closest public transportation
- Telehealth Station/Equipment availability
- On-site Language Capacity
- Language Line availability

Individual Provider Level Information

The term "rendering service provider" refers to the individual practitioner, acting within their scope of practice, who is providing services directly to beneficiaries. This includes Telehealth practitioners. The following elements are required to certify an Individual Provider participating in the Provider Network.

- Provider's first and last name
- NPI Number Type 1 associated with the individual provider
- NPI Number Type 2 associated with the sites served by the individual provider
- DEA Number (if applicable)
- Full address of sites where individual provider renders services
- Provider Type/Discipline
- Service Types offered by individual provider
- California Practitioner License Number (if applicable)
- Age Groups Served
- Full-Time Equivalent percentage available, by site, to serve beneficiaries of each age group
- Maximum caseload
- Current caseload

- Language Capacity
- Cultural Competence Training Hours Completed in the past 12 months
- Telehealth Provider status
- Field-Based services capacity
- Distance provider travels to deliver field-based services

Calculating Full-Time Equivalents

A provider may be counted as one Full-Time Equivalent (FTE) position if the individual's full-time job assignment is direct service delivery to Medi-Cal beneficiaries. In the case where an individual is assigned to direct service delivery on a part-time basis, the FTE should be calculated based on the percentage of time the individual could be dedicated to direct service delivery on an ongoing basis over the course of a year. A FTE position is 2,080 hours per year (i.e., 40 hours per week). Only direct providers of Specialty Mental Health Services and Psychiatrist Services should be included as network providers.

Administrative Staff

These staff and/or members of leadership can only be included as network providers if they genuinely have capacity to serve clients on a regular and on-going basis. If an administrative staff employee is needed to function 100% in their administrative role (e.g., director, medical director, quality improvement manager) but could pick up a client on an emergency basis, the employee should not be included as they do not have actual capacity to serve clients. The FTE, if included, should accurately reflect the amount of time the individual can actually be available to directly provide services to a beneficiary over the course of a year.

Time and Distance Standards

DHCS has established time and distance standards for adult and pediatric behavioral health providers. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. The time and distance standards determined for Sonoma County Outpatient Mental Health Services (including Targeted Case Management, Crisis Intervention, and Psychiatrist Services) are up to **30 miles and 60 minutes** from the beneficiary's place of residence. Time and distance standards **DO NOT APPLY** to residential or inpatient settings, or to out-of-county provider sites.

Timely Access to Services

Sonoma MHP and its provider network are required to meet State standards for timely access to care and services, taking into account the urgency of the need for services. The following table depicts timely access requirements by type of service and urgency level.

Appointment Type	Standard
Initial Request for Service/Assessment	Within 10 business days of the request for service
Urgent request for services that do not require prior authorization	Within 48 hours of the request for appointment
Urgent request for services that require prior authorization	Within 96 hours of the request for appointment

Request for Psychiatry Services	Within 15 business days of the request for appointment
Request for non-Psychiatry Services (i.e., therapy)	Within 10 business days of the request for appointment

Please note that periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of their practice.

Provider sites shall ensure that hours of operation during which services are provided to Medi-Cal beneficiaries are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. It is essential that all treatment sites provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities.

Language Assistance Capabilities

DHS-BHD is required to report in the Provider Directory the cultural and linguistic capabilities of network providers. In support of this, program sites shall track and update monthly the language capabilities (including American Sign Language) offered by individual providers or skilled medical interpreters at the provider's office. Additionally, programs should record hours of cultural competence training completed by staff annually.

System Infrastructure

To certify system infrastructure, provider organizations shall maintain current provider directories and organizational charts detailing clinical teams, including identification of deputy directors, clinical managers/supervisors, clinicians, and staff.

Reporting Requirements

DHS-BHD must submit the annual network certification to the State on April 1 of each year. The data reporting period covered is December through February. The Quality Improvement (QI) team will send data requests to contracted providers during the first week of March, with a 2 week due date to allow time for validation, analysis, and remediation before final submission. The QI team pre-sets the data submission tool with the most current provider directory data to streamline the data updating process for contracted providers.

Medi-Cal Site Certification/Recertification Overview

In order for a provider to receive Medi-Cal beneficiary referrals from Sonoma County Department of Health Services Behavioral Health Division (DHS-BHD) and begin billing for services, the provider must first be Medi-Cal certified by the California Department of Health Care Services (DHCS) or its designee, DHS-BHD.

Providers must pass the Medi-Cal site certification in order to become a contracted Med-Cal provider with DHS-BHD. Compliance with site certification standards is monitored by DHS-BHD Quality Assurance (QA) staff. Providers will receive notice from DHS-BHD QA staff regarding the timing of certification visits. The exact timing of the site certification will be up to the discretion of DHS-BHD. Providers must allow DHS-BHD staff access to their sites to allow for certification/recertification visits in order to maintain their status as a DHS-BHD contracted provider.

DHS-BHD will conduct site certifications during new provider contract initiation and will conduct recertification as required to ensure compliance with all federal and state guidelines. At a minimum, contracted providers must be recertified once every three (3) years. Each contracted provider must remain in compliance with certification requirements at all times.

General Requirements

DHS-BHD QA staff shall certify providers that contract with DHS-BHD to provide covered services in accordance with Cal. Code Regs., tit. 9, §1810.435 (State Contract). The on-site review required by Cal. Code Regs., tit. 9, § 1810.435(e), shall be conducted of any site owned, leased, or operated by the provider (organization) and used to deliver covered services to beneficiaries, except that an on-site review is not required for public school or satellite sites. DHS-BHD shall complete any required on-site review of a provider's site(s) within six months of the date the provider begins delivering covered services to beneficiaries at the site (State Contract).

NOTE: "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which specialty mental health services are delivered by no more than two employees or contractors of the provider (State Contract).

DHS-BHD may allow a contracted provider to begin delivering covered services to beneficiaries at a site subject to on-site review prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on-site review is the latest of these three (3) dates: 1) the date the provider's request for certification is received by DHCS in accordance with DHS-BHD certification procedures; 2) the date the site was operational; or 3) the date a required fire clearance was singed as "granted."

DHS-BHD may allow a contracted provider to continue delivering covered services to beneficiaries at a site subject to on-site review as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances (State Contract).

As part of the Medi-Cal Site Certification process, DHS-BHD shall verify that each provider (CCR §1810.435):

- Possesses the necessary license to operate, if applicable, and any required certification.
- Property owned, leased or operated by the provider and used for services or staff meets local fire codes.
- Establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of beneficiaries and staff.
- Provides for appropriate supervision of staff.
- Has as Head of Service a licensed mental health professional (as defined in Cal. Code Regs., tit. 9, §622 through §630).
- Possesses appropriate liability insurance.
- Has a current administrative manual which includes: personnel policies and procedures (including staff screenings and licensure requirements), general operating procedures, service delivery policies, any required state or federal notices (DRA), and procedures for reporting unusual occurrences relating to health and safety issues. Store and dispense medications in compliance with all pertinent State and Federal standards.
- Maintains beneficiary records in a manner that meets State and Federal standards.
- Has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
- When applicable, stores and dispenses medications in compliance with all pertinent State and Federal standards.

In particular:

- All drugs obtained by prescription are labeled in compliance with Federal and State laws. Prescription labels are altered only by persons legally authorized to do so.
- Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.
- All drugs are stored at proper temperatures: room temperature drugs at59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
- Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.
- Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.
- A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.
- Policies and procedures are in place for dispensing, administering and storing medications.

The duration of the on-site review may vary depending on the size of the provider and the complexity of the Modes of Service to be certified. The certification process can take 60-90 calendar days to complete. This certification shall be performed prior to the date on which the provider begins to deliver services under the provider's contract at these sites and once every three years after that date, unless the DHS-BHD MHP determines an earlier date is necessary.

Additional certification review may be conducted when:

- The provider makes major staffing changes.
- The provider makes organizational and/or corporate structure changes (e.g., conversion from non-profit status).
- The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.
- There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
- There is change of ownership or location.
- There are complaints against the provider.
- There are unusual events, accidents or injuries requiring medical treatment for beneficiaries, staff or members of the community.

Certification Process: Overview

In order for the DHS-BHD QA to complete the Medi-Cal site certification process, the provider must:

1. Have a National Provider Identifier (NPI) number in the National Plan and provider Enumeration System (NPPES) that will be uniquely associated with only one active provider/site.
2. Ensure that their NPPES "Other Name" and "Primary Practice Address" are accurate.
3. Obtain a provider number from DHCS, requested by DHS-Revenue Management (RMU) as part of the Provider File Update (PFU) process.
4. Obtain a current and valid Fire Clearance (defined by DHCS as within 12 months of the certification on-site review).
5. Submit a Head of Service License (HOS). The HOS must be on the provider's official staff roster (either as an employee or through a contractual relationship) and meet DHS-BHD requirements.
6. Demonstrate compliance with the current DHCS Short Doyle/Medi-Cal (SD/MC) Certification Protocol.
7. Complete and submit all of the required documents included in the ***Site Certification Application Packet*** *(see Desk Review)*.
8. Successfully pass the Medi-Cal site certification desk and on-site review.

The following steps outline the DHS-BHD Medi-Cal certification process:

1. At the point of contract initiation, or amendment DHS-BHD Administrative Support staff will notify DHS-BHD RMU and DHS-BHD QA of the intent to contract with the provider.

2. At the time of contract initiation/amendment, or at the time of Medi-Cal recertification, DHS-BHD QA will contact the provider and e-mail to them the (*see* **Desk Review**).
3. DHS-BHD RMU will send to the provider the Rate and Cost Proposal template – *Contractor has (7) business days to complete and return the form to DHS-RMU.*
4. The provider must submit to DHS-BHD QA all the documents identified in the *Site Certification Application Packet*.
5. DHS-BHD QA will conduct a *desk review* of all documents obtained by way of the *Site Certification Application Packet* (*see Desk Review*).
6. DHS-BHD QA and the provider will coordinate the date/time of the on-site review.
7. DHS-BHD QA conducts the on-site review using the most current DHCS SD/MC Certification Protocol and DHS-BHD *QA Site Certification Documents Checklist* to ensure the provider meets all program and contractual requirements (see *On-site Review*).
8. Once the provider has successfully passed the desk and on-site reviews, DHS-BHD QA submits required documents to DHCS for approval. DHCS may take up to four weeks to complete the approval process (up to 3 months for STRTPs).
9. When DHS-BHD QA receives approval from DHCS, DHS-BHD QA informs DHS-BHD RMU and Administrative Support of the approval and provides them the supporting documents.
10. DHS-BHD Administrative Support will initiate final execution of the provider contract.
11. DHS-BHD RMU enters the necessary information into the DHS-BHD electronic system for billing and claiming.
12. DHS-BHD QA e-mails the Consolidated Medi-Cal Certification Approval Letter to the provider. The Letter serves as official notice of the approval for Medi-Cal site certification of the provider.
13. With each initial Medi-Cal certification that requires a new Provider Identification Number (PIN), the permanent Medi-Cal PIN is sent directly to the provider by DHCS. The PIN is required in order for the provider to check for the Medi-Cal eligibility of potential beneficiaries. A temporary PIN may be used while waiting for the permanent PIN.

The provider may submit claims back to the Medi-Cal Activation/Effective Date of Medi-Cal certification. The Activation/Effective Date of certification is the date designated as such on the Consolidated Medi-Cal Certification Approval Letter.

Desk Review

Prior to conducting the on-site review, DHS-BHD QA will e-mail to the provider the ***Site Certification Application Packet*** *and additional instructions*. This packet includes the DHCS SD/MC Certification Protocol, the **QA Site Certification Documents Checklist** and additional accompanying documents. The **QA Site Certification Documents Checklist** lists documents required to conduct the desk review portion of the certification. Below is a list of required documents listed in the **QA Site Certification Documents Checklist** and a description of each:

1. *MHS 154 Medi-Cal Certification/Recertification Application:* DHS-BHD form used to initiate Medi-Cal certification. It is a tool to gather information to verify Medi-Cal provider eligibility.

2. *MHS 155 Program Description:* DHS-BHD form used to verify that program services match the Medi-Cal certification and meet specific certification criteria (e.g. head of service, hours of operation, medication storage, building cleaning/maintenance, etc.).

3. *Informing Materials Check List and Instructions:* A list of required Medi-Cal informing materials the provider must have on-site. Provides directions for issuance and posting.

4. *Medi-Cal Policy and Procedure Documents:* In line with the DHCS SD/MC Protocol, providers must demonstrate compliance with specific requirements. As such, DHS-BHD requires the provider to have in place policies and/or procedures that cover the following areas:
    a. Confidentiality and Protected Health Information
    b. Emergency evacuation
    c. Screening licensed personnel/providers and checking the excluded provider lists, etc.
    d. General Operating Procedures
    e. Maintenance of Facility (copy of maintenance & cleaning agreement if done by outside agency)
    f. Services Delivery (types of service, intake process, referral and linkage, length of services, discharge, and discontinuation of services)
    g. Unusual Occurrences Reporting
    h. Process for referring individuals to a psychiatrist when necessary
    i. Dispensing, administering, storing, and the disposal of medications

5. *Staff List:* List of ***all*** provider employees. This list shall include identification of licensed employees and the NPI's for employees who are eligible to bill Medi-Cal (this list is cross referenced with exclusion screening results).

6. *Exclusion Screening Results:* The list of results from your exclusion screenings (Office of Inspector General, DHCS Medi-Cal List of suspended or ineligible providers, System for Award Management, and Social Security Death Master file) per each employee listed. Submit 1 per month (3 total) closest to certification or recertification (See exhibit F of your contract for frequency of screenings).

DHS-BHD QA staff will review the submitted documents for accuracy, completeness, and compliance with DHCS Medi-Cal site certification requirements. An on-site review will be conducted after the provider demonstrates full compliance with the desk review portion of the Medi-Cal site certification process.

On-site Review

DHS-BHD QA conducts the on-site review once the provider demonstrates compliance with the desk review portion of the Medi-Cal certification. To ensure full compliance with Medi-Cal certification requirements, DHS-BHD QA will use the DHCS SD/MC Provider Certification and Re-Certification Protocol, which includes review of the following areas:

1. Posted Brochures and Notices
    a. Client brochure, provider list, grievance/appeal/expedited appeal forms, etc.
2. Fire Safety Inspection

3. Physical Plant
    a. Cleanliness, structural integrity, safety, PHI security
4. Policies and Procedures *(practice cross referenced with policies and procedures submitted as part of the desk review)*
    a. PHI, emergency evacuation, personnel, general operation, maintenance, service delivery, unusual occurrences reporting, referral to psychiatrist or physician, HOS
5. Head of Service and Licensed Staff *(verification of appropriate HOS designation based on program specifics and setting)*
6. Medication Support Services *(practice cross referenced with policies and procedures submitted as part of the desk review)*
    a. Storage of medications on-site, labeling, medication logs, auditing supplies of controlled substances, medication disposal

Medi-Cal Site Certification: Plan of Correction

Any items found out of compliance must be corrected by the provider and verified by DHS-BHD QA. The need for a Plan of Correction will cause a delay in the submission of documents to DHCS and may require an additional on-site review.

The provider is required to correct any deficiency(ies), and demonstrate compliance of site certification requirements to the DHS-BHD within 30 days of notification. Failure to provide evidence of correction of or compliance with the deficiencies within the 30 days will result in withholding of payments for current and future claims and/or contract termination.

Beneficiary Liability for Payment

Contractor agrees to not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (Cal. Code Regs., tit. 9, § 1810.365 (a)).

Contractor agrees to repay beneficiaries for all medically necessary services that they were eligible to receive and that they paid for out-of-pocket during the three-month retroactive eligibility period, evaluation period for eligibility, and after eligibility was approved.

In addition to the period of eligibility specified in Section 50195, an applicant shall be eligible for Medi-Cal in any of the three months immediately preceding the month of application or reapplication if all of the following requirements are met in that month:

1. The county department determines that the applicant would have been eligible for one of the programs specified in Section 50201, except as specified in (c), had an application been made.
2. The applicant received health services.
3. The applicant was not previously denied Medi-Cal for the month in question, unless the application was denied for one of the following reasons:
    a. County error.
    b. The applicant's failure to cooperate, when that failure, or the applicant's subsequent failure to reapply, was due to circumstances beyond the control of the applicant.

Beneficiary/Client Rights

1. Be treated with respect and with due consideration for his or her dignity, and privacy.
2. Receive information on available treatment options and alternatives presented in a manner appropriate to his or her condition and ability to understand.
3. Participate in decisions regarding his or her health care, including the right to refuse treatment.
4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
5. Request and receive a copy of his or her medical records, and request that they be amended or corrected.
6. Ask for a provider who can communicate in his/her language.
7. Whenever possible, receive mental health services at times and places that are convenient for him/her.
8. Be told what his/her diagnosis means and get answers to questions.
9. Get a second opinion when the first assessment indicates no need for treatment.
10. Know the benefits, risks, and costs of treatment before giving permission for services.
11. File a grievance about the services received or about the way that he/she was treated.
12. Choose another person to represent him/her in the grievance process.
13. Have his/her mental health records and personal information kept private.
14. Be told about program rules and changes.
15. File an appeal when services are denied, in part or in whole.
16. Have access to the beneficiary handbook and materials on how to file a grievance, appeal, and State Fair Hearing.
17. Receive mental health services in accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.206 through 438.210, which cover requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, coverage and authorization of services and to receive information in accordance with Title 42, CFR, Section 438.10, which describes information requirements.

Beneficiary Request for Service Process

Beneficiary Request for Service Overview

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) and contracted providers shall ensure that all medically necessary covered Specialty Mental Health Services (SMHS) are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. Services shall be provided in accordance with the State Plan to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan.

DHS-BHD and its contracted providers must ensure that all Medi-Cal beneficiaries who are eligible for SMHS through the DHS-BHD network are informed of their right to request continued services (Continuity of Care – COC) when there is a pre-existing provider relationship, and to request for out-of-network (OON) services when covered services are unavailable in-network, or in a timely manner.

All Beneficiary Requests for Service (BRS) are processed in accordance with state and federal mandates. DHS-BHD contracted providers are required to process BRS when a DHS-BHD beneficiary requests services from the provider that are not included in the provider's contract with DHS-BHD, or not made available in a timely manner. DHS-BHD in partnership with contracted providers are required to make determinations about beneficiary requests for service within 14 calendar days from the date of request.

Medi-Cal beneficiaries are informed of access to care rights via provided Medi-Cal Informing Materials. Medi-Cal Informing Materials shall be made available in public spaces at provider sites (*see Medi-Cal Site Certification*). At the time of assessment contracted providers will offer Medi-Cal Informing Materials and inquire about pre-existing provider relationships. Contracted providers must document inquiry about pre-existing providers and availability of Informing Materials (Acknowledgement of Receipt).

Pre Existing Provider & Continuity of Care – Qualifying Event

A pre-existing provider is one that the beneficiary has engaged in treatment with at least once in the 12 months prior to transferring their care to DHS-BHD, or the contracted provider.

All beneficiaries who meet medical necessity for SMHS have a right to request COC with their pre-existing provider when any of the following Qualifying Events occurs:

1. The provider has voluntarily terminated employment or the contract with the MHP;
2. The provider's employment or contract has been terminated for a reason other than issues related to the quality of care or eligibly of their provider to participate in the Medi-Cal program;
3. The beneficiary is transitioning from one county MHP to another MHP due to a change in the beneficiary's county of residence;
4. The beneficiary is transitioning from a Managed Care Plan (MCP) to a MHP; or,
5. The beneficiary is transitioning from Medi-Cal Fee for Service (FFS) to a MHP.

A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a request with the provider for COC, in writing, or via telephone and shall not be required to submit an

electronic or written request. The provider shall deliver reasonable assistance to beneficiaries in completing requests for COC, including oral interpretation and auxiliary aids and services.

BRS Filing Process

At the time of a Qualifying Event, upon request for a service not currently provided to the beneficiary, or when required services are not available in a timely manner (see Timely Access Standards), the contracted provider shall offer appropriate and available services covered in the provider's DHS-BHD contract. If the beneficiary agrees to utilize the offered services, then no BRS form needs to be completed.

If the beneficiary declines offered services, then the provider shall process the beneficiary request for service by completing the Beneficiary Request for Service form on behalf of the service requester (beneficiary, or their representative).

If the provider determines that the requested service is ***not medically necessary, or clinically appropriate*** the provider shall either deny or modify the BRS. A denial is made when no additional services will be provided in response to the BRS. A modification is made when alternate covered services will be offered in response to the BRS – meaning more services that are covered in the CBO contract are offered to the beneficiary.

The provider shall verbally inform the requestor of this determination within 24 hours of the decision to deny, and issue the Service Denial or Modification Notice of Adverse Benefit Determination (NOABD) within 2 calendar days of the decision to deny the request. ***All denied or modified BRS forms along with issued NOABDS shall be submitted to DHS-BHD on a quarterly basis*** (BHQA@sonoma-county.org).

If the provider determines that the requested service is ***medically necessary and clinically appropriate***, but the requested services are not covered in the provider's contract with DHS-BHD, then the provider shall forward the completed BRS to DHS-BHD for processing (BHQA@sonoma-county.org).

The BRS form can be obtained here: https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

BRS Form Completion

The Beneficiary Request for Service form has 3 sections:

Section 1: Contracted Provider Clinical staff completes (reviewed & approved by CBO Health Clinical Manager)

Section 2: DHS-BHD Program Manger completes (reviewed & approved by DHS-BHD)

Section 3: DHS-BHD Section Manager completes (reviewed & approved by DHS-BHD)

*Section 1 (**Completed by the contracted provider**)* includes the following:

Beneficiary Information:

- Date of Service Request – date requested by beneficiary, beneficiary's legal representative, or provider
- Case Manager Name – name of the person completing the BRS form on behalf of the requester

- Case Manager Number – name of the person completing the BRS form on behalf of the requester
- Agency & Program Name – name of the agency that is submitting the form to DHS-BHD
- Insurance Type – check all types of insurance that apply to the beneficiary
- Beneficiary Name – first and last names of the beneficiary associated with the service request
- Beneficiary Medical Record Number – ***SKIP*** (to be completed by DHS-BHD staff)
- Beneficiary Age – current age of the beneficiary
- Diagnosis – all current diagnoses
- Name and Relationship of Person making the request – name of the person making the request and their relationship to the beneficiary
- Service being requested and why – a description of the service that is being request and for what reason, from the perspective of the service requester

Service Details:

- Recommended Type of Service – from the provider's perspective, indicate the recommended type of service
- Proposed frequency – from the provider's perspective, indicate the recommended number of time per week and hours per day
- Proposed duration – from the provider's perspective, indicate the recommended timeframe
- Contact information for the Requested Service Provider – mailing address, phone number, and e-mail address of the requested service provider
- Is the beneficiary currently receiving services from the Requested Service Provider? – YES or NO response; if YES provide an explanation of the relationship status and last service date
- If YES, list the dates of attempted contacts made by DHS-BHD staff to verify the existing relationship – ***SKIP***
    - *In instances when the BRS is a request for COC with a pre-existing, DHS-BHD staff will validate the pre-existing provider relationship. DHS-BHD staff will notify the provider, service requestor, and the pre-existing provider relationship authorization decision within the required timeframes.*
- Indicate the urgency of the service need based on level of risk – rank level of need for the requested service, consider the clinical implications of not having the services provided to the beneficiary

Clinical Rationale In Support of the Service Authorization:

- Associated Impairments – indicate impairments that would be reduced as a result of the requested service

- Treatment Team's Input – what is the provider's clinical impression about the beneficiaries needs and the requested service
- Current/Requested Service Provider's Input – ***SKIP***

Clinical Documentation In Support of Service Authorization:

- Is it in the Assessment – indicate if the requested service is identified as a need in the assessment. If YES, then provide a description of the associated need/impairment.
- Is it in the Client Plan – indicate if the requested service is identified as a service on the client plan. If YES, then provide a description of the identified service.

DHS-BHD BRS Authorization Determination Process

When the contracted provider determines the requested service(s) is medically necessary and clinically appropriate, they shall forward the BRS to DHS-BHD for processing. Providers must complete BRS forms promptly and submit it to DHS-BHD within 24 hours of initial request (BHQA@sonoma-county.org).

Once the provider submits the BRS to DHS-BHD, the Sonoma County Mental Health Plan (MHP) will review the BRS and issue a final decision regarding authorization.

If the BRS is ***denied***, DHS-BHD Program Staff will inform the provider of the denial and the MHP will issue the proper NOABD to the service requestor.

If the BRS is ***approved***:

- DHS-BHD Program Staff will inform the provider of the approval.
- The provider will notify the service requestor of the determination related to the BRS and provide updates as needed.
- DHS-BHD Administrative Support & Contracts staff will steward the BRS through the contracting process and provide updates to the contracted provider, DHS-BHD Program Staff, and QAPI staff.
- As appropriate, the contracted provider will ensure that the authorized service is reflected in the client plan (addendum – post BRS approval).
- As appropriate, the contracted provider will monitor the beneficiary's progress in treatment, verify that medical necessity for SMHS are met, and that the beneficiary is actively participating in and benefitting from the authorized service.
- As appropriate, the contracted provider will inform DHS-BHD program staff of any expected/required changes to the terms of the BRS agreement (e.g. *term extension, termination of services, reduction, and/or addition of services*).
- DHS-BHD staff will work with the contracted provider to ensure the creation of a transition of care plan to ensure safe transfer to an in-network provider within the required timeframes.

Beneficiary Rights: Notice of Adverse Benefit Determination (NOABD)

Provision of Notice of Adverse Benefit Determination

An adverse benefit determination is the delay, denial, or limited authorization (modification) of a requested service, or previously authorized service. This includes determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. A Notice of Adverse Benefit Determination (NOABD) informs beneficiaries of a delay, denial, limitation, or change to their Specialty Mental Health Services (SMHS).

The provider shall issue a NOABD when authorization and timely access timeframes are not met and when there has been a denial, limitation, or change to of the beneficiaries SMHS due to medical necessity criteria not being met. NOABDs specify what action was taken, the clinical justifications, and cite the corresponding regulations. A NOABD also informs beneficiaries of their rights to appeal the determination and pursue a State Hearing. *NOTE: contracted providers are not responsible for processing or resolving appeals or State hearings.* Contracted providers must immediately forward any requests for appeals and State hearing to the DHS-BHD QA Manager via BHQA@sonoma-county.org.

Providers shall issue a NOABD to beneficiaries under the following circumstances:

- Failure to provide services in a timely manner (see Timely Access Standards, p19).
- Failure to provide service authorizations in a timely manner (14 calendar days from the date of request receipt –see Beneficiary Request for Service, p29).
- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit (see Beneficiary Request for Service, p29).
- Reduction, suspension, or termination of a previously authorized service.
- Failure to resolve grievances in a timely manner (see Beneficiary Resolution Process, p39)

The provider must ensure timely issuance and adequate notice of an adverse benefit determination in writing using a NOABD. The NOABD must be available in the prevalent non-English languages in the providers particular service area (Sonoma County - Spanish). They must include taglines and be printed in a conspicuously visible font size. They must also explain the availability of written translation or oral interpretation to understand the information provided. NOABDs must be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. Alternative formats and language assistance must be made available upon request of the potential beneficiary or beneficiary at no cost.

The NOABD will either be hand-delivered to the beneficiary on the date of the adverse benefit determination or mailed.

d Decisions should be communicated first by telephone or in person within 24 hours of the determination, and then in writing per the issuance timeframes below (except for decisions rendered retrospectively).

The provider agrees to log all issued NOABDs, including the date of issuance and to whom the NOABD was sent. The provider shall retain copies of all issued NOABDs in a centralized file accessible to DHS-BHD. The provider

must allow DHS-BHD and DHCS to engage in reviews of the provider's records pertaining to NOABDs to ensure timely and accurate issuance. All issued NOABD and the corresponding quarterly report must be e-mailed to the DHS-BHD Grievance Coordinator on a quarterly basis (BHQA@sonoma-county.org).

All email communications containing beneficiary identification or other health protected information must use encryption to secure transmitted electronic health information.

Format of NOABD

Providers must use the State Department of Health Care Services (DHCS) uniform NOABD templates, or the electronic equivalent of these templates generated from DHS-BHD. The notice templates include both the attached NOABD and "Your Rights" documents to notify beneficiaries of their rights in compliance with the federal regulations. All text must be at least 12 point font and the documents must be ADA complaint. https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

NOABD "Your Rights" Attachment

The "Your Rights" attachment is a new form that informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution (NAR). These attachments must be sent to beneficiaries with each NOABD or NAR. The "NOABD Your Rights" attachment provides beneficiaries with the following required information pertaining to NOABD:

- The beneficiary's or provider's right to request an internal appeal with DHS-BHD within 60 calendar days from the date on the NOABD;
- The beneficiary's right to request a State hearing only after filing an appeal with DHS-BHD and receiving a notice that the Adverse Benefit Determination has been upheld;
- The beneficiary's right to request a State hearing if DHS-BHD fails to send a resolution notice in response to the appeal within the required timeframe;
- Procedures for exercising the beneficiary's rights to request an appeal;
- Circumstances under which an expedited review is available and how to request it; and,
- The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits (also known as "Aid Paid Pending").

Language Assistance, Non-Discrimination Notice and Taglines

The provider will follow the requirements of DHCS MHSUDS Information Notice No. 18-010E regarding written material requirements for denial and termination NOABDs. Including availability in threshold languages and alternative formats, "Non-Discrimination Notice" and "Language Assistance" taglines made available by DHCS or adapted for use by DHS-BHD, as permitted in DHCS MHSUDS Information Notice No.18-010E.

Nondiscrimination Notice and Language Assistance Taglines

Federal regulations require the provider to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. Providers may utilize the templates provided by DHCS, or use the modified template created by DHS-BHD. The Nondiscrimination Notice and Language Assistance Taglines, must be sent in conjunction with each of the following significant notices sent to beneficiaries: *NOABD, grievance acknowledgment letter, appeal acknowledgment letter, grievance resolution letter, and NAR.*

NOABD Template Contents

The NOABD must explain the following:

- The adverse benefit determination the provider has made or intends to make.
- The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The beneficiary's right to request an appeal of the provider's adverse benefit determination, including information on exhausting the DHS-BHD one level of appeal and the right to request a State fair hearing.
- The procedures for exercising the rights related to the NOABD, appeal, and State Hearing.
- The circumstances under which an appeal process can be expedited and how to request it.
- The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

The following is a description of adverse benefit determinations and the corresponding NOABD template.

- ***NOABD Service Denial Notice****:* Denial of authorization for requested services
    - Use this template when the provider denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- ***NOABD Payment Denial Notice***: Denial of payment for a service rendered by provider
    - Use this template when the provider denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.
- ***NOABD Delivery System Notice****: Delivery system
    - Use this template when the provider has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the contracted provider. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.
- ***NOABD Modification Notice****:* Modification of requested services
    - Use this template when the provider modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.
- ***NOABD Termination Notice****:* Termination of a previously authorized service

- Use this template when the provider terminates, reduces, or suspends a previously authorized service.

- ***NOABD Authorization Delay Notice****: Delay in processing authorization of services
    - Use this template when there is a delay in processing a request for authorization of specialty mental health services or substance use disorder residential services. When the provider extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.
        - For standard authorization decisions, the provider will provide notices as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days.
        - For expedited authorization decisions, the provider will provide notices as expeditiously as the beneficiary's health condition requires and within 72 hours following receipt of the request for service with a possible extension of up to 14 calendar days.
- ***NOABD Timely Access Notice****:* Failure to provide timely access to services
    - Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. Refer to DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No. 18-011 for the applicable timeframes, depending on the specific service provided by the MHP.
- ***NOABD Financial Liability Notice****:* Dispute of financial liability
    - Use this template when the contracted provider denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
- ***NOABD Grievance and Appeal Timely Resolution Notice***: Failure to timely resolve grievances and appeals
    - Use this template when the contracted provider does not meet required timeframes for the standard resolution of grievances (90 calendar days from when the contracted provider receives the grievance) and appeals (30 calendar days from when the contracted provider receives the appeal).

* *Contracted providers typically issue these types of NOABDs.* All other types are typically issued by DHS-BHD.

Timing of NOABD

Adverse benefit determinations should be communicated first by telephone or in person within 24 hours of the determination, and then in writing per the issuance timeframes below.

NOABD shall be issued within the following timeframes:

- For termination, suspension, or reduction of a previously authorized specialty mental health service, ***at least 10 days before the date of action***, except as permitted under 42 CFR §§ 431.213 (Exceptions from advanced notice) and 431.214 (Notice in cases of probable fraud);

- For denial of payment, at the time of any action denying the provider's claim; or,

- For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, ***within two business days of the decision***.

    - The contracted provider must also communicate the decision to the affected provider within 24 hours of making the decision.

- For standard service authorizations that deny or limit services, ***as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days*** following the receipt for request for services. (42 C.F.R. § 438.404(c)(3); 42 C.F.R. 438.210(d)(1).)
- If a provider indicates, or the contracted provider determines, that following the standard service authorization timeframe could seriously jeopardize the beneficiary's life or health or his or her ability to attain, maintain, or regain maximum function, the contracted provider must make an expedited service authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. 438.210(d)(2)(i).)
    - The contracted provider may extend the 14 calendar day notice of adverse benefit determination timeframe for standard service authorization decisions that deny or limit services up to 14 additional calendar days if the contracted provider justifies a need to the Department, upon request, for additional information and shows how the extension is in the beneficiary's best interest. (42 C.F.R. § 438.404(c)(4); 42 C.F.R. 438.210(d)(1)(ii).)
    - The contracted provider may extend the 72 hour expedited service authorization decision time period by up to 14 calendar days if the beneficiary requests an extension, or if the contracted provider justifies to the Department, upon request, a need for additional information and how the extension is in the beneficiary's interest. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. § 210(d)(2)(ii).) 10)
    - Written notice must include the reason for the extension and inform the beneficiary of the right to file a grievance if he/she disagrees with the decision; (42 C.F.R. § 438.404(c)(4)(i); 42 C.F.R. 438.210(d)(1)(ii).) Provider must issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date of the extension. (42 C.F.R. § 438.404(c)(4)(ii); 42C.F.R. 438.210(d)(1)(ii).)
    - The contracted provider shall give notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations. (42 C.F.R. § 438.404(c)(5).)
    - The contracted provider shall deposit the NOABD with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires. (Cal. Code Regs., tit. 9, § 1850.210(f).)

NOABD Quarterly Reporting

Per California Code of Regulations, Title 9, Chapter 11 Section 1810.375(a) DHS-BHD must submit NOABD data to Department of Health Care Services (DHCS) on an annual basis. This report runs from July 1 of the previous year through June 30 of the current year, and must be submitted to DHCS by October 1st of each year. Included in this report are a count of NOABDs filed concerning services delivered by DHS-BHD contracted providers.

The DHS-BHD Grievance Coordinator distributes the NOABD Quarterly Report with instructions to providers via e-mail. All contracted providers are required to complete this quarterly report and submit copies of all related documents to DHS-BHD within the timeframes noted below (retain originals for your records).

Below is the NOABD Quarterly Reporting schedule, including reporting periods and the corresponding due date.

Quarterly Reporting Schedule		
Quarter Period		**Report Due to SCBH**
Quarter 1:	July 1, 2019 - September 30, 2019	October 1, 2019
Quarter 2:	October 1, 2019 - December 31, 2019	January 1, 2019
Quarter 3:	January 1, 2020 - March 30, 2020	April 1, 2020
Quarter 4:	April 1, 2020 - June 30, 2020	July 1, 2020
Submit Completed Report and All Supporting Documents (via secure e-mail) to: bhqa@sonoma-county.org		

NOABD Issuance Tracking

For each reporting period the contracted provider shall input a count of NOABDs into the appropriate NOABD subcategories by quarter. Each quarter's information shall be retained in the report and all data fields should contain a response, enter (0) if no NOABDs were obtained. At the end of the 4th quarter, all data fields should be completed.

Contracted Provider Name:				
Notice of Adverse Benefit Determination				
CATEGORY	**REPORTING PERIOD**			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Service Denial Notice				
Delivery System Notice				
Modification Notice				
Termination Notice				
Authorization Delay Notice				
Timely Access Notice				
Financial Liability Notice				
TOTAL	0	0	0	0

Beneficiary Problem Resolution Process

Consumer Grievance Overview

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) must have a grievance system in place to ensure that consumers and beneficiaries are informed about their rights and procedures to resolve grievances, and to assure compliance with State and Federal regulations and guidelines. The grievance resolution process is a shared responsibility between DHS-BHD and contracted providers. This includes distribution of materials concerning beneficiaries' rights and the grievance process. Additionally, this process includes adhering to DHS-BHD processes for ensuring timely resolution of grievances to assure fair and equal treatment for all. DHS-BHD contracted providers are also responsible for submitting grievance forms and data to DHS-BHD in a timely manner.

A grievance is an individual's verbal or written expression of dissatisfaction about any matter other than a matter covered by a Notice of Adverse Benefit Determination (see *Notice of Adverse Benefit Determination*). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights regardless of whether remedial action is requested.

There is no distinction between an informal and formal grievance. A consumer does not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. A complaint shall be considered a grievance unless it meets the definition of an appeal to a Notice of Adverse Benefit Determination (see *Notice of Adverse Benefit Determination*). A grievance filer cannot appeal a Grievance Resolution. They can only file a new grievance. Anyone can file a grievance, but appeals and expedited appeals are only available to DHS-BHD Medi-Cal beneficiaries.

DHS-BHD and contracted providers shall not discourage the filing of grievances. Even if a consumer expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievances will be analyzed by DHS-BHD to monitor trends. System of care trends identified through the DHS-BHD Consumer Grievance process will be forwarded to the Quality Improvement Committee (QIC), Behavioral Health Plan Administration Committee (BHPA) and Quality Improvement Steering (QIS) Committee for review and, if applicable, used to inform subsequent system changes.

All contracted providers must inform consumers of the Grievance Resolution process. Grievance related information is available to consumers through the required Medi-Cal informing materials that contracted providers shall make freely available in lobbies, office areas, or other public waiting areas. Notices explaining the grievance process shall be posted in prominent locations at all contracted Medi-Cal provider sites.

These Informing Materials are:

- The Sonoma County Mental Health Plan Beneficiary Specialty Mental Health Services Handbook 2019
- Client Rights Poster

- Client Rights and Grievance/Appeal Process and Form, including self-addressed, no postage necessary envelopes (available for beneficiaries to pick up at all provider sites without having to make a verbal or written request)

Informing Materials can be found at https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

Consumer Grievance Filing and Reporting Process

If an individual is dissatisfied with the service delivered by the contracted provider, the provider shall offer the member the DHS-BHD grievance form (MHS-406) to complete. The grievance form can be completed by either the consumer, their treatment provider, family member/friend, or by a community member. Grievances can be filed verbally (in person or over the phone), or in writing. The provider shall offer assistance with completing the grievance form and shall provide assistance if asked.

Individuals who choose to file a grievance will have the opportunity to present information at any time during the resolution process. Grievance filers are encouraged (but not required) to discuss their grievance with staff or an agency representative.

Upon receipt of a grievance, the provider shall ensure that the all sections of the grievance form are completed. If the grievance is filed verbally, the provider shall attempt to resolve the grievance with the filer by inquiring about what actions the provider can take to address the complaint. If the grievance is filed in writing via physical mail, the provider shall forward the submitted grievance form to the DHS-BHD Grievance Coordinator for resolution.

Exempt Grievances

With verbal grievances, when appropriate, the provider will work to resolve the grievance to the satisfaction of the filer by the end of next business day – making the grievance ***exempt***. An ***exempt grievance*** does not require a full investigation on the part of the DHS-BHD Grievance Coordinator.

When the provider satisfactorily resolves the grievance, they shall document on the grievance form the support provided to the filer in an effort to resolve the grievance (do not include any identifying information about staff cited in the grievance itself). If the grievance is ***resolved*** by the end of the next business day, the provider shall:

1. Mark the “grievance” box at the top of the form.
2. In Section 3 indicate what action was taken by the provider to resolve the grievance.
3. In the Staff Use Only Section
    a. Check the “Exempt” box
    b. Note the date the grievance was resolved
4. Send the completed form to the DHS-BHD Grievance Coordinator immediately: E-mail to bhqa@Sonoma-county.org.

Upon receipt of the grievance, the DHS-BHD Grievance Coordinator will follow-up with the provider to obtain additional information when necessary.

Non-Exempt Grievances

If the filer submits a grievance via physical mail, or if after speaking with the provider the filer remains unsatisfied with the provided resolution, the grievance is ***non-exempt***. A ***non-exempt grievance*** is a complaint that was not resolved to the satisfaction of the filer by the end of the next business day following the filing of the grievance. When filers mail grievances, the next business day timeframe is exceeded and therefore it cannot be exempt. All ***non-exempted grievances*** require a full investigation on the part of the DHS-BHS Grievance Coordinator. If the grievance is ***non-exempt***, the provider shall:

1. Mark the "grievance" box at the top of the form.
2. In the Staff Use Only Section
    a. Check the "Non-Exempt" box
3. Send the completed form to the DHS-BHD Grievance Coordinator immediately: E-mail to bhqa@Sonoma-county.org (ensure e-mail is sent *Secure*).

Upon receipt of the grievance, the DHS-BHD Grievance Coordinator will send an acknowledgement letter to the grievance filer, within **5 calendar** days from the grievance filing date. Within **90 calendar days**, DHS-BHD Grievance Coordinator will review and investigate the grievance, and a written Notice of Grievance Resolution (NGR) will be provided to the grievance filer, or their authorized representative.

Referred Grievances

If a filer submits a grievance that is not associated with a complaint about the contracted provider, or DHS-BHD, this is considered a ***referred grievance***. While grievances in this category are not within the provider's jurisdiction to resolve, the provider shall refer the grievance to the appropriate agency or department. Also, the provider shall ensure that a completed grievance form is submitted to the DHS-BHD Grievance Coordinator. If the grievance is ***referred***, the provider shall:

1. Mark the "grievance" box at the top of the form.
2. In the Staff Use Only Section
    a. Check the "Exempt" box and write "***referred***"
    b. Note the date the grievance was referred and to whom.
3. Send the completed form to the DHS-BHD Grievance Coordinator immediately: E-mail to bhqa@Sonoma-county.org (ensure e-mail is sent *Secure*).

Quarterly Reporting

Per California Code of Regulations, Title 9, Chapter 11 Section 1810.375(a) DHS-BHD must submit grievance data to Department of Health Care Services (DHCS) on an annual basis. This report runs from July 1 of the previous year through June 30 of that year, and must be submitted to DHCS by October 1st of each year. Included in this report are a count of grievances filed concerning services of DHS-BHD contracted Medi-Cal providers.

The DHS-BHD Grievance Coordinator distributes the Grievance Quarterly Report with instructions to providers via e-mail. All contracted Medi-Cal providers are required to complete this quarterly report and submit copies of all related documents to DHS-BHD within the timeframes noted below (retain originals for your records).

Documents Submittal Timeframe

Grievance Forms to DHS-BHD: *Due immediately, or by the end of the next business* (ensure e-mail is sent *Secure*)

Quarterly Reporting Schedule		
Quarter Period		**Report Due to SCBH**
Quarter 1:	July 1, 2019 - September 30, 2019	October 1, 2019
Quarter 2:	October 1, 2019 - December 31, 2019	January 1, 2019
Quarter 3:	January 1, 2020 - March 30, 2020	April 1, 2020
Quarter 4:	April 1, 2020 - June 30, 2020	July 1, 2020
Submit Completed Report and All Supporting Documents (via secure e-mail) to: bhqa@sonoma-county.org		

For each reporting period the provider shall input a count of grievances into the appropriate grievance subcategories by quarter. Each quarter's information shall be retained in the report and all data fields should contain a response, enter (0) if no Grievances were obtained. At the end of the 4th quarter, all data fields should be completed.

CATEGORY	REPORTING PERIOD			
ACCESS	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Service Not Available				
Service Not Accessible				
Timeliness of Services				
24/7 Toll-free Access Line				
Linguistic Services				
Other Access Issues				
TOTAL	0	0	0	0
QUALITY OF CARE	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Staff Behavior Concerns				
Treatment Issues or Concerns				
Medication Concerns				
Cultural Appropriateness				
Other Quality of Care Issues				
TOTAL	0	0	0	0
CHANGE OF PROVIDER	Quarter 1	Quarter 2	Quarter 3	Quarter 4
TOTAL	0	0	0	0
CONFIDENTIALITY CONCERN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
TOTAL	0	0	0	0
OTHER	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial				
Lost Property				
Operational				
Patients' Rights				
Peer behaviors				
Physical environment				
Other grievance not listed above				
TOTAL	0	0	0	0
GRAND TOTAL	0	0	0	0

Additionally, in the Disposition section of the report, the provider shall input by quarter and type the count of grievances that were **Resolved** by the provider (**Exempt**) or **Referred** (**Exempt**).

CATEGORY		
ACCESS	Resolved Quarter 1	Referred Out Quarter 1
Service Not Available		
Service Not Accessible		
Timeliness of Services		
24/7 Toll-free Access Line		
Linguistic Services		
Other Access Issues		
TOTAL	0	0
QUALITY OF CARE	Resolved Quarter 1	Referred Out Quarter 1
Staff Behavior Concerns		
Treatment Issues or Concerns		
Medication Concerns		
Cultural Appropriateness		
Other Quality of Care Issues		
TOTAL	0	0
CHANGE OF PROVIDER	Resolved Quarter 1	Referred Out Quarter 1
TOTAL	0	0
CONFIDENTIALITY CONCERN	Resolved Quarter 1	Referred Out Quarter 1
TOTAL	0	0
OTHER	Resolved Quarter 1	Referred Out Quarter 1
Financial		
Lost Property		
Operational		
Patients' Rights		
Peer behaviors		
Physical environment		
Other grievance not listed above		
TOTAL	0	0
GRAND TOTAL	0	0

The final component of the Disposition section of the report is the number of grievances that are **Pending** resolution at the close of the quarter. Grievances in the **Pending** category are those that were filed on the day the report was sent to DHS-BHD and the provider is working to resolve with the filer (see **Exempt Grievances** above).

CATEGORY	
ACCESS	Pending Close of Quarter 1
Service Not Available	
Service Not Accessible	
Timeliness of Services	
24/7 Toll-free Access Line	
Linguistic Services	
Other Access Issues	
TOTAL	0
QUALITY OF CARE	Pending Close of Quarter 1
Staff Behavior Concerns	
Treatment Issues or Concerns	
Medication Concerns	
Cultural Appropriateness	
Other Quality of Care Issues	
TOTAL	0
CHANGE OF PROVIDER	Pending Close of Quarter 1
TOTAL	0
CONFIDENTIALITY CONCERN	Pending Close of Quarter 1
TOTAL	0
OTHER	Pending Close of Quarter 1
Financial	
Lost Property	
Operational	
Patients' Rights	
Peer behaviors	
Physical environment	
Other grievance not listed above	
TOTAL	0
GRAND TOTAL	0

Provider Problem Resolution & Payment Appeal Process

Sonoma County Department of Health Service Behavioral Health Division (DHS-BHD) has established a process for identifying and resolving provider concerns and problems regarding payment, other complaints and concerns. Providers may contact DHS-BHD at any time to begin a problem resolution process. DHS-BHD staff will work with providers to resolve problems and concerns as quickly and as easily as possible.

Provider concerns/complaints, or appeals may be submitted to DHS-BHD Provider Relations by telephone, in person, or in writing (mail, fax, or e-mail) by using the Provider Problem Resolution & Payment Appeal form, located at https://sonomacounty.ca.gov/Health/Behavioral-Health/Forms-and-Materials/

The completed form may be returned by:

Mail to:
Sonoma County DHS-BHD
ATTN: Provider Relations
2227 Capricorn Way, Suite 207
Santa Rosa CA 9540
Phone: (707) 565-4767
Fax: (707) 565-2202
ATTN: Provider Relations
Email: SCBHProviderRelation@sonoma-county.org

All e-mail communications containing beneficiary identification or other health-protected information must use encryption to secure transmitted electronic health information.

Provider Problem Resolution Process

Provider concerns/complaints may address, but are not limited to, the following issues:

- Contracts, including, but not limited to, payment agreement, scope of work, etc.
- Disagreement with monitoring/audit review findings by DHS-BHD Quality Assurance staff (monitoring/audit review appeals are due *within 15 business days* of the provider's receipt of findings/audit report).
- Disagreement with service decisions made by DHS-BHD staff
- Any other concerns/complaints

Efforts will be made to resolve concerns/complaints at the lowest level of DHS-BHD involvement, though the provider has the option of submitting a Provider Problem Resolution & Payment Appeal form at any time. When efforts to resolve concerns/complaints at an informal level have failed to achieve a resolution of the issue, DHS-BHD staff will direct the provider to complete the Provider Problem Resolution & Payment Appeal form and return the completed form to DHS-BHD Provider Relations.

Provider Payment Appeal Process

Providers have the right to initiate the provider payment appeal process at any time before, during, or after the provider problem resolution process has begun. DHS-BHD Provider Relations will inform the provider whether initiating the provider problem resolution process will affect the provider's timelines for accessing the provider payment appeal process.

Providers may only file a payment appeal for the following three reasons:

- Denied request for payment
- Modified request for payment
- Dispute concerning the processing or payment of a provider's claim including, but not limited to, a delay in payment

Providers ***must*** submit a completed Provider Problem Resolution & Payment Appeal form to DHS-BHD Provider Relations within:

- 90 calendar days of the receipt or fax date of notification of payment denial/modification, or
- 90 calendar days of DHS-BHD's failure to act upon the request for payment

Providers must include, with the completed Provider Problem Resolution & Payment Appeal form, written statements, chart documentation and/or other materials in support of the provider's claim.

The Behavioral Health Plan Administration committee (BHPA) shall review the appeal and make a recommendation of resolution to DHS and BHD Senior Administrators, who will provide the final decision on payment appeals to Quality Assurance (QA). A final written decision concerning the appeal resolution will be issued to the provider within (60) calendar days from receipt of the appeal. This written response will include a statement of the reasons for the decision that addresses each issue raised by the provider and any action required by the provider to implement the action. If a response is not issued to the provider within (60) calendar days from receipt of the appeal, the appeal will be considered denied in full.

DHS-BHD staff involved in the initial denial of the request for payment will not participate in the appeal resolution decision.

Revised Request for Payment

- If the appeal in approved in full, no further action is required.
- If the appeal is modified, a provider shall submit a revised request within (30) calendar days of receipt of appeal decision. The DHS Revenue Management Unit will process the provider's revised request for payment within (14) calendar days from the date of receipt of a provider's revised request.
- For denied or modified appeals associated with requests for payment for Specialty Mental Health Services, or administrative days not met, the provider may appeal the denial or modification to the Department (DHCS). To obtain a "second level appeal" the provider must submit an appeal in writing to DHCS within (30) calendar days of receipt of DHS-BHD appeal determination letter.

Documentation - Assessments

Assessment Definition

Assessment is defined as a service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes, but is not limited to, mental status examination, analysis of the client's clinical history, analysis of relevant cultural issues and history, diagnosis, and/or the use of testing procedures.

Assessments should be conducted in the client's preferred language/format and documented in the medical record, including whether interpreter services were utilized. For children or certain other clients unable to provide a history, information may be obtained from caregivers.

Required Content Areas of the Mental Health Assessment

All sections must be completed. It is not acceptable to leave questions or sections blank.

- Assessment completion date and client's date of birth.
- Identifying information—Age, gender, marital status, significant others, living situation, ethnicity, preferred language, conservatorship.
- Presenting problem—Reason for seeking help in client's own words, staff impression, parent or caregiver's impression; who referred the client; history (hx) of presenting problem(s); current level of functioning; relevant family hx and current family information.
- Relevant conditions and psychosocial factors affecting physical and mental health—including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, religious/spiritual considerations, hx of trauma or exposure to trauma.
- Mental health history—Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records and relevant psychological testing and/or consultation reports.
- Medical history—Relevant physical health conditions as reported by the client or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the hx must include prenatal and perinatal events and relevant/significant developmental hx. If possible, include other medical information from medical records or relevant consultation reports.
- Medications—Information about medications the client has received or is receiving to treat mental-health and medical conditions, including duration of medical treatment. Must include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.
- Substance exposure/substance use—Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications (CAM), over-the-counter drugs, and illicit drugs.
- Client strengths—Documentation of the client's strengths in achieving the Client Plan goals related to the client's mental health needs and functional impairments as a result of the mental health condition.

- Risk factors—Situations that present a risk to the client and/or others, including past or current trauma. For example, history of Danger to Self (DTS) or Danger to Others (DTO), previous inpatient hospitalizations for DTS or DTO, prior suicide attempts, lack of family or other support systems, prior arrests, currently on probation, history of alcohol/drug abuse, history of trauma or victimization, history of self-harm behaviors (e.g., cutting), history of assaultive behavior, physical impairment that may make client vulnerable to others (e.g., limited vision, D/deaf or hard of hearing, uses a wheelchair), psychological or intellectual vulnerabilities (e.g., intellectual disability, traumatic brain injury, dependent personality).
- A mental status exam
- A complete diagnosis—ICD-10 diagnosis that is the primary focus of treatment. An excluded diagnosis may be noted along with the primary diagnosis. The primary ICD-10 diagnosis must be made using DSM-5. Diagnosis must be consistent with the presenting problems, hx, mental status examination, and other clinical data. Document rationale for diagnosis.
- Level of Care—Includes rationale for recommended level of care based on medical-necessity criteria evaluated during the assessment.

Timeliness/Frequency Standards

All initial assessments are completed within the first 30 days of opening the client to specialty mental health services. Reassessments for youth clients (0-17 years old) are completed at least every six months or when the client has experienced a significant medical or clinical change. Reassessments for adult clients (18 years and older) are completed at least annually or when the client has experienced a significant medical or clinical change. (See “CANS/ANSA Reassessment” section.)

Clinical Signature Requirements

Include the signature of the person providing the service and their professional degree, licensure, or job title. Assessments must also include a licensed supervisor/manager’s signature (including professional degree, licensure, or job title) and date of signature.

Provision of Services Prior to Completion of the Initial Assessment

Before the Initial Assessment is completed, only Crisis Intervention, Assessment, and urgent Medication Support Services may be claimed.

Crisis Intervention are those services to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to assessment, collateral, and therapy. Crisis Intervention services may either be face-to-face or by telephone with the client or the client’s significant support people and may be provided anywhere in the community.

Urgent Medication Support Services are services for those conditions that, without timely intervention, are highly likely to result in an immediate emergency psychiatric condition. Providers must document within the progress note that the client’s condition required urgent intervention.

CANS/ANSA Reassessment

Reassessments are required to assure that changes in the client's symptoms, behaviors, and diagnoses, as well as updates to the client's needs and strengths, are documented. Reassessments establish the continued medical necessity for specialty mental health services. Reassessments are updates to the initial assessment and are not intended to review known, documented history (such as developmental history, mental health history, medical history, and substance use history) that was collected and documented in the medical record at the time of the Initial Assessment. Reassessments must include a recent Mental Status Exam.

Reassessments should be completed based on clinical interview or conversation with the client whenever possible. Reassessments based on chart review are acceptable only if the client is missing or refuses to interact with the assessor. Progress notes should reflect the assessor's attempt to engage the client in the reassessment process.

Reassessments should also include consultations with the client's other treatment providers to gather relevant clinical information to assess the client's current needs and strengths.

If a non-diagnosing staff completes the reassessment, the current diagnosis must be established by a qualified diagnosing staff and the Mental Status Exam must be conducted by qualified diagnosing staff member.

Claiming for Assessment

Assessment activities, including diagnostic services, are reimbursable by a provider acting within their scope of practice when an assessment is in process or when the assessment results in a non-included diagnosis or determines that the client does not meet medical-necessity criteria for SMHS.

CANS/ANSA Manuals

For information on scoring the CANS/ANSA, see the manuals for further information.

Documentation - Client Plans

The Client Plan is an agreement between the client and clinician that identifies the focus of the client and treatment team as the client works to attain their recovery goals. Treatment planning with the client is a clinical intervention in itself. The clinician coaches the client to develop meaningful, measurable goals that allow the client to track their own progress.

The Client Plan includes the client's specific treatment goals and authorizes treatment interventions to help the client reach those goals. The Client Plan is revised to reflect changes necessary to assist the client to reach their goals and monitors the client's progress over time. The clinical record must include documentation of the client's participation in the development of, and agreement with, the Client Plan. If a client is not expected to be in "long term treatment" (that is, the client will be in services less than 30 days), then the client is not required to have a Client Plan.

The provider may prepare a Client Plan within a short period of time of the client being opened to services in order to quickly begin providing services that cannot be provided without a Client Plan. However, all Client Plan requirements must be met. The Client Plan is a dynamic and living document, and services can be added over time based on the individual client's needs. Additional goals and interventions may be added to a Client Plan through a Client Plan addendum.

Client Plans should be developed in consultation with the client's other treatment providers in order to develop goals and interventions that meet the client's needs.

Goals/Objectives

Goals or objectives describe what the client wants to achieve in the context of their mental health recovery.

Goals or objectives must be:

- Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health condition.
- Linked to the client's mental health needs, functional impairments, and risk behaviors/factors identified by the current assessment and CANS/ANSA.
- Directly related to the qualifying mental health diagnosis and medical necessity criteria.

Whenever possible, goals/objectives should focus on the **outcome** of reducing symptoms, rather than on symptom-reduction itself. Remember that the purpose of specialty mental-health services is to help clients function better in their daily life, not simply reduce symptoms. SAMHSA's four dimensions of recovery can be helpful in guiding clients to identify areas they would like to work on or expand: Home, Health, Purpose, and Community.

Goals and objectives should also be written in ways that the client can understand and therefore legitimately agree to. Try to avoid "clinical-ese" or writing goals that might look great to other mental healthcare providers

but be incomprehensible to clients. Remember that goals and objectives are what the client wants to accomplish, and so should be developed in collaboration with the client, not simply assigned to the client by the clinician.

It's also important to note that goals and objectives are not promises. They are statements about what the client would like to accomplish. Inspiring goals can inspire creative treatment and spur a client's recovery. Restrictive or protective goals – those that are scaled back due to worry that the client may fail in achieving their real goals – can hamper rapport, generate stale treatment, and stall a client's progress.

Meaningful goals are individual and meaningful to the client, not "cookie cutter" goals that are almost identical across your client base. By investing the time to co-develop meaningful goals at the treatment-planning stage, treatment moves away from "reactive" services.

Because goals are not promises, it is possible that a client will not have achieved a goal from a previous plan and that you'll consider carrying over that goal to the new plan. However, please be thoughtful about whether to carry over previous goals. If the client could not achieve the goal on the previous plan, you probably want to work with the client on breaking the goal down into more achievable steps as well as asking whether the goal is truly relevant, meaningful, or motivating for the client. If not, work on developing a new goal for that area of need.

Example goals or objectives:

- Jo would like to be able to attend the movies one time per week for the next 12 months without having a panic attack, by self-report via tracking log.
- Naomi would like to reduce her depression enough that she can shower and leave the house three times a week for a full year, by self-report and staff observation.
- Anjali would like to be able to attend her part-time job every day she's scheduled for the next year without having to call in sick due to anxiety, by self-report.

Interventions

All planned specialty mental-health services provided during the client-plan period must be authorized on the Client Plan in these interventions, including Targeted Case Management/ICC, Mental Health Services (therapy, collateral, rehab, and IHBS), Medication Support, Adult Residential, STRTP, Intensive Services Foster Care, and Therapeutic Behavioral Services (TBS). The Client Plan must also authorize the frequency and duration for the treatment team's proposed interventions that will be needed to help the client progress toward their goals.

Interventions must:

- Name the provider of the intervention
- Identify the proposed type(s) of intervention/modality, including treatment category (e.g., Targeted Case Management, Mental Health Services, etc.).

- Include a detailed description of the intervention to be provided (i.e., what will be done beyond simply the type or category of intervention).
- Have a proposed frequency and duration of the intervention(s). Duration refers to the total expected timespan of the service and can be the length of the client plan (e.g., for up to one year). The proposed frequency for delivery of an intervention must be stated specifically (e.g., daily, weekly, etc.) or as a frequency range (e.g., 1-4 x's monthly).
- Avoid frequencies of "as needed," "PRN," or "ad hoc" (all services should be provided as needed! The client plan must set an upper limit).
- Avoid frequencies of "at least…" (the Client Plan must set an upper limit).
- Focus on and address the identified functional impairments as a result of the mental health condition or emotional disturbance.
- Be consistent with the Client Plan goal(s)/objective(s) and with the qualifying diagnoses.

Interventions on the Client Plan are "proposed interventions," meaning that these are the interventions the Client Plan author and client believe will be necessary to help the client progress toward their goals. The progress notes then document the interventions as they are provided.

Example interventions:

- Mental Health Services: [Agency] to provide psychiatric rehab, collateral services, and therapy, including [DBT Skills, motivational interviewing, substance-use/co-occurring disorders skills, coaching on life-domain skills, modeling skill development, etc.], up to X hours per month [or X times per week] for 12 months.
- Targeted Case Management: [Agency] to provide targeted case management, including identifying and linking client to resources [BE SPECIFIC!] and coordinating with other providers [BE SPECIFIC!], up to X hours per month [or X times per week] for 12 months.
- Medication Support Services: [Agency] to provide medication support to manage medications, monitor psychiatric symptoms and side effects, refill prescriptions, and review labs and vital signs in order to help with medication adherence and symptom reduction up to X hours a month for 12 months.
- Residential Treatment: [Agency] to provide residential independent living skills, housing, and psychiatric rehab services, up to [6-12] months.
- TBS: [Agency] to provide therapeutic behavioral services, including functional analysis, intensive behavior modification services, and Positive Parenting Program work, up to six times per week for up to 180 days.
- Therapy: [Agency] to provide [CBT, DBT, behavior-modifying, trauma-informed, trauma-focused, play, etc.] individual, group, and family therapy, up to 26 weekly sessions.

Interventions: Type of Service & Provider

The Specialty Mental Health Services listed in each category may be (but are not required to be) grouped together into a single intervention. For example, a single intervention might authorize Collateral, Therapy, and Rehabilitation services up to one hour a week for the next year, because those services all fall into the "Mental

Health Services" category. Services that are in different categories may **not** be grouped together; for example, a single intervention may **not** authorize Collateral services and Targeted Case Management.

- **Mental Health Services**
  - Collateral – Individual
  - Collateral – Group
  - Family Therapy
  - Individual Therapy
  - Group Therapy
  - Rehabilitation – Individual
  - Intensive Home-Based Services (IHBS)
  - Rehabilitation – Group
- **Targeted Case Management/ICC**
  - Targeted Case Management
  - Intensive Care Coordination
- **Medication Support**
  - Non E&M Medication Support
  - Medication Support – Telehealth
  - Medication Injections
  - Medication Support New or Established Clients
- **Adult Residential**
  - Includes any contractor providing adult residential services, like:
    - Opportunity House
    - A Step Up
    - E Street
    - Parker Hill Place
- **Therapeutic Behavioral Services (TBS)**
  - Therapeutic Behavioral Services *(Please note, this service is **not** the same as therapy!)*
- **Intensive Services Foster Care (ISFC)**
- **Short-Term Residential Therapeutic Program (STRTP)**

Goals vs Interventions

Providers often confuse goals/objectives and interventions. Remember:

- Goals identify what the *client* wants to achieve
- Interventions authorize what the *service providers will do* to help the client achieve their goals.

Beware of interventions disguised as goals! Statements like "Client will attend 90% of all MD appointments for the next 12 months" or "Client will take medications as prescribed 100% of the time for the next year" are not really goals; they describe instead what services will be offered to the client. "Client will adhere to interventions" is usually not much of a goal. *What will the client be able to accomplish* if the intervention is successful? That's the actual goal!

Timeliness & Frequency

All Client Plans must be completed within the first 30 days of admission for long-term treatment clients. Client Plans should be completed prior to service delivery for all planned services, even if those planned services fall within those first 30 days. For information on services that can be claimed before the client plan is complete, see "Provision of Services Prior to a Client Plan Being in Place" below.

Client Plans must be updated at least annually, and your contract may require them to be updated every six months. They must also be updated, through a Client Plan Addendum, when client services are added, to reflect any changes necessary to assist the client to reach their goals, or when there are significant changes in the client's condition. Significant changes might include a client who has never been suicidal making a suicide attempt, a client who regularly participates in services suddenly not coming to appointments, or major new life events affecting the client's condition, like job loss, the birth of a child, the death of a family member or significant other, a change in relationship status (such as divorce), or a change in living situation.

Services Allowed Before a Client Plan Is in Place or During a "Gap"

Prior to the Client Plan being completed, or during a "gap" that results from a Client Plan expiring and an amount of time passing before the updated Client Plan is in effect, the following service activities are reimbursable:

a. Assessment
b. Plan Development
c. Crisis Intervention
d. Crisis Stabilization
e. Medication Support Services* (for assessment, evaluation, or plan development; or if there is an **urgent need**, which must be documented)
f. Targeted Case Management (TCM)* and Intensive Care Coordination (ICC)* (for referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services)

** For TCM, ICC, and Medication Support Services provided prior to a Client Plan being in place, the progress notes must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved Client Plan being in place, and not a component of a service that cannot be provided prior to an approved Client Plan being in place.*

Planned Services That Require a Client Plan

Specialty Mental Health Services must be provided based on medical-necessity criteria and to reduce impairment(s), restore functioning, or prevent significant deterioration in an important area of life functioning outlined in the Client Plan. An approved Client Plan must be in place prior to any of these services:

- Mental Health Services (Individual/Group/Family Therapy, Individual/Group Collateral, Individual/Group Rehabilitation), except Assessment and Client Plan Development
- Intensive Home Based Services (IHBS)

- Specific components of TCM and ICC: Monitoring and follow up activities to ensure the client's Client Plan is being implemented and that it adequately addresses the client's individual needs
- Therapeutic Behavioral Services (TBS)
- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential Treatment Services
- Medication Support (non-emergency)

Required Signatures

Treatment Team Signatures

A Client Plan must be signed (or the electronic equivalent) and dated by:

- The person providing the services, including their type of professional degree, licensure, or job title; AND
- A licensed supervisor/manager; AND
- One of the following providers, if the client plan indicates that some services will be provided by a staff member under the direction of one of the categories of staff listed below and/or the person signing the client plan is not one of the categories of staff listed below:
    - A physician
    - A licensed/waivered psychologist
    - A licensed/registered/waivered social worker
    - A licensed/registered/waivered marriage & family therapist
    - A licensed/registered/waivered professional clinical counselor
    - A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists

Client Signature

The client or legal guardian must sign the Client Plan to document their participation and agreement with it. A copy of the Client Plan must be offered to the client.

If the client refuses to sign or is unavailable for signature, the Client Plan must document date(s) of the progress note(s) that explain the reason(s) for the refusal or unavailability. Progress note(s) must include documentation of concerted efforts by staff to obtain the client's signature or to proceed without client signature, as applicable. Although not required, it is best practice to make additional attempts to obtain the client's signature and document the attempts in the client record.

Plan Start & End Dates

The Client Plan is only effective once all required signatures are obtained. (If the client/legal guardian's signature is missing, a progress note documenting the reason is sufficient.) See "Required Signatures."

Start Date for NEW Clients following an Initial Adult/Child Assessment

The start date for the initial Client Plan (whenever it is completed) is the date that all required staff have signed the plan. There is no "grace period" for any client plans. Only services that Medi-Cal allows to be billed without a client plan in place will be allowed before the client plan start date.

Examples for New Client Start Dates of Client Plans:

- If a client's episode admission date is 6/8/21 and the Client Plan was signed by the licensed supervisor on 7/3/21 and the RN on 7/4/21, the Client Plan start date would be 7/4/21.
- If a client's episode admission date is 6/8/21 and the Client Plan that authorized Medication Support Services was signed by the RN on 7/19/21 and the Clinical Supervisor on 7/21/21, the Client Plan start date would be 7/21/21.

Please note that when you submit claims, you must testify that all claims are accurate, follow DHCS guidelines and other regulations, and were provided in accordance with the clients' written treatment plans. Only certain services (see "Services Allowed Before a Client Plan Is in Place or During a "Gap"") may be submitted for reimbursement without an active Client Plan.

Start Date for EXISTING clients who already have a Client Plan

The start date for an existing client's updated Client Plan depends whether the "new" Client Plan was done on time, early, or late. "Existing" clients would include clients transferred into services with an existing Sonoma County Behavioral Health Client Plan.

- If the Client Plan was completed and has all required signatures **on time or early** for an existing client:
  - The start date begins one day after the end date for the previous Client Plan. Staff can complete and sign the Client Plan anytime within the 30 days prior to the due date.

- If the Client Plan was signed **late** for an existing client:
  - The start date begins on the date the last required staff signs the plan. Only services that Medi-Cal allows to be billed without a client plan in place will be allowed between the end date of the prior plan and the start date of the new plan (see "Services Allowed Before a Client Plan Is in Place or During a "Gap""). Signature dates can NEVER be back dated.

Examples for Existing Client Start Dates of Client Plans:

- **Client Plan completed on time or early:** If the end date for the previous Client Plan is 6/8/21, and the new Client Plan, which has Medication Support Services authorized, was signed by the Clinical Supervisor on 6/4/21 and the RN on 6/6/21, then the new Client Plan start date would be 6/9/21.
- **Client Plan completed late:** If the end date for the previous Client Plan is 6/8/21, and the new Client Plan was signed by the RN on 8/4/21 and the Clinical Director on 8/6/21, then the new Client Plan start date would be 8/6/21.

Client Plan End Date

For new clients, the Client Plan end date should be one year minus one day (no need to figure in 30 or 31 days or leap years) from the episode admission date for annual plans, or six months minus one day (no need to figure in 30 or 31 days) for six-month plans.

Client Plans for existing clients (not transferred clients) will almost always end a year from the start date (same day of the month) minus one day (no need to figure in 30 or 31 days) for annual plans, and six months minus one day for six-month plans.

The **EXCEPTION** to this rule for existing clients is if the Client Plan was late, then the end date would be the same that it would have been if the Client Plan had been completed on time.

Examples for Client End Dates

- **For New Clients**: If a client's start date was 6/8/21, and the client's admission date was 6/5/21, the Client Plan end date would be 6/4/22 for an annual plan, or 12/4/21 for a six-month plan.

- **For Existing Clients:**
  - **Client Plan completed on time or early:** If the previous Client Plan end date is 6/8/21, and the new Client Plan start date is 6/9/21, then the Client Plan end date would be 6/8/22 (annual) or 12/8/21 (six-month).
  - **Client Plan completed late:** If the previous Client Plan end date is 6/8/21, the new Client Plan was signed by all required staff on 8/4/21 and the start date is therefore 8/4/21, the Client Plan end date would stay the same as it should have been if the Client Plan was on time: 6/8/22 (annual plan) or 12/8/21 (six-month plan).

Start & End Dates for Addendums

An addendum gets added to the existing client plan; it does not replace it. The start date for an addendum is the date the last required staff signs it. The End Date for an addendum is the same end date as the existing client plan. Addendums have the same signature requirements as client plans.

Start Date and End Date Examples, Annual Plans	
Initial Client: Episode admission date: 04/01/21 CP signed by RN: 04/03/21 CP signed by supervisor: 04/04/21 Start date: 04/04/21 End date: 03/31/22	**Example #2:** Episode admission date: 04/07/21 CP signed by supervisor: 05/15/21 CP signed by RN: 05/16/21 Start date: 05/16/21 End date: 04/06/22
Existing Client- Late CP: Last Client Plan end date: 03/31/21 CP signed by manager: 05/03/21 CP signed by RN: 05/04/21	**Example #2:** Last Client Plan end date: 03/12/21 CP signed by RN: 05/03/21 CP signed by supervisor: 05/03/21

Start date: 05/04/21 End date: 03/31/22	Start date: 05/03/21 End date: 03/12/22
Existing Client- On-time/early CP: Last Client Plan end date: 03/31/21 CP signed by RN: 03/16/21 CP signed by supervisor: 03/19/21 Start date: 04/01/21 End date: 03/31/22	**Example #2:** Last Client Plan end date: 03/12/21 CP signed by RN: 02/27/21 CP signed by supervisor: 02/28/21 Start date: 03/13/21 End date: 03/12/22
Start Date and End Date Examples, Six Month Plans	
Initial Client: Episode admission date: 04/01/21 CP signed by RN: 04/03/21 CP signed by supervisor: 04/04/21 Start date: 04/04/21 End date: 10/31/21	**Example #2:** Episode admission date: 04/07/21 CP signed by supervisor: 05/15/21 CP signed by RN: 05/16/21 Start date: 05/16/21 End date:10/06/21
Existing Client- Late Client Plan: Last Client Plan end date: 03/31/21 CP signed by manager: 05/03/21 CP signed by RN: 05/04/21 Start date: 05/04/21 End date: 09/31/21	**Example #2:** Last Client Plan end date: 03/12/21 CP signed by RN: 05/03/21 CP signed by supervisor: 05/03/21 Start date: 05/03/21 End date: 09/12/21
Existing Client- On-time/Early: Last Client Plan end date: 03/31/21 CP signed by RN: 03/16/21 CP signed by supervisor: 03/19/21 Start date: 04/01/21 End date: 09/30/21	**Example #2:** Last Client Plan end date: 03/12/21 CP signed by supervisor: 02/27/21 CP signed by RN: 02/28/21 Start date: 03/13/21 End date: 09/12/21

Example Plans

Adult Client Plan: Bill

Need/Risk: Major Depressive Disorder

Goal: Bill would like to improve his depression from an 8 out of 10 (10 high) to a 5 out of 10 most days, as evidenced by his ability to attend school at least 80% of the time, within the next six months.

Intervention: Sonoma County Department of Health Care Services Behavioral Health Division (DHS-BHD) to provide medication support up to weekly for the next year to manage medications, provide IM medications, monitor psychiatric symptoms and side effects, refill prescriptions, and review labs and vital signs in order to help with medication adherence and symptom reduction.
Type: Medication Support **Provider: DHS-BHD**

Intervention: DHS-BHD to provide mental health services (psychiatric rehab, collateral services, and therapy), including teaching depression-reduction techniques like meditation, deep breathing, and guided imagery, up to 5 hours per month for the next year.
Type: Mental Health Services **Provider: DHS-BHD**

Need/Risk: Housing situation unstable

Goal: Bill would like to clean his apartment, do two loads of laundry, and get rid of all the rotten food in his refrigerator at least once a week for the next 12 months, as evidenced by his weekly tracking log and staff observation.

Intervention: DHS-BHD to provide case management, including linking Bill to Buckelew SCIL, IHSS, and other agencies and then coordinating with them to help with housing skills and resources, up to 3 hours a month for the next year.
Type: Targeted Case Management **Provider: DHS-BHD**

Intervention: Buckelew SCIL will teach Bill basic housekeeping skills, up to two times per week for the next six months.
Type: Mental Health Services **Provider: Buckelew SCIL**

Goal: Bill would like to remain in his current apartment and receive no warnings from his landlord for the next 12 months, as evidenced by self-report and staff observation.

Intervention: Buckelew SCIL will meet weekly with Bill to teach budgeting skills for the next six months.
Type: Mental Health Services **Provider: Buckelew SCIL**

Adult Client Plan: Yolanda

Need/Risk: Severe Anxiety

Goal: Yolanda would like to reduce her panic attacks from daily to weekly, by self-report and tracking log, within the next six months.

Intervention: DHS-BHD to provide medication support up to 5 hours a month for the next year to manage medications, monitor psychiatric symptoms and side effects, refill prescriptions, and review labs and vital signs in order to help with medication adherence and symptom reduction.
Type: Medication Support **Provider: DHS-BHD**

Intervention: DHS-BHD to provide weekly psychiatric rehab and collateral to teach anxiety-management skills, including deep-breathing and guided meditation exercises, and family-support skills, up to 5 hours a month for the next year.
Type: Mental Health Services **Provider: DHS-BHD**

Need/Risk: Housing situation unstable

Goal: Yolanda would like to live independently in a shared living situation within the next year.

Intervention: A Step Up to provide adult residential independent living skills, housing, and psychiatric rehab services, up to 12 months.
Type: Adult Residential **Provider: A Step Up**

Intervention: DHS-BHD to provide targeted case management to link Yolanda to housing resources, including Burbank Housing and IHSS, up to 3 hours a month for the next year.
Type: Targeted Case Management **Provider: DHS-BHD**

Youth and Family Client Plan: Julia

Need/Risk: School Conduct

Goal: Julia would like to reduce emotional outbursts and physical aggression from 3-5x/day to 2x/week per self-report, staff observation, and teacher report, over the next 12 months.

Intervention: LifeWorks to provide TBS services, including functional behavior analysis, behavioral interventions, and working with Julia's caregivers and teachers to implement the TBS behavior plan, up to three times a week for the next six months.
Type: TBS **Provider: Lifeworks**

Intervention: DHS-BHD to provide Intensive Care Coordination, including assessment, care planning, and coordination of services, up to 10 hours a month for the next 12 months.
Type: Targeted Case Management/ICC **Provider: DHS-BHD**

Need/Risk: Depression, Major, Severe Recurrence

Goal: Julia would like to improve her depression from an 8 out of 10 (10 high) most days to a 5 out of 10 most days, by self-report and tracking log over the next year.

Intervention: DHS-BHD to provide medication support up to 5 hr./month for the next year to manage medications, monitor psychiatric symptoms and side effects, refill prescriptions, and review labs and vital signs in order to help with medication adherence and symptom reduction.
Type: Medication Support **Provider: DHS-BHD**

Intervention: SAY to provide weekly collateral, individual, and family therapy, including CBT, DBT, trauma-informed, and family-systems interventions, up to twice a week for the next six months.
Type: Mental Health Services **Provider: SAY**

Need/Risk: Non-suicidal Self-harm

Goal: Julia would like to decrease her use of non-suicidal self-harm from 3x/week to 2x/month, by self-report and staff observation, over the next six months.

Intervention: SAY to provide weekly therapy with interventions focused on harm-reduction and alternative coping skills, for the next 6 months.
Type: Mental Health Services **Provider: SAY**

Documentation - Progress Notes

Progress Notes Defined

Progress notes are the evidence of a provider's services to or on behalf of a client and relate to the client's progress in treatment. Progress notes must contain the clinical details to support the medical necessity of each claimed service. In order to obtain payment for services, there must be a complete and filed progress note for that service in the client's clinical record. A good progress note attests that the following criteria are met:

- Progress notes must clearly relate to the mental health objectives and goals of the client as established in the Client Plan. A note that focused on a depressed mother in a family session that does not address how her depression impacts the client/child's mental health needs would not meet this criteria.
- Each progress note must "stand alone" regarding medical necessity. Recording objective data about the client's presentation, symptoms, and frequencies of problematic behavior give clear evidence of medical necessity. Identifying a clear link to the Client Plan also helps meet this rule.
- Progress notes clearly describe the client's progress in treatment, including a description of their current symptoms, functional impairment(s), and response to treatment interventions.
- Progress notes become part of the clinical record which, per HIPAA, may be requested for review by the client at any time.
- Progress notes include information such as psychotherapy session duration times, the modalities of treatment furnished, results of psychological testing, medication prescription and monitoring (only under a doctor's care), and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, and progress to date.
- Progress notes contain only the succinct description of clinically relevant information. Information documented is objective and clinical.

A progress note is NOT the same thing as a "psychotherapy note" or process note. Psychotherapy notes receive special protection under HIPAA if they are filed separately from the client's clinical record. Examples of psychotherapy notes are notes that describe dream content, specific memories of child abuse, verbatim transcripts of a session or analysis of a session, a clinician's thought process about the client's issues, or a clinician's personal feelings or countertransference. While details such as these may prove helpful to the clinician in treatment planning and process, they are not needed in the clinical record.

An analogy to consider:
Progress notes are the invoice, showing that a service was rendered and payment is due.
Process notes are a diary, containing details that may not need to be seen.

Medi-Cal Medical Necessity Criteria for Specialty Mental Health Services

(OUTPATIENT)

Title 9: California Code of Regulations
§1830.205 & 1830.210

The Medi-Cal beneficiary must meet all three criteria listed below.

Criterion #1: Must have an included ICD-10 diagnosis that is the primary focus of treatment. (An excluded diagnosis may be noted along with the primary diagnosis). The primary ICD-10 diagnosis must be made using DSM-5. Please see Appendix A for a list of included primary diagnoses.

Criterion #2: Must have at least one of the following impairments as a result of the diagnosis(es) listed in Criterion #1 above:

- A significant impairment in an important area of life functioning.
- A reasonable probability of significant deterioration in an important area of life functioning.
- Children also qualify if there is a reasonable probability the child will not progress developmentally as individually appropriate. (A child is a person under 21 years old.)
- For full-scope Medi-Cal clients under age 21, a condition as a result of a mental disorder or emotional disturbance that Specialty Mental Health Services can correct or ameliorate.

Criterion #3: Must have each of the intervention criteria below:

- The focus of the proposed intervention addresses the condition identified in Criterion #1-2 above.
- Expectation that the proposed intervention will:
    - significantly diminish the impairment,
        OR
    - prevent significant deterioration in an important area of life functioning,
        OR
    - allow a child to progress developmentally as individually appropriate.
    - for full-scope Medi-Cal clients under 21, to correct or ameliorate the condition.
- The condition would not be responsive to physical healthcare-based treatment.
- Interventions that address the condition(s) identified in Criterion #1-2 must be clearly documented in the progress notes.

PIRPL Format for Medically Necessary Services

The PIRPL (Purpose, Intervention, Response, Plan) progress note format helps establish that medical-necessity criteria have been met. To document that a service meets medical necessity for specialty mental-health services, the progress note must:

- Establish that the client has an included diagnosis as their primary focus of treatment.
    - Describe the client's current symptoms that would support the qualifying diagnosis.
    - You can also name the diagnosis.
- Document how the client's symptoms are creating functional impairments or impeding development, including:
    - A significant impairment in an important area of life functioning
    - A probability of significant deterioration in an important area of life functioning
    - A probability that the child will not progress developmentally as individually appropriate

    - For Medi-Cal clients under the age of 21 years, the condition being treated must be as a result of the mental disorder that specialty mental health services can correct or ameliorate (e.g., the child's condition must be treatable with mental healthcare intervention).
- Target your specialty mental-health interventions toward:
    - Significantly diminishing the identified impairment(s),
    - Preventing deterioration in the identified impaired area(s) of life functioning, or
    - Allowing the child to progress developmentally as individually appropriate.

Remember, the goal is to provide and document medically necessary services. If you provide non-specialty mental health services or services that are not medically necessary, you may document them for your clinical records, but you cannot claim reimbursement for them.

PIRPL Components

P: PURPOSE

Why did I provide the intervention?

- Generally a good place to establish medical necessity components
- Focus on reducing impairments associated with the identified symptoms
- Good practice to mention the billing code description (e.g., therapy)
- Examples:
    - *Individual therapy to help Bob decrease his social isolation caused by symptoms of Schizophrenia.*
    - *Individual rehabilitation to teach Andrea anxiety-management and grounding skills to reduce symptoms of PTSD so she can succeed at client-plan goal of returning to school.*

I: Intervention

What did **I** do?

- Should be heavy on the verbs: Provided, helped, advocated, completed, linked
- Centered on treatment of mental-health condition and the impairments caused by its symptoms
- Appropriate to the procedure code
- No client responses in this section
- Examples:
    - *Discussed Bob's fear of riding the bus and how it is keeping him from being able to visit friends. Processed childhood fears of bullying and being laughed at by peers and examined how those childhood experience may be contributing to paranoia when riding the bus now. Using cognitive-behavioral techniques, helped Bob work to replace negative self-talk ("I'll never be safe on the bus," "All these people hate me") with more positive statements ("I feel unsafe but I am probably safe," "I don't actually know what these people are thinking about me").*
    - *Introduced and taught deep-breathing exercises. Practiced previously taught grounding exercises, including naming 5 things she can see, 4 things she can touch, 3 things she can hear, 2 things she can smell, and 1 thing she can taste. Identified and discussed obstacles to using these skills in her daily life.*

R: RESPONSE

How did the client respond to what I did?

- Include objective description of client's presentation, response, and progress in terms of symptoms and functional impairments
- Attribute all quotations
- Limit background information. Focus on response to this intervention.
- No clinician interventions in this section
- Examples:
    - *Bob was pleasant and appropriately dressed but malodorous. He reported that he had been emotionally and physically bullied for years as a pre-teen, and he was able to draw some parallels between how he felt then and how he feels in public now. He practiced the more positive self-talk statements in session but complained that he "can't believe that everything's great all the time." He rated his paranoia at an 8 out of 10 (10 high) when he arrived for the session and said it had dropped to a 6 by the end of the session.*
    - *Andrea reported that she had become anxious several times in the past week but felt "silly" doing breathing exercises in public. She did not believe that the breathing exercises would help, but she agreed to try the grounding exercise at least one time this week, saying, "That one's really useful." Andrea continues to make little eye contact, and she reported that she is having flashbacks 3-5 times per week. She said she feels "too overwhelmed to even think about school right now."*

PL: PLAN

What's the next step, based on client's response to this intervention?

- Document any clinical decision-making, especially if the intervention did not go as planned.
- Examples:
    - Next session with Bob in one week. Will continue to work on negative self-talk and negative self-image. Over the next week, Bob will practice using more positive self-talk and keep log of whether his paranoia increases or decreases each time.
    - Continue working with Andrea on grounding techniques. At next session, consider breaking down school application process into smaller steps to help her feel less overwhelmed. Discuss her continued high anxiety levels with her psychiatrist.

All of the parts of the note should flow together:

Purpose: Here's the reason I did what I did.

Intervention: Here's what I did.

Response: Here's how the client responded.

Plan: Here's what we'll do next.

Non-Reimbursable Medi-Cal Services/Activities

You want to document cancellations and no-shows, and any time you spent traveling to or preparing for those appointments. Though you cannot submit canceled or no-show appointments for reimbursement, they should be documented in the clinical record.

Non-Reimbursable Activities:

The following activities cannot be claimed as specialty mental-health services:

- Academic/educational services
- Clerical tasks (faxing, copying, mailing, leaving messages, scheduling appointments)
- Writing or reading text or email messages
- Payee-related tasks
- Personal care services provided to the client
- Recreation
- Socialization without individual intervention and/or that is not related to client plan goals
- Transportation
- Vocational Services that have as a purpose actual work or work training
- Supervision (consultation that does not benefit the client)
- Translation/interpretation
- Discharge paperwork that does not directly benefit the client
- Completing mandatory reports (CPS, APS, Tarasoff)
- Completing LPS Competency forms or hearings
- Any service provided after the death of a client

Travel Time

You may claim for travel time from a Medi-Cal certified site to a non-Medi-Cal certified site and between non-Medi-Cal certified sites (except for commuting between your home and your work site).

Examples:

Provider's Home	⟺	Non-Medi-Cal certified site
Provider's Home	⟺	Client's home
Medi-Cal certified site	⟺	Non-Medi-Cal certified site

Time claimed should be in actual minutes traveled. The time required for travel is reimbursable when the travel is a component of a reimbursable specialty mental-health service, whether or not the time is on the same day as the reimbursable service activity (Cal. Code Regs., tit. 9 § 1840.316).

You may NOT claim for travel time between…

Starting Location	Ending Location
Provider's Home	Medi-Cal certified site
Medi-Cal certified site	Medi-Cal certified site

List of Medi-Cal Certified Sites

DHS-BH Locations

- Adult Access Team
- Adult Medication Support Services
- Child FSP/FASST
- Community Mental Health Centers
  - Cloverdale, Guerneville, Petaluma, Sonoma
- Community Treatment and Referral Team (CTRT)
- Crisis Stabilization Unit (CSU)
- Forensic Assertive Community Treatment (FACT)
- Foster Youth Team (FYT)
- Integrated Recovery Team (IRT)
- Mental Health Adult Services Team (AST)
- Older Adult Team (OAT)
- Transitional Age Youth (TAY)
- Transitional Recovery Team (TR)
- Valley of the Moon Children's Home (VOM)
- Youth Access Team
- Youth and Family Services (YFS)

Contractor Sites

- Alternative Family Services
- Buckelew Programs
- Community Support Network
  - A Step Up, Bridges, E Street, Opportunity House
- LifeWorks
- Progress Foundation
  - Harstad House CRU, Parker Hill Place, Progress Sonoma CRU
- Psynergy
  - Greenfield, Morgan Hill, Sacramento
- SAY – Tamayo Village Telecare (Sonoma ACT)
- Seneca
  - Santa Rosa, Petaluma, Oakland
- Social Advocates for Youth
- TLC Child and Family Services
- Victor Treatment Centers
  - Santa Rosa

Short-Term Residential Therapeutic Program (STRTP) Sites

- Seneca Compass (Petaluma STRTP)
- St. Vincent's School for Boys
- TLC Child and Family Services STRTP
- Victor Treatment Centers STRTPs
  - Clover House, Country Club House, Irwin House, Juniper House, Lane House, Wright House

Other Required Progress Note Elements

In addition to documenting medical necessity, progress notes must also include (MHSUDS Information Notice No.: 17-040):

- Location of services
- Service date
- Any referrals to community resources and other agencies, when appropriate
- Documentation of follow-up care, or as appropriate, a discharge summary
- The amount of time taken to provide services
- The signature of the person providing the service (or electronic equivalent) and the provider's type of professional degree, licensure, or job title
- Documentation date, usually included by dating the provider's signature on the progress note

Progress notes must be completed in a timely manner after the service date in accordance with your agency's requirements.

Preventing Fraud, Waste, & Abuse

All providers must avoid fraud, waste, and abuse in claiming and documentation. Fraud, waste, and abuse may include such things as billing for services not rendered to the client, providing services to clients that are not medically necessary, balance-billing a Medi-Cal member for Medi-Cal covered services, up-coding or billing for more expensive services than actually performed, or receiving remuneration or kickbacks for referrals. Sonoma County Health Services may review contractor documentation to ensure that services are provided, documented, and claimed appropriately.

Samples

Progress Note Template

ESSENTIAL ELEMENTS: P – (Purpose) I – (Intervention) R – (Response) PL – (Plan)

1 - CSU	2 - Field	3 - Health Clinic/ER/Medical Hospital		4 - Home
5 - Shelter	6 - Inpatient Psych	7 - Jail/Juvenile Hall	8 - Office	9 - Phone
10 - Adult Residential		11 - Youth Residential	12 - School	13 - Telehealth

DATE (MM, DD, YY)	HRS: MI	LOC	PROC. CODE
NOTES:			
Sonoma County Department of Health Services Behavioral Health Division		Client Name:	
Progress Notes		Client Number:	

Verbs to Use (Interventions)

Acknowledged
Addressed
Administered
Affirmed
Analyzed
Answered
Asked
Assessed
Assisted
Assuaged
Assured
Attempted
Attended

Called
Challenged
Clarified
Completed
Commented
Confirmed
Considered
Concluded
Concurred
Consulted
Contacted
Continued
Contracted
Coordinated

Demonstrated
Determined
Directed
Discontinued
Discussed
Developed

Empathized
Emphasized
Encouraged
Engaged
Evaluated
Examined
Explained
Explored
Expressed

Facilitated
Focused

Guided

Helped

Identified
Implemented
Initiated
Intervened
Interviewed
Inquired

Joined

Led
Limited (set a limit)
Linked
Listened

Maintained
Managed
Modeled
Monitored

Normalized
Noted (pointed out)

Offered (feedback)

Planned
Prepared
Problem-solved
Processed
Prompted
Provided

Questioned

Reality-tested
Recommended
Referred
Reflected
Reinforced
Relayed
Reported
Resolved
Reviewed

Shaped
Stabilized
Stated
Strategized
Structured
Suggested
Supported

Terminated
Tracked

Used
Utilized

Validated

Worked

Verbs to Use (Responses)

Abided By
Accelerated
Accepted
Accessed
Acknowledged
Agreed
Answered
Argued
Asked
Asserted
Attempted
Attended

Blamed
Blushed

Calmed
Challenged
Commented
Communicated
Complained
Completed
Complied
Concentrated
Confirmed
Confronted
Consented
Considered
Continued
Contributed
Controlled
Cooperated
Cried

Decided
Declined
Decreased
Deescalated
Delayed
Demonstrated
Denied
Developed
Disclosed
Discontinued
Disengaged
Disobeyed
Disoriented
Displayed
Dissociated
Distracted
Discussed

Elaborated
Endorsed
Engaged
Escalated
Explained
Expressed
Exhibited
Externalized

Fidgeted
Fought
Focused
Followed
Functioned

Generalized
Gestured
Grimaced

Identified
Implemented
Improved
Increased
Indicated
Inhibited
Initiated
Interacted
Internalized
Interrupted
Inquired

Limited
Listened

Maintained

Negated

Obeyed
Oriented (x3)

Paced
Participated
Perceived
Performed
Perseverated
Planned
Played
Practiced
Prepared
Presented
Problem-solved
Processed

Questioned

Rated (on a scale)
Reacted
Reality-tested
Realized
Recalled
Recognized
Refused
Regressed
Related
Relaxed
Remembered
Repeated
Reported
Requested
Required
Resolved
Responded
Restated
Revealed
Reviewed
Role-played

Said
Shouted
Shut down
Slowed
Stabilized
Stated
Strategized

Talked
Terminated
Tested (the limits)
Threatened
Tolerated

Used
Utilized

Validated
Verbalized

Whined
Whispered
Withdrew
Worked

DSM Diagnosis Codes

In order to meet medical-necessity criteria for SMHS, the client's primary diagnosis MUST be one of the following:

Diagnosis Code	DSM-5 Diagnosis Description
F20.9	Schizophrenia
F21	Schizotypal Personality Disorder
F22	Delusional Disorder
F23	Brief Psychotic Disorder
F23	Brief Psychotic Disorder with Postpartum Onset
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
F31.0	Bipolar I Disorder, Current or Most Recent Episode Hypomanic
F31.11	Bipolar I Disorder, Current or Most Recent Episode Manic, Mild
F31.12	Bipolar I Disorder, Current or Most Recent Episode Manic, Moderate
F31.13	Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
F31.2	Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features
F31.31	Bipolar I Disorder, Current or Most Recent Episode Depressed, Mild
F31.32	Bipolar I Disorder, Current or Most Recent Episode Depressed, Moderate
F31.4	Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
F31.5	Bipolar I Disorder, Current or Most Recent Episode Depressed, with Psychotic Features
F31.71	Bipolar I Disorder, Current or Most Recent Episode Hypomanic, in Partial Remission
F31.72	Bipolar I Disorder, Current or Most Recent Episode Hypomanic, in Full Remission
F31.73	Bipolar I Disorder, Current or Most Recent Episode Manic, in Partial Remission
F31.74	Bipolar I Disorder, Current or Most Recent Episode Manic, in Full Remission
F31.75	Bipolar I Disorder, Current or Most Recent Episode Depressed, in Partial Remission
F31.76	Bipolar I Disorder, Current or Most Recent Episode Depressed, in Full Remission

F31.81	Bipolar II Disorder
F31.89	Other Specified Bipolar and Related Disorder
F31.9	Bipolar I Disorder, Current or Most Recent Episode Depressed, Unspecified Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified Bipolar I Disorder, Current or Most Recent Episode Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild Major Depressive Disorder, Single Episode, Mild, with Peripartum Onset
F32.1	Major Depressive Disorder, Single Episode, Moderate Major Depressive Disorder, Single Episode, Moderate, with Peripartum Onset
F32.2	Major Depressive Disorder, Single Episode, Severe Major Depressive Disorder, Single Episode, Severe with Peripartum Onset
F32.3	Major Depressive Disorder, Single Episode, With Psychotic Features Major Depressive Disorder, Single Episode, with Psychotic Features, with Peripartum Onset
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission Major Depressive Disorder, Single Episode, in Partial Remission, with Peripartum Onset
F32.5	Major Depressive Disorder, Single Episode, in Full Remission Major Depressive Disorder, Single Episode, in Full Remission, with Peripartum Onset
F32.89	Other Specified Depressive Disorder
F32.9	Unspecified Major Depressive Disorder Unspecified Major Depressive Disorder with Peripartum Onset
F33.0	Major Depressive Disorder, Recurrent, Mild Major Depressive Disorder, Recurrent, Mild, with Peripartum Onset
F33.1	Major Depressive Disorder, Recurrent, Moderate Major Depressive Disorder, Recurrent, Moderate, with Peripartum Onset
F33.2	Major Depressive Disorder, Recurrent, Severe Major Depressive Disorder, Recurrent, Severe, with Peripartum Onset
F33.3	Major Depressive Disorder, Recurrent, With Psychotic Symptoms Major Depressive Disorder, Recurrent, With Psychotic Symptoms, with Peripartum Onset
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission Major Depressive Disorder, Recurrent, in Partial Remission, with Peripartum Onset
F33.42	Major Depressive Disorder, Recurrent, in Full Remission Major Depressive Disorder, Recurrent, in Full Remission, with Peripartum Onset
F33.9	Major Depressive Disorder, Recurrent, Unspecified Major Depressive Disorder, Recurrent, Unspecified, with Peripartum Onset

F34.0	Cyclothymic Disorder
F34.1	Persistent Depressive Disorder (Dysthymia)
F34.81	Disruptive Mood Dysregulation Disorder
F40.00	Agoraphobia
F40.10	Social Anxiety Disorder
F40.218	Specific Phobia, Animal
F40.228	Specific Phobia, Natural Environment
F40.230	Specific Phobia, Fear of Blood
F40.231	Specific Phobia, Fear of Injections and Transfusions
F40.232	Specific Phobia, Fear of Other Medical Care
F40.233	Specific Phobia, Fear of Injury
F40.248	Specific Phobia, Situational
F40.298	Specific Phobia, Other
F41.0	Panic Disorder
F41.1	Generalized Anxiety Disorder
F41.8	Other Specified Anxiety Disorder
F41.9	Unspecified Anxiety Disorder
F42.2	Obsessive-Compulsive Disorder
F42.3	Hoarding Disorder
F42.4	Excoriation (Skin-Picking) Disorder
F42.8	Other Specified Obsessive-Compulsive and Related Disorder
F42.9	Unspecified Obsessive-Compulsive and Related Disorder
F43.0	Acute Stress Disorder
F43.10	Posttraumatic Stress Disorder
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder, With Depressed Mood
F43.22	Adjustment Disorder, With Anxiety
F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder, With Disturbance of Conduct

F43.25	Adjustment Disorder, With Mixed Disturbances of Emotions and Conduct
F43.8	Other Specified Trauma- and Stressor-Related Disorder
F43.9	Unspecified Trauma- and Stressor-Related Disorder
F44.0	Dissociative Amnesia
F44.1	Dissociative Amnesia, with Dissociative Fugue
F44.4	Conversion Disorder, With Abnormal Movement Conversion Disorder, With Speech Symptoms Conversion Disorder, With Swallowing Symptoms Conversion Disorder, With Weakness/Paralysis
F44.5	Conversion Disorder, With Attacks or Seizures
F44.6	Conversion Disorder, With Anesthesia or Sensory Loss Conversion Disorder, With Special Sensory Symptoms
F44.7	Conversion Disorder, With Mixed Symptoms
F44.81	Dissociative Identity Disorder
F44.89	Other Specified Dissociative Disorder
F44.9	Unspecified Dissociative Disorder
F45.1	Somatic Symptom Disorder
F45.21	Illness Anxiety Disorder
F45.22	Body Dysmorphic Disorder
F45.8	Other Specified Somatic Symptom and Related Disorder
F45.9	Unspecified Somatic Symptom and Related Disorder
F48.1	Depersonalization/Derealization Disorder
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
F50.2	Bulimia Nervosa
F50.81	Binge-Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Feeding or Eating Disorder
F50.9	Unspecified Feeding or Eating Disorder
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder

F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive-Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Unspecified Personality Disorder
F63.0	Gambling Disorder
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent Explosive Disorder
F64.0	Gender Dysphoria in Adolescents and Adults
F64.2	Gender Dysphoria in Children
F64.8	Other Specified Gender Dysphoria
F64.9	Unspecified Gender Dysphoria
F65.0	Fetishistic Disorder
F65.1	Transvestic Disorder
F65.2	Exhibitionist Disorder
F65.3	Voyeuristic Disorder
F65.4	Pedophilic Disorder
F65.51	Sexual Masochism Disorder
F65.52	Sexual Sadism Disorder
F65.81	Frotteuristic Disorder
F65.89	Other Specified Paraphilic Disorder
F65.9	Unspecified Paraphilic Disorder
F68.10	Factitious Disorder
F68.A	Factitious Disorder Imposed on Another
F80.82	Social (Pragmatic) Communication Disorder

F80.9	Language Disorder Unspecified Communication Disorder
F84.0	Autism Spectrum Disorder
F88	Other Specified Neurodevelopmental Disorder
F89	Unspecified Neurodevelopmental Disorder
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Presentation
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive/Impulsive Presentation
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Presentation
F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder
F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Specified Disruptive, Impulse-Control, and Conduct Disorder
F91.9	Unspecified Disruptive, Impulse-Control, and Conduct Disorder
F91.9	Conduct Disorder, Unspecified Onset
F93.0	Separation Anxiety Disorder
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder
F94.2	Disinhibited Social Engagement Disorder
F95.0	Provisional Tic Disorder
F95.1	Persistent (Chronic) Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Specified Tic Disorder
F95.9	Unspecified Tic Disorder
F98.0	Enuresis
F98.1	Encopresis
F98.21	Rumination Disorder
F98.3	Pica, in Children

F98.4	Stereotypic Movement Disorders
G21.0	Malignant Neuroleptic Syndrome
G21.11	Neuroleptic-Induced Parkinsonism
G25.1	Medication-Induced Postural Tremor
G25.70	Medication-Induced Acute Akathisia
G25.71	Tardive Akathisia
G25.79	Other Medication-Induced Movement Disorder
F32.81	Premenstrual Dysphoric Disorder
R15.9	Other Specified Elimination Disorder, With Fecal Symptoms Unspecified Elimination Disorder, With Fecal Symptoms
Z03.89	Observation for Suspected Mental Condition* * May be used when providing crisis intervention, crisis stabilization, or during the assessment phase of a client's treatment when a diagnosis has yet to be established. There is no DSM-5 crosswalk for this ICD-10 diagnosis.

Procedure Codes For Client-Related Activities

Approved procedure codes vary between contracted providers. Please consult your contract for guidance on which procedure codes and services you are authorized to provide

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
Residential Services		
141 Crisis Residential Treatment 191 Adult Residential Treatment	**Crisis Residential Treatment Services (CRTS)** are therapeutic or rehabilitative services provided in a non-institutional, residential setting that provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. CRTS include a range of activities and services that support clients in their efforts to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, 7 days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention. **Adult Residential Treatment Services (ARTS)** are rehabilitative services provided in a non-institutional, residential setting for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. ARTS include a range of activities and services that support clients in their efforts to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, 7 days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, and collateral. **CRTS Examples:** **Progress Sonoma (CRU); Harstad House (CRU II)** • Residential treatment for clients experiencing an acute psychiatric episode or crisis who do not have medical complications or require nursing care.	All direct services staff from Designated CRT and ART Providers who have prior Authorization to provide residential treatment services.

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	ARTS Examples: **Progress Parker Hill; CSN (E St., ASU)** • Residential treatment for clients who are not experiencing crisis but require residential support to prevent crisis and require support in practicing independent living skills.	
Case Management		
301 Targeted Case Management (TCM) 401 Telehealth Targeted Case Management 303 Intensive Care Coordination (ICC) 403 Telehealth Intensive Care Coordination	**Targeted Case Management (TCM)** is a service that assists a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development. **Intensive Care Coordination (ICC)** is a targeted case management service (for children/youth under the age of 21) that facilitates assessment, care planning for, and coordination of services, including urgent services for clients with intensive needs. (Initial Mental Health Assessments and CANS/ANSA Re-assessments should be claimed as 331.) ICC must be delivered using a Child and Family Team (CFT) and is intended for children/youth with more intensive needs and/or whose treatment requires cross-agency collaboration. **TCM Examples:** 1. Linking clients to community resources to address client's symptoms and functional impairments. 2. Coordinating placement within 30 days of	All direct service staff

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	discharge from inpatient hospital. 3. Discussing individual's progress with collaborative treatment providers.* 4. Monitoring client's progress on the client plan goals. * *For collaboration with parents, family members, and other "significant support persons," use* Collateral.*)* **ICC Examples:** 1. Assessing the adequacy and availability of resources. 2. Reviewing information from family and other sources. 3. Evaluating effectiveness of previous interventions. 4. Ensuring the active participation of client and individuals involved and clarifying their roles. 5. Identifying the interventions/course of action targeted at the client's and family's assessed needs. 6. Monitoring to ensure that identified services and activities are progressing appropriately. 7. Changing and redirecting actions targeted at the client's and family's assessed needs. 8. Developing a transition plan for the client and family to foster long- term stability, including the effective use of natural supports and community resources.	
Collateral		
311 Collateral – Individual 411 Telehealth Collateral	**Collateral** means a service activity to a significant support person in a client's life for the purpose of meeting the needs of the client in terms of achieving the goals of the client's Client Plan. Collateral may include but is not limited to consultation and training of the significant	All direct service staff

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
310 Collateral – Group 410 Telehealth Collateral Group	support person(s) to assist in better utilization of specialty mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity. NOTE: Must be provided to significant support person(s) for ONE client. **"*Significant support person*"** is defined as "persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client. **Collateral Group** is the same as above, but the service is provided to significant support person(s) in a group setting for TWO or MORE clients. A "***group***" is two or more clients. **Collateral Examples:** 1. Educating and helping parents/family members understand mental illness or serious emotional disturbances in order to help improve the client's mental health status so that Client Plan goals can be met. 2. Receiving information from parents/spouse/family members in order to help client meet Client Plan goals. 3. Gathering information about client from family member, care provider, other *significant support persons*.* 4. Instructing parent about carrying out treatment-related activities at home. 5. Instructing significant support people from two or more clients about carrying out	

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	treatment-related activities at home or in the community. * *For collaboration with probation officer, minister, school staff in an IEP meeting, staff from other agencies or other professionals and persons who know the client but are not significant support persons, use* Targeted Case Management.*)*	
Assessment		
331 Assessment 431 Telehealth Assessment	**Assessment** means a service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the client's clinical history, analysis of relevant cultural issues and history, diagnosis, and the use of testing procedures.** **Assessment Examples:** 1. Assessment interview, CANS/ANSA completion, and write-up of assessment form (new clients). 2. Conducting CANS/ANSA Re-Assessments with existing clients. 3. Discussion w/ individual parent and appraisal of child's functioning during the assessment process. 4. While part of an assessment, review of medical record or evaluation instruments (new or ongoing clients) in order to complete the assessment. ****Testing can be done only by licensed psychologists. Waivered psychologists, psychological assistants, and clinical psychology graduate students may provide testing with oversight and co-signature by a licensed psychologist or psychiatrist with training in psychological assessment.**	SCSS/MHRS can gather mental health, medical, and substance use histories and identify strengths, risks, and barriers to achieving goals. Licensed and Registered LCSWs, LMFTs, LPCCs, MDs, Psychologists, PNPs (if permitted through the Delegated Service Agreement or Standardized Procedure), and Graduate Students with oversight and co-signature of a licensed staff can do the above as well as diagnosis, MSE, medication history, and assessment of relevant conditions and psychosocial factors affecting the client's physical and mental health.
Therapy		

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
316 Family Therapy 416 Telehealth Family Therapy	**Family Therapy** is a therapeutic intervention service delivered to a family with a focus on symptom reduction as a means to improve functional impairments of the client or to prevent deterioration and to assist the client in meeting the goals on their client plan. Family therapy can be provided to parent(s) and client, client and siblings, or couples. The client must be present for this service activity. **Family Therapy Examples:** 1. Providing services to a family or subset of the family (with the client present) with the focus on family dynamics relevant to the client's symptoms and impairments and Client Plan goals. 2. Providing services to a child-parent dyad in order to improve caregiver and client relationship (as part of Client Plan goals).	Licensed and Registered LPCCs, MDs, Psychologists, PNPs (if permitted through the PA Delegated Service Agreement or PNP Standardized Procedure), Graduate Students with oversight and co-signature of a licensed staff.
341 Individual Therapy 441 Telehealth Individual Therapy	**Individual Therapy** means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments of the client or to prevent deterioration and to assist the client in meeting the goals on their Client Plan. Individual therapy is delivered to an individual client. **Individual Therapy Example:** 1. Therapeutic intervention to treat behavioral, interpersonal, and psychological problems (insight-oriented, behavior-modifying, and/or supportive treatment to individuals using established mental health therapeutic techniques). 2. Providing evidence-based practices in order to meet Client Plan goals (e.g., CBT strategies of cognitive restructuring and systematic desensitization to improve anxiety).	Licensed and Registered LCSWs, LMFTs, LPCCs, MDs, Psychologists, PNPs (if permitted through the PA Delegated Service Agreement or PNP Standardized Procedure), Graduate Students with oversight and co-signature of a licensed staff.

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
351 Group Therapy 451 Telehealth Group Therapy	**Group Therapy** is the same as individual therapy, but the service is delivered to more than one opened client in a group setting and may be provided by one or two clinicians. A "***group***" is two or more clients. **Group Therapy Examples:** 1. Group psychotherapy focusing on interpersonal dynamics and skill building while addressing Client Plan goals such as reducing depression or anxiety or improving interpersonal relationships. 2. Group psychotherapy focusing on anger management to achieve Client Plan goals.	Licensed and Registered LCSWs, LMFTs, LPCCs, MDs, Psychologists, PNPs (if permitted through the PA Delegated Service Agreement or PNP Standardized Procedure), Graduate Students with oversight and co-signature of licensed staff.
Therapeutic Behavioral Services		
345 Therapeutic Behavioral Services (TBS) 445 Telehealth Therapeutic Behavioral Services (TBS)	**Therapeutic Behavioral Services (TBS)** are one-to-one, behavioral mental health services available to children/youth with serious emotional challenges who are under age 21 and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal). TBS can help youth and caregivers, foster parents, group home staff, and school staff learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kinds of behavior that will allow children/youth to be successful in their current environment and prevent out of home placement at the lowest appropriate level. TBS are designed to help youth and caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the needs of the youth and family. TBS is not a "***stand alone***" therapeutic intervention and must be used in conjunction with another Mental Health Service. TBS includes developing a plan	All direct services staff from Designated TBS Providers who have prior Authorization to provide TBS services.

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	clearly identifying specific target behaviors. **TBS Examples:** 1. Functional behavior analysis of challenging behaviors in order to develop TBS plan. 2. Designing a specific behavior intervention plan to address targeted behavior. Teaching parents/caregivers how to implement the TBS behavior plan.	
Medication Support		
361 nonEM Medication Support 361 (Community Contractor Only) Medication Support 363 Medication Support – Telehealth 365 Medication Injections	**Non E&M Medication Support** are evaluation and management services provided in a Board and Care setting, or any medication support services not involving evaluation and management services. Services include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of, and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the client. **Medication Support (Contractor)** are the same as Non E&M Medication Support services, but performed by community contractors. **Medication Support Telehealth** is a mode of delivering medication support service utilizing an interactive video and audio communication at a Telehealth site approved by Sonoma County. **Medication Injection** consists of the	RN, MD, PA, PNP, LVN, and LPT (within their scope of practice only). Medication Support Telehealth: May only be used by psychiatrists who are pre-approved by Sonoma County Department of Health Care Services Behavioral Health Division (DHS-BHD) Medical Director.

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	administration of a therapeutic, prophylactic, or diagnostic injection, whether subcutaneous or intramuscular, and represents a single IM/SQ injection. **Medication Support Examples:** 1. Obtaining informed consent and reviewing purposes, use, and potential side effects of medication. 2. Consultation with other professionals re: individual's medications. 3. Prescribing & documenting medication response and compliance. 4. Evaluation/assessment of symptoms related to need for medication. 5. Plan development re: medications. **6.** 365 = Psychotropic Injections incident to physician orders.	
E&M Medication Support		
361 NT Time- Based E&M Service, New Client (CPT 99201-5 [10-60min.]) 361 ET Time-Based E&M Service, Established Client (CPT 99211-5 [5-40min.])	**E&M Medication Support** means office or other outpatient medication visit for the evaluation and management of a new or established client. **New Client:** An individual who did NOT receive any face-to-face, Medication Support Services from any DHS-BHD prescriber within the previous three (3) years. **Established Client:** An individual who received any face-to-face, Medication Support Services from any DHS-BHD prescriber within the previous three (3) years.	MD, PA, PNP

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	E&M Medication Support Examples: 1. Identifying the client's chief complaint; obtaining the history of the present illness; conducting a review of systems; reviewing past, social, and medical history; conducting a psychiatric examination of the client; reviewing/ordering labs, tests, or medical records for the purposes of medical decision making; evaluating risk associated with presenting problems and proposed interventions; prescribing and documenting medication response and compliance; and developing plan for follow-up if needed. 2. Services that include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness in which 50% or more of the face-to-face service time consists of counseling or coordination of care.	
Crisis Intervention		
371 Crisis Intervention 471 Telehealth Crisis Intervention	**Crisis intervention** means a service, lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to assessment, collateral, and therapy. Crisis intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements or, if eligible, the service is provided at a site other than a certified CSU site. **Crisis Intervention Examples:** 1. Phone or individual contact related to individual in crisis. Urgent appointment to assess suicidality, grave disability, danger to self or others, or other type of crisis.	All direct services staff
Plan Development		

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
391 Plan Development	**Plan development** is a service activity consisting of developing Client Plans, approving Client Plans, and/or monitoring a client's progress on their documented Client Plan goals.	All direct service staff
491 Telehealth Plan Development	**Plan Development Examples:** 1. Developing client plans. 2. Discussing Client Plan goals/interventions with client. 3. Multi-disciplinary Team collaboration of Client Plan Goals prior to developing Client Plan Goals with the client. 4. Discussing individual's progress on Client Plan goals with collaborative treatment providers. 5. Team meetings devoted to specific clients where solution-focused team consultation is needed to make clinical/client care decisions related to the client's progress on their Client Plan.	
Rehabilitation		
511 Rehabilitation – Individual 415 Telehealth Rehabilitation – Individual 503 Intensive Home Based Services (IHBS) 417 Telehealth Intensive Home Based Services (IHBS)	**Rehabilitation – Individual** means a service activity which includes, but is not limited to, assistance in improving, maintaining, or restoring a beneficiary's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. **Intensive Home Based Services (IHBS)** are mental health rehabilitation services provided to Medi-Cal beneficiaries under age 21 as medically necessary. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and at improving the child/youth's family ability to help the child/youth successfully function in the home and community.	All direct services staff

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
	The difference between IHBS and more traditional outpatient specialty mental health service is that the service is expected to be of significant intensity to address the mental health needs of the child/youth, consistent with the plan and the Core Practice Model, and will be predominantly delivered outside an office setting and in the home, school, or community. **Rehab/Individual Examples:** 1. Improving rehabilitation skills as linked to functional impairments and Client Plan goals (e.g., assisting with daily living skills, practicing grooming and hygiene skills, increasing use of good sleep hygiene skills and habits to improve sleep). **IHBS Examples:** 1. Skill-based interventions for the remediation of behaviors or improvement of symptoms, including the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant others to assist them in implementing the strategies. 2. Development of functional skills to improve self-care, self- regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others. 3. Support child/youth's success in achieving educational objectives or in seeking and maintaining housing and living independently.	

Procedure Codes	Descriptions & Examples of Specialty Mental Health Services	Who Can Provide?
514 Rehabilitation – Group 414 Telehealth Rehabilitation – Group	**Rehabilitation – Group** is the same as Individual Rehabilitation, but the service is delivered to more than one opened client in a group setting and may be provided by one or two clinicians. A "***group***" is two or more clients. **Rehab Group Examples:** 1. Skill building for rehabilitation skills as linked to functional impairments and Client Plan goals. 2. Support groups focusing on skills training. 3. 534 = rehab groups that occur in Juvenile Hall or other non- claimable locations.	All direct services staff

Documentation - Medication Consent

General Medication Consent Requirements

Providers must obtain and retain a written medication consent form signed by the client agreeing to the administration of psychiatric medication. The documentation must include the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects that may occur to clients taking such medication beyond three months; and that the consent, once given, may be withdrawn at any time by the client.

These requirements apply to all clients. For specific consent requirements applicable to foster children, see below.

Consent for Antipsychotic Medications

In addition to the above requirements, a voluntary patient shall be treated with antipsychotic medications only after they have been informed of their right to accept or refuse such medications and have consented to the administration of such medications. In order to make an informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible), which shall include the following:

- The nature of the patient's mental condition;
- The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
- The reasonable alternative treatments available, if any;
- The type, range of frequency, and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications;
- The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient;
- The possible additional side effects which may occur to patients taking such medications beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

Medication Consent Forms

Multiple Medications & Dosages

There may be more than one medication listed on a consent form as long as all the required elements are present for each of the medications. A change in dosage would require the client to sign a new consent form, but providers may use a "dosage range" on the consent form to reduce the frequency with which medication consent forms would need to be changed.

Attestations

The medication consent can include attestations, signed by the provider and the client, that the provider discussed each of the required components of the medication consent with the client. For example, a physician may indicate that he or she discussed the type, range of frequency, amount, method (i.e., oral or injection), and duration of the medication(s), rather than specifying, "Prozac, for depression, 10-20mg, p.o BID for 6 months." The provider and client must sign and acknowledge the statement of attestation.

Check boxes

The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the client. The reasons a provider prescribed a medication for a client must be documented in the client's medical record, but is not required specifically on the medication consent form.

Foster Children

The Court Forms authorizing the administration of psychotropic medication to a foster child (Forms JV-217 through JV-224) do not currently include all of the required components for informed consent to medication(s); specifically, the court forms do not include information on the method of administration (oral or injection) or additional side effects if the child were to take the medication for more than three months. The method of administration for each medication must be documented in the medical record. The side effects (if the child were to take the medication for more than three months) may be documented in the client's medical record or may be included in written information about the medication which is provided to the client or the client's legal representative.

In addition, the client's and/or the client's legal representative's signature is required to be on the medication consent form.

Credentialing

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services as part of the Sonoma County Behavioral Health provider network. Credentials are documented evidence of licensure, education, training, experience, or other qualifications.

Types of Providers

Providers of SMHS fall into five credentialing categories, outlined below.

Provider Categories	Provider Types
Licensed Staff	Physician (MD/DO) Licensed Psychologist (PhD/PsyD) Licensed Clinical Social Worker (LCSW) Licensed Marriage and Family Therapist (LMFT) Licensed Professional Clinical Counselor (LPCC) Registered Nurse (RN) Licensed Vocational Nurse (LVN) Psychiatric Technician (PT) Other Medical Professionals (i.e., PA/NP)
Waivered Professionals	Registered Psychologist Registered Psychological Assistant Out of State Licensees
Registered Associates	Registered Associate Marriage and Family Therapist (AMFT) Registered Associate Clinical Social Workers (ASW) Registered Associate Professional Clinical Counselor (APCC)
Graduate Students	Master's and Doctoral Degree candidates
Unlicensed Workers	Mental Health Rehabilitation Specialists Adjunct Mental Health Staff

Credentialing Process

To add new staff to the provider network, Contractors are to complete the *MHS 144 Staff Number Request Form* (https://sonomacounty.ca.gov/Health/Behavioral-Health/Forms-and-Materials/) and submit it (along with the required documents for their credentialing category) to the Claims Unit. When approved, a staff number will be issued to the provider along with an effective date. Services may be provided and claimed for by the provider using the assigned staff number beginning with the effective date. Any services provided prior to the effective date are not billable.

Required Documents/Processes for All Provider Types

For any staff participating in the provider network, maintain documentation of the following:

- Relevant work history of the provider
- A National Provider Number (NPI) verified in the National Plan and Provider Enumeration (NPPES) system

- Review of published Federal and State lists regarding the sanctioning, suspension, or exclusion of individuals or entities, specifically:
    - The Office of Inspector General List of Excluded Individuals/Entities (LEIE)
    - DHCS Medi-Cal List of Suspended or Ineligible Providers (LSIP)
    - System for Award Management (SAM)
    - Social Security Death Master File
- A signed Attestation Form specifying the following:
    1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation6;
    2. A history of loss of license or felony conviction;7
    3. A history of loss or limitation of privileges or disciplinary activity;
    4. A lack of present illegal drug use; and
    5. The application's accuracy and completeness.

Required Documents by Provider Type

The following table outlines the required documentation to be submitted for each provider type.

Provider Type	Required Documents
Physician	• Copy of current Drug Enforcement Administration (DEA) license • Copy of current Physician license from the Medical Board of California • Evidence of completing an accredited psychiatry residency program (certificate, letter, OR Board Certification in Psychiatry) • Evidence of registration with Controlled Substance Utilization Review and Evaluation System (CURES 2.0) • Evidence of PAVE application
Psychologist	• Copy of current license from the California Board of Psychology • Evidence of PAVE application
LCSW/LMFT/LPCC	• Copy of current license from the California Board of Behavioral Sciences • For LPCCs working with couples/families, provide documentation confirming that they meet the necessary educational/experiential requirements • Evidence of PAVE application
Registered Nurse	• Copy of license from the California Board of Registered Nursing • Evidence of experience/training in psychiatric nursing
Licensed Vocational Nurse and Psychiatric Technician	• Copy of license from the California Board of Vocational Nursing and Psychiatric Technicians • Evidence of experience/training in psychiatric nursing

Provider Type	Required Documents
Other Medical Professionals: PA/NP	• Copy of current Drug Enforcement Administration (DEA) license • Copy of current Physician license from the Medical Board of California • Evidence of experience/training in psychiatric nursing/assisting • Evidence of registration with Controlled Substance Utilization Review and Evaluation System (CURES 2.0) • Evidence of PAVE application
Registered Psychologists and Psychological Assistants	• DHCS Waiver (requested by Sonoma County Department of Health Care Services Behavioral Health Division (DHS-BHD) Credentialing Manager) • Copy of current registration with the California Board of Psychology as a Registered Psychologist or Psychological Assistant. • Diploma or transcripts showing at least 48 semester/trimester or 72 quarter units of graduate coursework completed, not including thesis, internship or dissertation • Current resume
Out of State Licensees	• DHCS Waiver (requested by DHS-BHD Credentialing Manager) • Letter from the appropriate California licensing board stating that the licensee has sufficient experience to gain admission to the licensing examination • Copy of license/registration with their respective state licensing board
AMFT/ASW/APPC	• Copy of current registration from California Board of Behavioral Sciences
Graduate Students	• Name of graduate school and type of degree program (e.g., Master's, Doctorate, clinical psychology or school counseling) • Year in the above program (e.g., first-year, second-year student in a two year program) • Name, and license number of primary clinical supervisor (supervisor must meet all licensing board requirements for supervision of interns) • Effective dates of employment (start date and end date, if known) • The above information must be submitted annually until job class update/change or staff number termination

Provider Type	Required Documents

MHRS	• Job title and description
	• Evidence of meeting one of the following combinations of education and experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment:
	  ○ A Bachelor's Degree and four years of experience
	  ○ A Master's Degree and two years of experience
	  ○ An Associate's Degree and six years of experience

Adjunct Mental Health Staff	• Job title and description • Current resume • Plan of Supervision

Authorization and Review Requirements for Specialty Mental Health Services (SMHS)

Prior authorization is not required for the following services:

- Crisis Intervention
- Crisis Stabilization
- Mental Health Services: assessment and plan development
- Targeted Case Management: for assessment plan development and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services
- Intensive Care Coordination: for assessment plan development and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services
- Medication Support Services: for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented
- Coordinated Services: when MHP delegates conducting assessment to an organizational provider

Prior authorization is required for the following services:

- Intensive Home Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

Audit Tool

The Sonoma County Department of Health Services Behavioral Health Division (DHS-BHD) Quality Assessment Program Improvement (QAPI) program provides risk management to DHS-BHD through the auditing of Federal Health Care Programs (FHCP) for Mental Health services. QAPI is committed to ensuring that its audits of Sonoma County contractor partners are accurate, methodical and consistent. These programs have specific risks and requirements that are addressed with audit tools and monitoring processes, designed to meet regulatory requirements as well as state and county contractual agreements. Audit tools and monitoring processes are updated as needed to ensure compliance with changes to these standards.

The following table provides an example of an audit tool used by QAPI. **Please note, audit tools are updated as needed to meet changes to regulatory requirements.**

Audit Tool			
MENTAL HEALTH PLAN (MHP) REQUIREMENTS			
Assessment *Findings in this area will result in a Plan of Correction (POC)* *Findings in this area may result in disallowances per DHCS Reasons for Recoupment (RR)* **Assessment includes the following to establish** **Medical Necessity for Specialty Mental Health Services (SMHS)**			
1. The beneficiary has a current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract			
2. The beneficiary, as a result of an included mental disorder or emotional disturbance must have at least one (1) of the following criteria (a-d below):			
	2a	A significant impairment in an important area of life functioning	
	2b	A probability of significant deterioration in an important area of life functioning	
	2c	A probability that the child will not progress developmentally as individually appropriate	
	2d	For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbances that SMHS can correct or ameliorate	
3. Proposed and actual interventions meet the intervention criteria listed below			
	3a	The focus of the proposed intervention and actual intervention address the condition identified in a-c above, or for full-scope Medi-Cal clients under age 21 yrs., a condition as a result of the mental disorder or emotions disturbance the SMHS can correct or ameliorate AND	
	3b	The expectation that the proposed and actual intervention will do at least one of the following:	
		3bi	significantly diminished impairment
		3bii	prevent significant deterioration in an important area of life functioning

		3biii	Allow child to progress developmentally as individually appropriate
		3biv	For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition
	3c	The condition would not be responsive to physical health care based treatment.	
4. Initial Client Assessment with CANS/ANSA is done within 30 days of episode opening			
5. Diagnosis established by Licensed Practitioner of the Healing Arts (LPHA)			
6. Assessment is signed/dated by a licensed supervisor/manager			
7. Assessment includes the following:			
	7a	Presenting problems (client's chief complaint, history of presenting problem, current level of functioning, relevant family history)	
	7b	Relevant conditions and psychosocial factors affecting the client's physical health and mental health (including living situation, daily activities, social support, culture/linguistic factors, history of trauma)	
	7c	Mental Health History (previous treatment, including providers, therapeutic modality and response, inpatient admissions)	
	7d	Medical History (relevant physical health condition, name/address of current source of medical treatment; children/adolescent including prenatal and perinatal events and relevant significant developmental history)	
	7e	Medications (past/ current medication to treat MH and medical conditions, including duration of medical treatment; documentation of absence/ presence of allergies or adverse reactions to medication and documentation of informed consent for medications)	
	7f	Substance Exposure/Substance Use (past and present use of tobacco, alcohol, caffeine, complementary and alternative medications (CAM) and over-the-counter and illicit drugs)	
	7g	Client strengths (in achieving client treatment plan goals related to client's MH needs and functional impairments)	
	7h	Risks (Danger to Self (DTS)/Danger to Others (DTO), past or current trauma, Substance Use history, probation status, vulnerabilities, etc.)	
	7i	Mental Status Exam (MSE)	
	7j	A complete DSM diagnosis (current ICD-code, included primary diagnosis)	
	7k	Level of Care includes rationale for the recommended service(s)	
8. Prior to completion of assessment, no other services besides the following are claimed: Assessment (331); Case management (301); Crisis intervention (371)			
CANS/ANSA Reassessment *Findings in this area will result in a Plan of Correction (POC)* *Findings in the area may result in disallowances per DHCS Reasons for Recoupment (RR)*			
9. CANS/ANSA Reassessment for clients are completed within required timeframe			
10. CANS/ANSA reassessment establishes that all 3 medical necessity criteria are met:			

	10a	Diagnostic Criteria
	10b	Impairment Criteria
	10c	Intervention Related Criteria
11. CANS/ANSA MH/Behavioral/Emotional Health scores consistent w/DSM/ICD diagnoses		
12. CANS/ANSA Level of Care includes rationale for the recommended service(s)		
13. CANS/ANSA signed/dated by provider AND by a licensed supervisor/manager		
Client Treatment Plan *Findings in this area will result in a Plan of Correction (POC)* *Findings in the area may result in disallowances per DHCS Reasons for Recoupment (RR)*		
14. Initial Client Treatment Plan is competed/signed within 30 days of episode opening		
15. Client Treatment Plan has been updated every 12 months, or when there are significant changes in the beneficiary's condition (diagnosis, focus of treatment, services). Client Treatment Plans are completed within required timelines: within 30 days of opening to the program and every 12 months thereafter.		
16. Client Treatment Plan that falls within the audit period has at least one goal and one intervention per service type claimed		
17. Prior to approved Client Treatment Plan or if there is a gap between plans, only services which are allowed are claimed (e.g. Medication Support, Assessment, Plan Development, Crisis Intervention or Stabilization, some Targeted Case Management, etc.)		
18. Services claimed are included in the service types listed on the completed Client Treatment Plan (e.g., Mental Health Services, Targeted Case Management, Medication Support)		
19. Has specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis		
20. Identifies proposed type(s) of intervention/modality including a detailed description of the intervention to be provided		
21. Has proposed frequencies and durations of interventions.		
22. Interventions focus on and address the identified functional impairments as a result of the mental disorder		
23. Interventions are consistent with Client Treatment Plan goal(s)/treatment objective(s)		
24. Interventions are consistent with the qualifying diagnoses		
25. Approved Client Treatment Plan includes the effective plan period, date plan was signed, signature of service provider, and is signed/dated by a licensed supervisor/manager		
26. Client Treatment Plan documents the client's participation in, and agreement with the Client Treatment Plan and a copy of the plan was offered to the client		
27. Client Treatment Plan must be either:		
	27a	Signed/dated by client or legal representative, OR

	27b	If client refused or unavailable for signature the Client Treatment Plan includes written explanation of the refusal/unavailability
Progress Notes *Findings in this area will result in a Plan of Correction (POC)* *Findings in the area may result in disallowances per DHCS Reasons for Recoupment (RR)*		
28. There is a progress note for every service contact claimed (Mental Health Service, Medication Support, Crisis Intervention, Targeted Case Management, etc.)		
29. The time claimed matches the time documented		
30. The documented date that the service was provided is the same as claimed service date		
31. Progress note was completed within the required timeframe per agency policy (3 business days)		
32. Date service was documented in the medical record		
33. The location of the intervention		
34. Notes clearly document medical necessity and describe how provided either:		
	34a	Reduce impairments outlined in the Client Plan, or
	34b	Restore functioning outlined in the Client Plan, or
	34c	Prevent significant deterioration in an important area of life functioning outlined in the Client Treatment Plan
35. Procedure codes claimed match the type of service actually provided per the documentation		
36. Progress notes include the purpose of the client contact or activity including actions taken at the time of service		
37. Notes for client encounters include interventions applied, the beneficiary's response to the interventions and the location where the interventions were provided		
38. Documentation includes a plan for future interventions, including clinical decisions made, referrals to community resources and other agencies, and alternative approaches, when appropriate		
39. Group service notes include specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable		
40. Number of clients in attendance		
41. The group service time is properly apportioned to all clients present		
42. Number of providers and specific involvement in the context of the Mental Health needs of the client		
43. Progress note signed by the person providing the service (or electronic equivalent)		
44. Progress note identifies provider's type of professional degree, licensure or job title		
45. Service was provided while client was NOT in lock-out setting, Institute of Mental Disorders (IMD), or Jail, Juvenile Hall (non-adjudicated, dependent minor), Psychiatric Facility		
46. Service provided was NOT SOLELY for:		

	46a	Supervision of provider that is not a MH service
	46b	Academic educational services
	46c	Vocational services
	46d	Recreation
47. Service provided was NOT SOLELY for: Socialization		
48. Service provided was NOT SOLELY for: Transportation		
49. Service provided was NOT SOLELY for: Clerical		
50. Service provided was NOT SOLELY for: Payee related		
51. Progress note documents the language that the service is provided in (if not provided in English)		
52. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed		
Discharge		
53. There is documentation of follow-up care, referrals to community resources and other agencies, as appropriate. Discharge is NOT claimable to Medi-Cal		
54. Closing Summary includes:		
	54a	CANS or ANSA (unless client left treatment before CANS/ANSA was completed)
	54b	Client discharged within 90 days or less of being opened
Scope of Practice *Findings in this area will result in a Plan of Correction (POC)* *Findings in the area may result in disallowances per DHCS Reasons for Recoupment (RR)*		
55. The service provided was within the scope of practice of service provider		
Informing Materials *Findings in this area will result in a Plan of Correction (POC)*		
56. Informed Consent For Treatment page:		
	56a	Has Informing Material boxes checked
	56b	Is signed by client/legal guardian
	56c	Is in client's preferred language
Release of Confidential Information *Findings in this area will result in a Plan of Correction (POC)*		
57. Releases of information on file are:		
	57a	Up to Date
	57b	In client's preferred language, when applicable
Consent to Receive Psychiatric Medications *Findings in this area will result in a Plan of Correction (POC)*		
58. Informed Consent to Receive Psychiatric Mediation is:		
	58a	Current
	58b	Signed by client/legal guardian

	58c	Signed by provider
	58d	Dated by the client/legal guardian
	58e	Dated by the provider
	58f	In the client's preferred language (Spanish) if applicable
59. Consent for Psychiatric Medications includes the following information so that the patient may make an informed decision regarding the Rx (in the patient's native language, if possible):		
	59a	The nature of the client's mental condition
	59b	The method of administration (oral or injection)
	59c	The reasonable alternative treatments available
	59d	The prescribed medication type, range of frequency and amount (including use of PRN/as needed orders)
60. The reasons for taking such medication, including:		
	60a	Consent, once given may be withdrawn at any time
	60b	The duration of taking the medication(s)
	60c	The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient
	60d	The likelihood of improving or not improving without such medication
	60e	The possible additional side effects which may occur to patients taking such medication beyond three months; The patient shall be advised that such side effects may include symptoms of tardive dyskinesia which are potentially irreversible and may appear after medications have been discontinued
Therapeutic Behavioral Services		
61. County Client Treatment Plan indicates a need for Therapeutic Behavioral Services (TBS)		
62. Client meets criteria for TBS Service:		
	62a	In or being considered for Rate Classification Level (RCL) 12 or higher; OR
	62b	Is currently psychiatrically hospitalized or has had at least one psych hospital in past 24 months; OR
	62c	Has previously received TBS; OR
	62d	Is needed to transfer to a lower level of care
63. TBS plan lists specific target behaviors or symptoms that jeopardize current residence or present a barrier to transitions to lower level of care		
64. TBS plan has specific interventions to resolve behaviors or symptoms		
65. TBS plan has specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and been replaced with adaptive behaviors		
66. TBS plan has a transition plan from the inception of TBS to decrease or discontinue TBS when services are no longer needed or when the TBS services appear to have reached a plateau in benefit effectiveness		

67. TBS plan documents the manner for assisting parents/caregivers with skills and strategies to provide continuity of care when the service is discontinued		
68. The TBS progress notes overall clearly indicate that TBS was NOT provided solely for the following reasons:		
	68a	For the convenience of the family, caregivers, physician or teacher; AND
	68b	To provide supervision or to ensure compliance with terms and conditions of probation; AND
	68c	To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch; AND
	68d	To address conditions that are not a part of the child's/youth's mental health condition
69. TBS services are authorized by County team. Request for Authorization for Therapeutic Behavioral Service Plan (Outpatient) form from County is included in the chart		
70. TBS services are provided in client/family preferred language		

Telehealth

Telehealth is an alternative to health care provided in-person, particularly to underserved areas. Telehealth is not a distinct service, but a way that providers deliver health care to their patients that approximates in-person care. The standard of care is the same whether the patient is seen in-person or through telehealth.

State law defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site."

Sonoma County telehealth procedure:

1. CBO will request from the DHS-BHD contract manager the need for telehealth services.
2. DHS-BHD contract manager will collaborate with the CBO to agree on the telehealth services that are needed for each applicable reporting unit.
3. DHS-BHD Contract liaison will email a telehealth information packet to CBO, which will include the following attachments:
    a. Privacy and Security Handbook for Telehealth Providers
    b. MHP-01: Use of Telehealth Modalities for Provision of Specialty Mental Health Services
    c. MHS 148 (01-15): Consent for Telehealth Services
    d. Telehealth Site Review Self-Assessment (to be returned to Privacy)
4. CBO will return requested documentation directly to the DHS Privacy Officer.
5. DHS Privacy Officer will work with the CBO to review, assess and complete the telehealth review process.
6. DHS Privacy Officer will inform CBO contractor of approval / denial to provide services via telehealth.

For any questions about this telehealth procedure, please contact your contract liaison (see page 8 of this manual or your contract directly). Additional information from DHCS about telehealth can be found on their website: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.