



November 2017

# MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER HANDBOOK

ACCESS  
Network Office  
Provider Relations  
Quality Assurance  
Utilization Management

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## **Alameda County Behavioral Health Care Services' (BHCS) Mission, Vision and Values**

BHCS' mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.

BHCS envisions communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

### **BHCS' values are:**

#### **Access**

BHCS values collaborative partnerships with consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them toward wellness, recovery and resiliency.

#### **Consumer & Family Empowerment**

BHCS values, supports and encourages consumers and their families to exercise their authority to make decisions, choose from a range of available options, and to develop their full capacity to think speak and act effectively in their own interest and on behalf of the others that they represent.

#### **Best Practices**

BHCS values clinical excellence through the use of best practices, evidence-based practices, and effective outcomes, include prevention and early intervention strategies to promote wellbeing and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.

#### **Health & Wellness**

BHCS values the integration of emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the biological, social and psychological effects of mental illness and substance use disorders.

#### **Culturally Responsive**

BHCS honors the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service setting, treatment options, and in the processes we use to engage our communities.

#### **Socially Inclusive**

BHCS values advocacy and education to eliminate stigma, discrimination, isolation and misunderstanding of persons experiencing mental illness and substance use disorders. BHCS supports social inclusion and the full participation of consumers and family members to achieve full lives in communities of their choices, where they can live, learn, love, work, play and pray in safety and acceptance.

## USING THIS HANDBOOK

Specific criteria for the type of provider will be outlined as needed throughout the handbook. Use the *MHP FFS Provider Type Guide* (see Appendix A) to determine applicable sections.

This MHP FFS Provider Handbook may be updated and as such, all changes to this handbook that are referenced in notices, letters and/or memorandums have the authority of policy and are binding, as indicated, to Alameda County BHCS and contracted providers (referred to as Providers).

This Handbook can be found at <http://www.acbhcs.org/providers/network/forms/handbook.pdf>.

Information pertaining only to outpatient or inpatient providers can be found following the blue ribbon headers.

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### OUTPATIENT PROVIDER

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Critical Provider requirements and information can be found in the dashed-red bubbles.

For quick access, procedures to comply with handbook can be found in the solid-blue bubbles.

Disclaimer: The documents included in this handbook and appendix are for reference purposes only. For the most current version of these documents, use the web links provided in the Appendices (see Table of Contents) or contact the appropriate BHCS unit (see Section II, *Introduction and Overview*, *How to Contact BHCS*, of this handbook).

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**Disclaimer:** The documents included in this Appendix are for reference purposes only. For the most current version of these documents, use the web link provided or contact the appropriate BHCS unit (see Section II, *Introduction and Overview, How to Contact BHCS*, of this handbook).

The Appendix can be found at

<http://www.acbhcs.org/providers/network/forms/handbook.appendices.pdf>.

Appendix	Section	Page	Form / Resource
A	I	2	Provider Type Guide (see <i>MHP FFS Provider Handbook, Section I. Provider Type Definitions</i> )
B	II	5	Medical Necessity for Specialty Mental Health Services that are the Responsibility of the Mental Health Plan <a href="http://www.acbhcs.org/providers/Forms/docs/Access/Medical_Necessity_Specialty_MH_Services.pdf">http://www.acbhcs.org/providers/Forms/docs/Access/Medical_Necessity_Specialty_MH_Services.pdf</a>
C	II	5	MH Screening Forms and Referral Instructions <a href="http://www.acbhcs.org/providers/Forms/Forms.htm">http://www.acbhcs.org/providers/Forms/Forms.htm</a> under ACCESS
C-1	III	8	MHP FFS Credentialing Application
D	VI	13	ACCESS Referral Letter – sample
E	VI	15	Request for Prior Consultation <a href="http://www.acbhcs.org/providers/Forms/docs/Access/Req_Prior_Consultation.pdf">http://www.acbhcs.org/providers/Forms/docs/Access/Req_Prior_Consultation.pdf</a>
F	VI	15	Beneficiary Registration for Prior Consultation <a href="http://www.acbhcs.org/providers/Forms/docs/Access/Benefit_Reg_Prior_Consult.pdf">http://www.acbhcs.org/providers/Forms/docs/Access/Benefit_Reg_Prior_Consult.pdf</a>
G	VI	18	Psychological Testing Authorization Request (PTAR) <a href="http://www.acbhcs.org/providers/Forms/docs/Access/ACBHCS_Psy_Testing_Auth_Request.pdf">http://www.acbhcs.org/providers/Forms/docs/Access/ACBHCS_Psy_Testing_Auth_Request.pdf</a>
G-1	VI	18	Provider Manual ACBHCS Psychological Testing <a href="http://www.acbhcs.org/providers/Forms/docs/Access/ACBHCS_Psy_Testing_Protocol.pdf">http://www.acbhcs.org/providers/Forms/docs/Access/ACBHCS_Psy_Testing_Protocol.pdf</a>
H	VII	21	Client Plan <a href="http://www.acbhcs.org/providers/Forms/Clinical/ProviderNetwork/Client_Plan.docx">http://www.acbhcs.org/providers/Forms/Clinical/ProviderNetwork/Client_Plan.docx</a>
I	VII	21	Initial MH Assessment – Short <a href="http://www.acbhcs.org/providers/Forms/Clinical/Children/Init_Assessment_Short.docx">http://www.acbhcs.org/providers/Forms/Clinical/Children/Init_Assessment_Short.docx</a>
J	VII	21	Initial MH Assessment – Long <a href="http://www.acbhcs.org/providers/Forms/Clinical/Adult/Init_Assessment_Long.docx">http://www.acbhcs.org/providers/Forms/Clinical/Adult/Init_Assessment_Long.docx</a>
K	VII	21	Managed Care Network Provider Attestation <a href="http://www.acbhcs.org/providers/Forms/AuthSvcs/Provider_Attestation_fillable.docx">http://www.acbhcs.org/providers/Forms/AuthSvcs/Provider_Attestation_fillable.docx</a>
L	VII	23	Utilization Management Letter of Approval or Denial – sample
M	VII	22	Request for Continued Services <a href="http://www.acbhcs.org/providers/Forms/AuthSvcs/Request_Continued_Service_RCS_fillable.docx">http://www.acbhcs.org/providers/Forms/AuthSvcs/Request_Continued_Service_RCS_fillable.docx</a>
N	VII	24	CMS 1500 – Instructions and sample
O	VIII	28	Share of Cost/Spend Down Clearance Request Form Instructions
P	VIII	29	Late Claim Submission Exception Request
Q	VIII	29	Remittance Advice – sample
R	VIII	29	Claims Return Letter – sample
S	VIII	29	Claims Denial Letter – sample



Appendix	Section	Page	Form / Resource
T	VIII	30	Claims Appeal
U	VIII	29	Claims Inquiry
U-1	VIII	33	Medi-Cal Review Request
V	IX	34	Informing Materials – Your Rights & Responsibilities and Acknowledgement of Receipt <a href="http://www.acbhcs.org/providers/QA/General/informing.htm">http://www.acbhcs.org/providers/QA/General/informing.htm</a>
W	IX	36	Progress Notes <a href="http://www.acbhcs.org/providers/Forms/Clinical/ProviderNetwork/Progress_Note.docx">http://www.acbhcs.org/providers/Forms/Clinical/ProviderNetwork/Progress_Note.docx</a>

## I. PROVIDER TYPE DEFINITIONS

**\*\*This Provider Handbook only pertains to the Mental Health Plan (MHP) Fee-for-Service (FFS) Providers.\*\***

### **DEFINITIONS**

- ❖ **Outpatient Provider** - Provider who renders mental health services in an outpatient setting.
  1. **Individual:**
    - Licensed clinician (LCSW, LPCC, MFT, PhD, and PsyD) who renders managed care outpatient specialty mental health services (SMHS), which include assessment, therapy, collateral, and brokerage services.
    - Licensed psychiatrist who renders psychiatric evaluations/treatment services, to include medication monitoring.
    - Licensed psychologist who provides psychological testing.
  2. **Group:** A group of two or more licensed clinicians who render managed care outpatient SMHS, which include assessment, therapy, collateral, and brokerage services.
  3. **Organization:** A Medi-Cal site certified organization that includes both licensed and unlicensed clinicians who render managed care outpatient SMHS, which include assessment, therapy, collateral, and brokerage services.
  
- ❖ **Inpatient Professional (IP) Service Provider** (In-Network and Non-Network) - Psychiatrist or psychiatry group who render psychiatric evaluation and treatment services to beneficiaries who have been admitted to an acute medical or psychiatric inpatient setting or medical emergency room.
  1. **Individual:** An individual licensed psychiatrist.
  2. **Group:** A group of two or more licensed psychiatrists.

APPENDIX A

**MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER TYPE GUIDE**

SERVICE TYPE	PROVIDER TYPE	Credentialing	License Monitoring	Insurance Monitoring	Medi-Cal Site Certification	Exclusion* Monitoring	Hospital Verification
<b>Outpatient</b>	Individual – Clinician	✓	✓	✓		✓	
	Individual – Specialty Provider	✓	✓	✓		✓	
	Individual – Psychiatrist	✓	✓	✓		✓	
	Individual – Psychologist	✓	✓	✓		✓	
	Group			✓		✓	
	Organization	✓		✓	✓	✓	
<b>Inpatient</b>	Non-Network – Individual Psychiatrist						✓
	Non-Network – Group Psychiatrist						✓
	In-Network – Group Psychiatrist	✓	✓	✓		✓	

\*Includes Debarment, Suspended & Ineligible List, and Social Security Death Master File

**MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER TYPE GUIDE**

SERVICE TYPE	PROVIDER TYPE	Trainings	Documentation Standards	Complaints & Grievances	Confidentiality & Breaches	Maintenance of Records	Beneficiary Rights
<b>Outpatient</b>	Individual – Clinician	✓	✓	✓	✓	✓	✓
	Individual – Specialty Provider	✓	✓	✓	✓	✓	✓
	Individual – Psychiatrist	✓	✓	✓	✓	✓	✓
	Individual – Psychologist	✓	✓	✓	✓	✓	✓
	Group	✓	✓	✓	✓	✓	✓
	Organization	✓	✓	✓	✓	✓	✓
<b>Inpatient</b>	Non-Network – Individual Psychiatrist		✓	✓	✓	✓	✓
	Non-Network – Group Psychiatrist		✓	✓	✓	✓	✓
	In-Network – Group Psychiatrist		✓	✓	✓	✓	✓

**MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER TYPE GUIDE**

SERVICE TYPE	PROVIDER TYPE	ACCESS Referral	Initial Authorization	Verify Medi-Cal Eligibility	UM Review	TAR	Billing/Claims
<b>Outpatient</b>	Individual – Clinician	✓	✓	✓	✓		✓
	Individual – Specialty Provider	✓	✓	✓	✓		✓
	Individual – Psychiatrist	✓	✓	✓	✓		✓
	Individual – Psychologist	✓	✓	✓	✓		✓
	Group	✓	✓	✓	✓		✓
	Organization	✓	✓	✓	✓		✓
<b>Inpatient</b>	Non-Network – Individual Psychiatrist			✓	✓	✓	✓
	Non-Network – Group Psychiatrist			✓	✓	✓	✓
	In-Network – Group Psychiatrist			✓	✓	✓	✓

## II. INTRODUCTION & OVERVIEW

Alameda County Behavioral Health Care Services (BHCS) is the public insurance (Medicaid/Medi-Cal) administrator which provides the behavioral health component of the insurance plan through its Mental Health Plan (MHP). The plan primarily serves Alameda County residents who are eligible for public benefits through, but not limited to and subject to change, the following:

- Medi-Cal
- Child and Family Services (CFS)
- CalWORKs
- Medically Indigent Children (MIC) Program
- HealthPAC (Health Program of Alameda County)

The MHP includes the following types of contracted Providers:

- Community Based Organization Master Contract Providers
- Mental Health Plan (MHP) Fee-For-Service (FFS) Provider Contractors also known as Fee-For-Service, which includes:
  - Organizational Providers
  - Group Providers
  - Individual or Solo Providers

The MHP FFS Provider is contracted by BHCS to provide outpatient specialty mental health services to Alameda County residents who are eligible for mental health benefits under Medi-Cal or other funding streams within BHCS MHP. Individuals served by MHP FFS Providers are experiencing moderate-severe mental illnesses that meet criteria for *Medi-Cal's Medical Necessity for Specialty Mental Health Services* (Appendix B) as well as the moderate-severe criteria indicated by the algorithm on the *Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary* also known as *Screening Form* (Appendix C). Some exceptions may apply based on funding source, i.e., CFS.

### A. HOW TO CONTACT BHCS

The MHP FFS Provider system is co-managed by several BHCS units. Each unit plays a distinct and important role in managing its network of providers. To ensure that Provider concerns and/or questions are handled in a timely and appropriate manner, Providers should use the guide below to contact the appropriate BHCS unit.

Unit	Topic	Contact Information
Acute Crisis Care & Evaluation for System-wide Services (ACCESS)	<ul style="list-style-type: none"> <li>• Referrals and Initial Authorization</li> <li>• Initial verification of MHP beneficiary eligibility</li> <li>• Screening for level of care</li> <li>• Pre-authorization for Psychological Testing</li> <li>• Updating availability and capacity</li> <li>• Clinical consultation</li> <li>• Requests for Prior Consultation forms (used by provider as alternate means of initial authorization)</li> </ul>	ACCESS 2000 Embarcadero, Suite 205 Oakland, CA 94606  <b>P:</b> (800) 491-9099 <b>F:</b> (510) 346-1083 <a href="mailto:accessdesk@acgov.org">accessdesk@acgov.org</a>
Network Office	<ul style="list-style-type: none"> <li>• MHP FFS Provider Application</li> <li>• Contract and/or amendments, including Urgent Interim Agreements</li> <li>• Credentialing and/or re-credentialing</li> <li>• Monitoring exclusions and debarments</li> </ul>	Network Office c/o MHP FFS 1900 Embarcadero, Suite 205 Oakland, CA 94606  <b>P:</b> (510) 383-2874

Unit	Topic	Contact Information
	<ul style="list-style-type: none"> <li>• Disenrollment</li> <li>• Insurance coverage</li> <li>• Updating contact information</li> </ul>	<p><b>F:</b> (510) 567-8290  procurement@acgov.org  <a href="http://www.acbhcs.org/providers/network/provider_network.htm">http://www.acbhcs.org/providers/network/provider_network.htm</a></p>
Provider Relations - Claims Processing Center (CPC)	<ul style="list-style-type: none"> <li>• Billing/Claims</li> <li>• Payments</li> <li>• Claim Appeals</li> <li>• Rates</li> <li>• Staff numbers</li> <li>• Beneficiary Insurance Eligibility</li> </ul>	Provider Relations P.O. Box 738 San Leandro, CA 94577-0738  <b>P:</b> (800) 878-1313 <b>F:</b> (510) 567-8081 Beneficiary Insurance Eligibility (888) 346-0605
Quality Assurance (QA)	<ul style="list-style-type: none"> <li>• Clinical care and documentation standards</li> <li>• Documentation training</li> <li>• Chart audits and site review</li> <li>• Informing Materials</li> <li>• Quality of care</li> <li>• Death and Incident reporting</li> <li>• HIPAA Breach reporting</li> <li>• Whistleblower Program</li> <li>• Certifying/re-certifying site for Medi-Cal (Organizations only)</li> </ul>	Quality Assurance 2000 Embarcadero, Suite 400 Oakland, CA 94606  <b>P:</b> (510) 567-8105 <b>F:</b> (510) 639-1346 <a href="mailto:QAOffice@acgov.org">QAOffice@acgov.org</a> Breach: <a href="mailto:BreachNotification@acgov.org">BreachNotification@acgov.org</a> Medi-Cal Cert: <a href="mailto:SiteCertification@acgov.org">SiteCertification@acgov.org</a> <a href="http://www.acbhcs.org/providers/QA/QA.htm">http://www.acbhcs.org/providers/QA/QA.htm</a>
Utilization Management Program (UM) Daily Coordinator	<ul style="list-style-type: none"> <li>• MHP Managed Care Network Provider Attestation form</li> <li>• Request for Continued Service forms (RCS)</li> <li>• Treatment Authorization Requests for Acute Psychiatric Hospital (TARs) or UB04 billing claim approval</li> </ul>	Utilization Management Program 2000 Embarcadero, Suite 400 Oakland, CA 94606  <b>P:</b> (510) 567-8141 <b>F:</b> (510) 567-8148

### III. PROVIDER CONTRACT REQUIREMENTS

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#### OUTPATIENT PROVIDER

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##### A. GENERAL PROVIDER RESPONSIBILITIES

Providers must adhere to the requirements outlined in this handbook along with the specifications in their signed contract. It is the responsibility of Providers to maintain the minimum number of three BHCS beneficiary slots at any given time and to update the MHP, by calling ACCESS at (800) 491-9099, when the Provider is temporarily unable to accept new beneficiary referrals. Providers designated to provide Specialty Services<sup>1</sup> may be exempt from the minimum client requirements. Please contact the Network Office if you are unsure. Upon receipt of a *Referral Letter*, (Appendix D), from ACCESS, the provider is expected to reach out to the beneficiary and schedule the initial appointment within 10 business days of the date on the *Referral Letter*. If the provider is unable to offer an appointment within 10 business days, the provider must inform ACCESS immediately and a new referral will be made for the beneficiary. Providers shall provide the same hours of operation as provided to all other patients served regardless of the MHP-sponsored health care coverage.

##### B. LICENSURE, PERMITS AND CERTIFICATES

As a condition of being a contracted BHCS MHP FFS Provider, Providers shall obtain and maintain during the term of the contract agreement, all appropriate licenses, permits and certificates required by all applicable Federal, State, County and/or municipal laws, regulations, guidelines and/or directives as may be amended from time to time for the operation of its facility and/or for the provision of services hereunder. Failure to keep required licensure, permits and certificates may result in contract termination.

##### C. LIABILITY INSURANCE

As a condition of being a contracted BHCS MHP FFS Provider, Providers shall maintain the minimum requirements set forth in the Exhibit C of their signed contract. BHCS must receive current certificates of insurance before they expire in order to avoid delays in processing submitted claims. Failure to adhere to these requirements will affect the Provider's good standing with the MHP. Failure to adhere to these requirements will result in a payment withhold of submitted claims and suspension of new client referrals beyond the insurance expiration date. Continuous non-compliance will also result in involuntary disenrollment and termination of the provider's contract.

##### D. ADMINISTRATIVE AND PROGRAM STANDARDS

As a condition of being a contracted BHCS MHP FFS Provider, Providers shall comply with all administrative standards and program requirements as specified by all applicable Federal, State, County and/or municipal laws, regulations, guidelines, and/or directives. Providers shall comply with the *Alameda County Ethical Code* as posted on the Alameda County General Services Agency website, at <http://www.acgov.org/auditor/sleb/documents/ethics.pdf>, and by the Ethical Code of Conduct of all professional organizations, applicable to Provider licensure.

##### E. CHANGES IN CONTACT INFORMATION

Providers must report any changes such as their name, phone number, fax number, address including changes in State-issued license, within 10 business days. Failure to report contact information changes will result in delays in: receiving payments, delivery of W-2s at the end of the

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<sup>1</sup> Specialty Services are defined in Section VI. Items C and D.



calendar year, and important information in order to maintain good standing as a MHP FFS Provider.

#### F. CREDENTIALING AND RE-CREDENTIALING

Credentialing is the process by which BHCS authorizes contracts/agreements with individual and group providers who are licensed to practice independently in order to provide services to beneficiaries. Eligibility to provide and be paid for services rendered is determined by the extent to which Providers meet defined requirements for education, licensure, professional standing, service availability and accessibility, and conformance with BHCS' utilization and quality management requirements (see *MHP FFS Provider Credentialing Application*, Appendix C-1). BHCS' decision to contract with any Provider may also be influenced by such non-credentialing factors, such as, but not limited to, geographic area, language and specialty of the Provider. It is BHCS' sole decision whether to enter into a contractual relationship with Providers. BHCS re-credentials individual and providers who are part of a group every three years from the initial date of credentialing. BHCS notes this date in the letter sent to Providers after initial credentialing. Providers who fail to comply with the County's re-credentialing standards within a timely manner may be involuntarily disenrolled from the MHP FFS Provider system.

#### G. ONGOING MONITORING FOR EXCLUSIONS AND DEBARMENT

##### Individual and Group Providers:

In addition to the initial credentialing and re-credentialing every three years, BHCS, or BHCS designee, monitors solo providers and individual providers that belong to a group on a monthly basis to ensure that they are in good standing with Centers for Medicare and Medicaid Standards (CMS) Department of Health and Human Services and not on any list of providers who are excluded from participation in federal and state health care programs (i.e., Office of Inspector General List of Excluded Individual and Entities) and State Medicaid programs (i.e., Medi-Cal Suspended and Ineligible List).

##### Organizational Providers:

Organizational Providers shall perform the following tasks related to Exclusion List Monitoring per BHCS' *OIG and Other Exclusion List Monitoring, Oversight and Reporting Policy* of the QA Manual, Section 15: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm):

- Update their BHCS Staff Roster with staff additions, departures, and staff information changes at least monthly using the *Staff Number Request E-Form*. **Staff** used in this context includes contractor's clinical and non-clinical employees, volunteers, and agents of contractor who provide goods and services under the contract with BHCS.
- Attest monthly that they have updated their Staff Roster using the *Monthly Staff Change Attestation E-Form*.
- Screen all potential employees, volunteers, and agents prior to employment or contracting.

Failure to comply with the OIG attestation requirements will result in a payment withhold of the provider's submitted claims.

#### H. VERIFYING BENEFICIARY MEDI-CAL ELIGIBILITY

As a condition of being a contracted BHCS MHP FFS Provider, Providers must verify beneficiary's Medi-Cal eligibility **prior to providing services**, and at a minimum, on a monthly basis. For assistance with basic Medi-Cal benefit questions, contact the Medi-Cal Benefits Help Desk at (888) 346-0605.

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*INPATIENT PROFESSIONAL SERVICE PROVIDER*

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**I. IN-NETWORK CONTRACTED PROVIDER**

BHCS only contracts with group providers to perform inpatient professional services in a hospital setting or at a facility located within Alameda County. These providers are part of the MHP and therefore follows the same contract requirements.

**J. NON-NETWORK PROVIDER**

Non-Network providers who rendered psychiatric evaluation and treatment services to Alameda County beneficiaries admitted in an acute medical or psychiatric inpatient setting or medical emergency room while travelling outside Alameda County must contact the Network Office to request a *Non-Network Provider Application*. Non-Network Providers are not credentialed or re-credentialed by BHCS but have to provide certification from the hospital in which they are affiliated that they are in good standing along with additional documentation.

**In order to become a Non-Network Provider, the following information must be submitted to the Network Office:**

- Completed and signed *Non-Network Provider Application* (with signed Certification page)
- Completed and signed W-9
- Verification from affiliated hospital of JCAHO Accreditation and certification statement that provider is in good standing

Network Office  
C/o MMHP FFS  
1900 Embarcadero, Suite 205  
Oakland, CA 94606

Or

Fax: (510) 567-8290 or Email @ [procurement@acgov.org](mailto:procurement@acgov.org)

For IP services to be reimbursed, a Non-Network Provider has 60 calendar days from the date they receive a rejection letter from the Claims Processing Center (CPC) to complete the Non-Network Provider Application process. Once all information above is received and all claims have been submitted and reviewed for accuracy and audit compliance, the Non-Network Provider will receive an approval letter. If all information is not received within the 60-day timeline, the Non-Network Provider Application, and the claims submitted for that provider will be denied.

**IV. TRAINING**

All Outpatient MHP FFS Providers are expected to attend BHCS trainings to learn how to obtain referrals, authorizations for ongoing services, complete and submit claims, ensure beneficiary eligibility, and follow documentation standards. These trainings will help to ensure that services provided by Providers are appropriate and payable. In most situations, Providers are encouraged to attend these trainings prior to submitting any claims to CPC.

Individual MHP FFS Providers are **required** to attend a clinical documentation training presented by the QA Office soon after being accepted as a MHP FFS Provider and again within the three-year credentialing period. Proof of completion of this training will be required as part of the re-credentialing process. Organizational supervisors are required to attend clinical documentation training annually, and are expected to train their organizational staff.

Providers must attend these trainings as soon as possible after they have been contracted with BHCS (or after receiving a Letter of Intent to contract with BHCS). BHCS offers MHP FFS Providers trainings in the following areas:

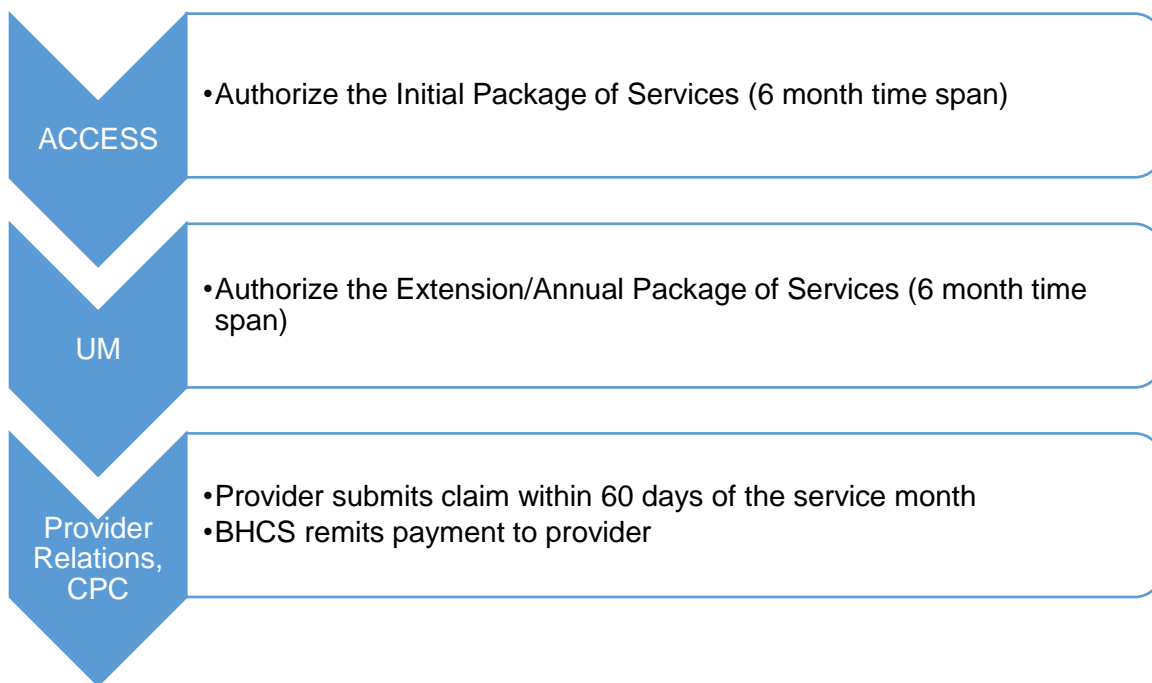
Training	Frequency
<p><u>MHP FFS Provider Training</u> This training includes MHP policies and procedures and a question and answer forum.</p> <ul style="list-style-type: none"> <li>• Overview (BHCS/MHP)</li> <li>• Contracting Terms</li> <li>• ACCESS referrals</li> <li>• Utilization Management</li> <li>• Quality Assurance</li> <li>• Billing/Claiming</li> </ul>	<p>This training is held on the third Thursday each month.</p> <p style="text-align: center;">Contact Provider Relations at (800) 878-1313 to schedule a training session.</p>
<p><u>Medi-Cal Eligibility</u> This training is offered by Provider Relations Unit and includes verification techniques and a question and answer forum.</p>	<p>This training is held on a monthly basis.</p> <p style="text-align: center;">Contact Provider Relations at (800) 878-1313 to schedule a training session.</p>
<p><u>Clinical Documentation Standards</u> This training is offered by the Quality Assurance Office.</p>	<p>Visit the QA Training site for more information and refer to the Medi-Cal Documentation Training for MHP FFS Providers. <a href="http://www.acbhcs.org/providers/QA/Training.htm">http://www.acbhcs.org/providers/QA/Training.htm</a></p>

**V. OVERVIEW OF AUTHORIZATION AND PAYMENT PROCESSES**

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*OUTPATIENT PROVIDER*

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**PACKAGE OF SERVICES*****Initial/Annual Package of Services*** (26 total services in 6 month time span)

Completed Assessment/Client Plan and MHP Managed Care Provider Attestation required prior to rendering treatment services

- 2 sessions- Assessment/Client Plan - CPT Code 90791 or 90792 (MDs only)
- 20 Therapy sessions- Individual, Family and/or Group Therapy
  - Individual (60 min) Family Therapy (60 or 90 min); Group Therapy (90 min)
- 2 hours- Brokerage/Linkage (30 and 60 min)
- 2 hours- Collateral (10 and 45 min)

***Extension Package*** (26 total services in 6 month time span)

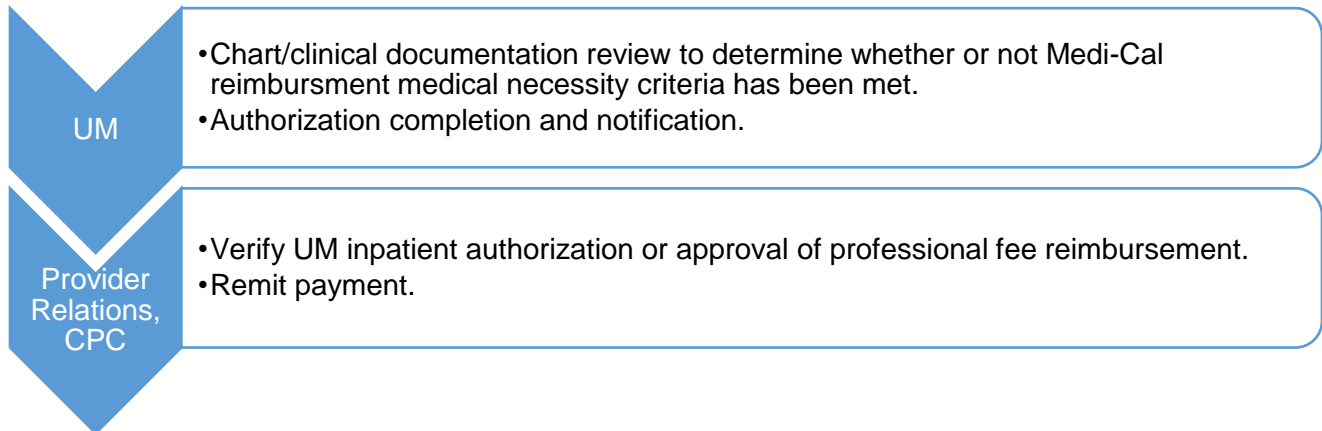
- 1 session- Assessment/Client Plan
- 20 Therapy sessions- Individual, Family and/or Group Therapy
  - Individual (60 min) Family Therapy (60 or 90 min); Group Therapy (90 min)
- 3 hours- Brokerage/Linkage (30 and 60 min)
- 2 hours- Collateral (10 and 45 min)

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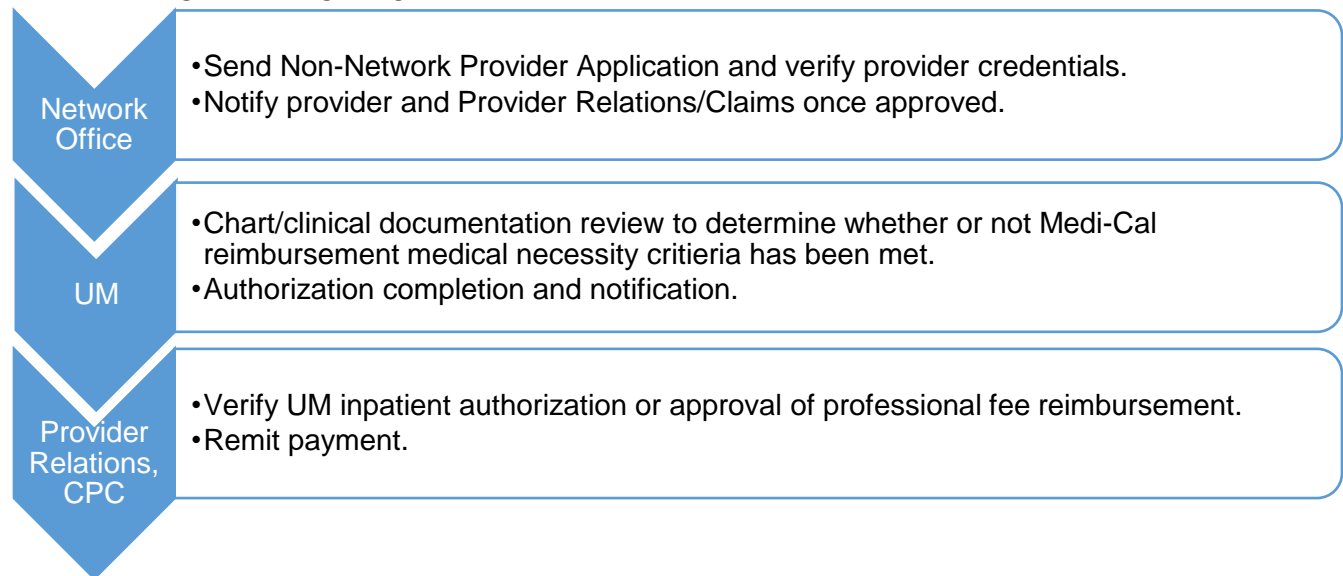
*INPATIENT PROFESSIONAL SERVICE PROVIDER*

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1. IN-NETWORK OVERVIEW



2. NON-NETWORK OVERVIEW



## VI. REFERRALS AND INITIAL AUTHORIZATIONS FROM ACCESS

### OUTPATIENT PROVIDER

ACCESS is the **front door** entry point for information, screening and referrals for outpatient mental health and substance use disorder services for Alameda County residents. ACCESS is a telephone service staffed from 8:30 a.m. to 5:00 p.m., Monday through Friday, by licensed mental health clinicians and administrative support staff for both general behavioral health questions and determination of eligibility for a range of outpatient services. After hours calls are answered by Crisis Support Services of Alameda County. The ACCESS telephone menu of options is provided in six languages: English, Spanish, Cantonese, Vietnamese, Mandarin and Cambodian. ACCESS staff utilizes Language Line Solutions for additional languages and California Relay for persons who are deaf or hard of hearing. Contact ACCESS at (800) 491-9099.

All initial authorization of services must come through ACCESS. Outpatient behavioral health care services include assessment and treatment, medication evaluation and monitoring, and psychological testing. ACCESS clinicians screen prospective beneficiaries to determine if they meet medical necessity criteria for Medi-Cal Specialty Mental Health Services (SMHS), verify that the beneficiary has an eligible insurance plan (see Section II, *Introduction & Overview*), check for duplication of services, and register the beneficiary with the Mental Health Plan. In addition, as a result of the Affordable Care Act, ACCESS now screens all prospective beneficiaries to determine if their impairments fall within the mild-moderate range or the moderate-severe range, utilizing the *Screening Form*, (Appendix C). Only those individuals who meet criteria for moderate-severe are eligible for SMHS. Those with mild-moderate impairments are expected to receive services through their managed care plan or primary care physician.

#### Referrals are contingent on:

- A Provider remaining in good standing (see Section III, *Provider Contract Requirements* of this handbook).
- A Beneficiary's continued insurance eligibility.
- A Beneficiary who continues to meet *SMHS Medical Necessity Criteria*
- A Provider completing all documentation requirements (i.e., *MHP Managed Care Provider Attestation, Assessment, Client Plan, RCS*) and within the specified timelines.

Referrals from ACCESS to Providers are based on clinical need and provider availability. Criteria for matching beneficiaries to Providers are based on several factors, e.g., beneficiary preferences, geographic location, language need, Provider's clinical specialties, etc. ACCESS provides this referral authorization in the form of a written referral letter with a tracking number. Providers should retain this written referral letter.

#### A. REFERRAL LETTER

ACCESS sends a *Referral Letter*, (Appendix D), by fax or US Mail notifying Providers that a beneficiary has been referred to them, including the requested service, the beneficiary's insurance plan, and any special instructions that correspond with that plan. ACCESS verifies Medi-Cal eligibility for the month of the referral only. It is the responsibility of the Provider to verify Medi-Cal status for all subsequent months. The *Referral Letter* pre-authorizes the following services over a six month period:

***Initial Package of Services*** (26 total services in 6 month time span)

Completed Assessment/Client Plan and MHP Managed Care Provider Attestation required prior to rendering treatment services

- 2 sessions- Assessment/Client Plan - CPT Code 90791 or 90792 (MDs only)
- 20 Therapy sessions- Individual (60 min), Family (60 or 90 min) and/or Group Therapy (90 min)
- 2 hours- Brokerage/Linkage (30 and 60 min)
- 2 hours- Collateral (10 and 45 min)

Upon receiving a *Referral Letter* from ACCESS, the Provider is expected to reach out to the beneficiary and offer the initial appointment that is within 10 business days of the date on the *Referral Letter*. If you are unable to offer an appointment date within 10 days, inform ACCESS immediately and a new referral will be made for the beneficiary. On the *MHP Managed Care Provider Attestation* form, the Provider will enter the first offered appointment date **and** the date of the first face-to-face service.

ACCESS makes a preliminary determination that the beneficiary meets *Medi-Cal SMHS Medical Necessity Criteria* for the moderate-severe level. However, Providers are responsible and delegated to make the medical necessity determination for the moderate-severe level at intake and on an ongoing basis by completing the *Screening Form* and must verify the existence of medical necessity in order to receive payment for services rendered. See *Eligibility, Referral, Authorization and Payment of Services* in the QA Manual, Section 7, *MHP Network Provider Documentation Standards* for the documentation requirements in regards to the *Screening Form*.

**Upon receipt of Initial Package of Services Authorization and *Referral Letter* the Provider should:**

- Contact beneficiary and offer the initial appointment that is within 10 business days of date on *Referral Letter*
- Verify Medi-Cal eligibility for all subsequent months
- Make the medical necessity determination for the moderate-severe level at intake and on an ongoing basis
- Submit *MHP Managed Care Provider Attestation* form to UM by fax (510) 567-8148

**B. AUTHORIZATION TO RENDER SERVICES**

If a potential beneficiary contacts the Provider directly, there are two ways to ensure that ACCESS refers that beneficiary back to the Provider. The beneficiary must meet medical necessity eligibility criteria to be referred for SMHS:

1. Direct beneficiary to contact ACCESS, at (800) 491-9099, to be screened for services and let the ACCESS clinician know to which provider the beneficiary wants to be referred.
- Or

2. Provider to complete and submit to ACCESS the *Request for Prior Consultation*, (Appendix E), the *Beneficiary Registration for Prior Consultation*, (Appendix F), and a completed *Screening Form* (appropriate age group). If beneficiary meets eligibility, ACCESS will send a written *Referral Letter* back to the referring Provider.

**Documentation requirements and timelines for the Initial Package of Services**

1. **MHP Managed Care Provider Attestation:** submit to UM prior to rendering 3<sup>rd</sup> session or first therapy session. <http://www.acbhcs.org/providers/Forms/Forms.htm#UM>
2. **Initial Assessment (short or long form):** complete prior to 3<sup>rd</sup> session and within 30 days. File in beneficiary chart. <http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm>
3. **Client Plan:** complete prior to 3<sup>rd</sup> session and within 60 days. File in beneficiary chart. [http://www.acbhcs.org/providers/Forms/Clinical/ProviderNetwork/Client\\_Plan.docx](http://www.acbhcs.org/providers/Forms/Clinical/ProviderNetwork/Client_Plan.docx)

**Please Note: ACCESS does not back-date referral requests.** Providers are at risk for nonpayment for services provided prior to ACCESS approval.

**C. SPECIALTY SERVICES**

1. **Services to Individuals Served by Social Services, Children and Family Services**

BHCS and Social Services' Children and Family Services (CFS) have an agreement in which Social Services pays for mental health services for minor dependent individuals and/or parent/caregivers who may or may not be eligible for Medi-Cal benefits or who do not meet medical necessity criteria for SMHS. Mental health services to individuals served by Social Services must be initiated by the individual's Child Welfare Worker (CWW) if the beneficiary is seeking treatment in order to meet a CFS court order or case plan. All authorizations of services must come through ACCESS.

**Providers shall deliver the services listed for each type of CFS Mental Health Services:**

<b>CFS Mental Health Services</b>	<b>Services to be Provided</b>
Psychosocial Assessment (also known as Mental Health Assessment)	Providers identify and clarify the beneficiary's presenting problem, the psychological impact of the trauma, the beneficiary's strengths and challenges, the beneficiary's mental health diagnosis, and recommendations regarding treatment and/or placement needs.
Treatment Plan	A treatment plan must be developed with input from the beneficiary, family (as indicated) and CWW before treatment services can begin.
Psychotherapy	Providers deliver treatment with the goal of decreasing the beneficiary's symptoms and improving functioning.
Psychological Evaluation/Testing	The testing may be provided by a licensed psychologist or an organization's doctoral intern under the supervision of a licensed psychologist. The Provider collects information, reviews records and administers a battery of tests. The Provider provides diagnostic clarification, identification and treatment recommendations. The Provider conducts interviews with parents/caregivers and reviews relevant beneficiary records. The Provider's testing report will include a mental health diagnosis, as appropriate; psychodiagnostic conclusions; and recommendations that address the CWW's specific questions. Psychological testing requests from CWW's that do not meet medical necessity criteria are paid for by Social Services (PTAR is not needed).



CFS Mental Health Services	Services to be Provided
Medication Evaluation and Monitoring	Providers evaluate whether medication would alleviate beneficiary’s symptoms, and if so, monitors effects of the medication. Only contracted psychiatrists, or the following disciplines within an organization: psychiatric nurse practitioners, physician assistants, or clinical psychiatric pharmacists working under the supervision of a psychiatrist, can provide these services.

**CFS Customized Services**

CFS may also request Customized Services, which are mental health services that address the unique needs of Social Services, but are not billable to Medi-Cal. If a CWW requests Customized Services, he or she must obtain supervisor approval and provide additional CFS authorization to ACCESS prior to ACCESS making a referral to Providers. Providers should not deliver Customized Services unless he or she has received a *Referral Letter* from ACCESS requesting this specific service.

**Upon receipt of ACCESS Referral Letter, Providers shall deliver the following CFS Customized Services listed below:**

**These services require CWW’s Supervisor signature prior to ACCESS’ referral.**

CFS Customized Services	Services to be Provided
Attachment Evaluation	Collect information on the quality of the attachment relationship between parent/caregiver and the minor and whether the relationship is able to meet the minor’s basic psychological and emotional needs. This evaluation is often given in conjunction with psychological testing of the child.
Caregiver Competence Evaluation	Collect information on the parent/caregiver’s ability to provide basic safety, stability and emotional care to the minor. This evaluation is often given in conjunction with psychological testing.
Developmental Assessment	Performs in-depth assessment of early childhood development.
In-Depth (procedure code is called Client Evaluation) Progress Report	Provide a written report, typically for presentation to the court that contains substantially more detail and takes more time than a standard progress report.

**Upon receipt of ACCESS Referral Letter, Providers shall deliver the following CFS Customized Services listed below:**

**These services may only be delivered by Providers that BHCS has pre-screened and authorized to render these services**

<b>CFS Customized Services</b>	<b>Services to be Provided</b>
Sexual Perpetrator Evaluation	Evaluate whether an individual may be victimizing others and provide treatment recommendations.
Sexual Perpetrator Treatment	Provide individual and/or group therapy with the goal of alleviating risk of victimizing others.
Evaluation of Dangerous Client	Perform court ordered psychological evaluation of an adult with history of violent behavior who may pose a risk to the provider.
Treatment of a Dangerous Client	Provide court ordered individual and group therapy to adult with history of violent behavior who may pose a risk to the provider.

**CFS Reports**

As a condition of being part of BHCS’ MHP FFS Plan and accepting CFS referrals, the Provider must submit written Progress Reports/Treatment Summary (procedure code listed as Casework Report) to the assigned CWW once every six months, or upon request. Generally, requests are given to Providers with ten working days’ notice. For new beneficiaries, Providers will generally be given 15 working days. The Provider may bill for this service (for rates see Exhibit B-1 in your contract). A CWW may request a more in-depth report (for rates see Exhibit B-1 in your contract).

Providers should contact the CWW to ensure the report’s purpose and expectations are clear. Reports should include a brief summary of relevant history with recommendations that are concrete, specific and relevant to the beneficiary’s current context. Providers’ interpretation must be confined to the Provider’s scope of practice and expertise. Reports provided by Providers may influence the results of a parent/caregiver’s termination of parental rights. When drafting reports, Providers should take care to consider:

- Limitations of the tests or methods used;
- Provider objectivity, such as, but not limited to, cultural biases and experiences; and
- The beneficiary’s situational factors, such as, but not limited to language/cultural differences, stress, etc.
- Proper grammar and spelling is expected

**These are a few basic categories of reports for CFS services a Provider must submit:**

CFS Reports	Report Criteria
CFS Progress Report/Treatment Summary (procedure code listed as Casework Report)	Unless the CWW indicates otherwise, this report must include presenting problems; a DSM-5 diagnosis; treatment goals and a narrative. The narrative must include attendance, engagement and progress toward goals. Generalizations are not sufficient. Providers may only bill for either the CFS Progress Report/Treatment Summary or the CFS Mental Health Assessment once every six months.
CFS Mental Health Assessment	This report provides a psychosocial assessment. Provider may bill for the time it takes to write the report under the same billing code as the progress report. Providers may only bill for either the CFS Progress Report/Treatment Summary or the CFS Mental Health Assessment once every six months.
Psychological Testing	Providers must write the report to address the specific questions of the CWW. Providers should address the limitations of testing and the potential uses of the report.

**2. Psychological Evaluation and Testing**

Psychological testing is authorized only for the purpose of treatment and requires prior screening and approval by ACCESS. The testing must be requested by the treating mental health provider utilizing the *Psychological Testing Authorization Request (PTAR)*, ([Appendix G](#)), and following an initial assessment and a minimum of 3 months of treatment. ACCESS staff will review materials and send the Provider a *Psychological Testing Authorization Request Response (PTAR-R)* form which will indicate whether the request for psychological testing was approved, denied or pending (additional information needed). The *PTAR-R* will also indicate who will be performing the testing and number of hours authorized. See *Provider Manual ACBHCS Psychological Test*, ([Appendix G-1](#)), for more information.

**To request Psychological Evaluation/Testing, Provider shall complete and submit a PTAR to ACCESS with requested records, after completing the initial assessment and a minimum of 3 months of treatment.**

**3. Services to Youth on Probation and/or CalWORKs Recipients**

All initial authorization of services, including those for youth on Probation and CalWORKs recipients, must come through ACCESS. If a probation officer or beneficiary contacts the Provider directly, refer that person to ACCESS.

**Providers may submit claims for two reports associated with providing CalWORKs services. Providers will be reimbursed by Alameda County CalWORKs for completing these reports.**

CalWORKs Reports	Report Criteria
Initial Assessment Report	Providers must complete this report within five days of the Initial Assessment and send to the CalWORKs program as indicated on the required form.
Monthly Progress and Attendance Report	Providers must complete this report by the fifth day of the following month, as indicated on the required form.

**4. Eating Disorder Services**

ACCESS refers beneficiaries who present with eating disorders to a MHP FFS Provider who is interested in working with this population. Most beneficiaries are referred to providers who have experience working with individuals with eating disorders, while those with more severe symptoms are referred to one of our eating disorder specialists. Providers can become eating disorder specialists by obtaining an Eating Disorders certificate from a credentialed program, or have extensive experience working in an Eating Disorder program, and satisfactorily completing the BHCS *Eating Disorder Supplemental Questionnaire*.

**D. OTHER REFERRAL SOURCES**

Some referrals may not originate from ACCESS such as:

**1. Murphy Conservatorship**

Providers may enroll with BHCS to provide services for beneficiaries who have an established Murphy Conservatorship through the courts. In order to bill for Murphy Conservatorship services, all Providers must receive a referral from the Social Services, Public Guardian Conservator Office.

**2. Competency to Stand Trial**

Qualified Providers may be asked to provide evaluation services for juvenile beneficiaries who are court ordered to receive an evaluation to determine if they are competent to stand trial. (Please contact the BHCS Guidance Clinic for more information).

**3. Educationally Related Mental Health Services (ERMHS)**

Providers designated to perform ERMHS assessments will receive a referral from the BHCS Children’s Specialized Services (CSS) unit to provide assessments and/or evaluations for children to determine ERMHS associated with the child’s special education plan. Providers are allowed to claim a maximum of 12 hours for the evaluation. This may be extended upon approval.

## **VII. UTILIZATION MANAGEMENT PROGRAM (UM)**

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### *OUTPATIENT PROVIDER*

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Utilization Management Program (UM) and the ACCESS Program serve as the BHCS MHP Point of Authorization (POA) for managed care outpatient Specialty Mental Health Services (SMHS). For detailed SMHS medical necessity criteria, reference the DHCS document: *Medical Necessity for Specialty Mental Health Services that are the Responsibility of the Mental Health Plan* (Appendix B). Under the Affordable Care Act, only beneficiaries who demonstrate functional impairments in the moderate-severe range due to their mental health condition are eligible for SMHS. Due to the current managed care environment, brief therapy modalities are advised. Alameda County pre-authorizes an initial package of services for a six-month period, but is not a guarantee of payment. Reimbursement claims are subject to retrospective review for verification of continued insurance eligibility and medical necessity, and timeliness of claim submission.

The Medi-Cal Managed Care Plans (MCPs) as indicated below and Primary Care Providers (PCP) are expected to provide mental health services to those assessed to have mild-moderate functional impairment. If a beneficiary is initially assessed or improves to a mild-moderate condition, the Provider is expected to appropriately refer and transition the beneficiary to either the MCP or PCP.

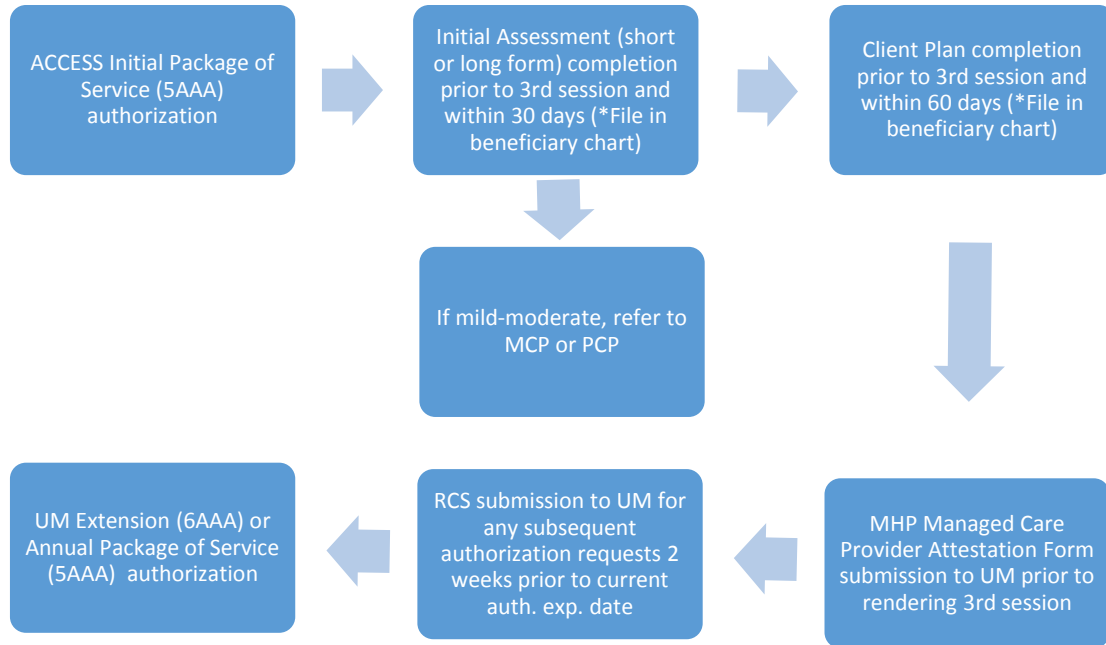
#### **A. INSURANCE ELIGIBILITY VERIFICATION**

- It is the Provider's responsibility to verify insurance eligibility at a minimum, on a monthly basis.
- It is strongly recommended for the Provider to know each of their beneficiary's Medi-Cal MCP to help ensure continuity of care as a beneficiary's condition improves from moderate-severe to mild-moderate. The three MCPs are as follows:
  1. **Alameda Alliance/Beacon**<sup>2</sup>: (855) 856-0577
  2. **Anthem Blue Cross**: (888) 831-2246
  3. **Kaiser**: (510) 752-1075
- If a Provider is interested in continuing to work with a beneficiary whose condition improves to mild-moderate impairment, it is recommended that the Provider become an Alameda Alliance/Beacon and/or Anthem Blue Cross provider.

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<sup>2</sup> Beacon manages the mental health services for Alameda Alliance Medi-Cal beneficiaries with mild-moderate impairment.

**B. TIMELINE FOR AUTHORIZATION AND DOCUMENTATION COMPLETION**



**C. UM AUTHORIZATION PROCESS**

**1. Initial Assessment (short or long form), Client Plan, and MHP Managed Care Provider Attestation**

- The applicable *Assessment* form must be completed prior to the 3<sup>rd</sup> session and within 30 days of the first face-to-face session. For the Initial Package of Service authorization by ACCESS, either the *Assessment Long or Short Form* is to be completed; for the Annual Package of Service authorization by UM, the *Assessment Long Form* is to be completed. Completed *Assessments* are to be filed in the beneficiary’s chart. *Assessment* Forms can be found at:
  - Assessment Short Form*: (see Appendix I)
  - Assessment Long Form*: (see Appendix J)
- The *Client Plan* form must be completed prior to the 3<sup>rd</sup> session and within 60 days of the first face-to-face session. Completed *Client Plans* are to be filed in the beneficiary’s chart.
  - Client Plan* form: (see Appendix H)
- Prior to rendering the 3<sup>rd</sup> session and within 60 days from the initial session, the *MHP Managed Care Provider Attestation* form must be completed, signed, and faxed or mailed to UM, attesting that a beneficiary currently meets medical necessity criteria for SMHS and that a full assessment and *Client Plan* have been completed.
  - Managed Care Provider Attestation* form: (see Appendix K)

**Upon receipt of Initial Package of Service Authorization and Referral Letter from ACCESS, Provider should:**

- Complete *Initial Assessment (short or long form)* prior to 3<sup>rd</sup> session and within 30 days (File in beneficiary chart)
- Complete *Client Plan* prior to 3<sup>rd</sup> session and within 60 days (File in beneficiary chart)
- Complete and submit *MHP Managed Care Provider Attestation* form to UM prior to rendering 3<sup>rd</sup> session and within 60 days

FAX to (510) 567-8148  
or mail to  
Utilization Management  
2000 Embarcadero Cove, Suite 400  
Oakland, CA 94606

- Treatment services, such as therapy, are not reimbursable without a completed *MHP Managed Care Provider Assessment* and *Client Plan*.
- Submit *RCS* to UM for any subsequent authorization requests 2 weeks prior to expiration of current authorization.

UM routinely requests specific beneficiary *Assessments* and *Client Plans* to be submitted for review.

## 2. Request for Continued Services (RCS)

- If additional services are needed beyond the Initial Package of Service authorization by ACCESS, submit to UM via FAX: (510) 567-8148 the *RCS*, (Appendix M), 2 weeks prior to the authorization expiration date. This is also true for any other subsequent *RCSs*. The *RCS* form is available online in two versions: fillable and printable at <http://www.acbhcs.org/providers/Forms/Forms.htm>, under Utilization Management Program.
- The *RCS* must document medical necessity for SMHS. Provide an included diagnosis from the DHCS document *Medical Necessity for Specialty Mental Health Services* (see Appendix B). Also provide supporting symptoms and describe behaviorally specific impairment or risk of specific impairment in an important area of life functioning; or if the beneficiary is a child, describe the probability that developmental progress may be impaired. Impairment and Intervention Criteria are also described in the aforementioned DHCS document.
- The *RCS* has a *Screening Form* and algorithm to help you make impairment severity determinations (i.e. moderate-severe vs. mild-moderate).
- Four pages of the *RCS* are required, including the signature block, which requires the signature of a licensed, registered, or waived clinician. The *RCS* contains *Screening Forms* for all ages. Please send only the *Screening Form* which is age appropriate for your beneficiary.
- For any subsequent *RCSs*, document continued medical necessity for SMHS with **current** significant functional impairment(s) that **directly** relates to mental health symptoms. Duplicates of previously received *RCSs* are not acceptable.

- Update the *Client Plan* with new goals/objectives for the next 6 month authorization period.

**To request continued services, Provider should:**

- Submit completed *RCS* 2 weeks prior to expiration date of current authorization  
FAX to (510) 567-8148
- Document medical necessity with current functional impairment directly related to mental health symptoms
- Complete only applicable screening form
- Sign the *RCS*
- Update the *Client Plan* with new goals/objectives for the next 6 months
- If there has been a lapse in service or a new service is being requested, indicate the start date for the requested 6 month authorization period.

**3. Letter of Approval or Denial**

- In response to the *RCS*, you will receive a *Letter of Approval or Denial* (Appendix L) by a licensed Clinical Review Specialist (CRS) and notification will also be sent to the beneficiary. Authorization is usually for a 6 month time span unless otherwise specified.
- A CRS may request additional information, such as “For beneficiary’s current medications, please list dosage and frequency.”
- A Provider may receive a phone call from a CRS requesting case consultation if continued need for services is not clearly documented on the *RCS*. If, by the 14<sup>th</sup> calendar day, the Provider fails to respond to a telephone request to help determine medical necessity, the service may be denied and notification sent to beneficiary regarding their rights and how to access alternative service.
- If the MHP is not the responsible payer, the Provider will receive a notice from a Health Information Technician (HIT) to this effect.
- If there has been a lapse in service or a new service is being added, indicate the start date for the requested 6 month authorization period.

**Authorizations are contingent on:**

- A Provider remaining in good standing (see Section III, *Provider Contract Requirements*, of this handbook)
- A Beneficiary’s continued insurance eligibility
- A Beneficiary who continues to meet *SMHS Medical Necessity Criteria*
- A Provider completing all documentation requirements (i.e., *MHP Managed Care Provider Attestation, Assessment, Client Plan, RCS*) and within the specified timelines

**D. SPECIAL RULES**

- Missed appointments cannot be claimed or billed to the beneficiary or to BHCS.
- For family therapy, if there are multiple billable beneficiaries, only one service may be claimed.
- CFS Customized Services require CWW approval. An approval form must be sent to ACCESS by the CWW prior to delivery of the service. This includes CFS reports requested more frequently than 6 months or requiring more than 2 hours preparation time.
- Requests for reimbursement for non-treatment services provided at the request of other agencies should be directed to those agencies. This includes IEP’s, court appearances, and child custody evaluations.



- Assessments for purposes of evaluating for SSI are not covered by Medi-Cal except for beneficiaries using CalWORKs insurance.
- Services that do not require authorization
  - Supplemental bilingual services.
  - Standard CFS court reports every 6 months.
  - CalWORKs reports.

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### *INPATIENT PROFESSIONAL SERVICE PROVIDER*

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UM serves as the BHCS MHP Point of Authorization (POA) responsible for acute inpatient chart review to determine whether Medi-Cal medical necessity reimbursement criteria (see [Appendix B](#)) has been met. Psychiatric evaluation/treatment services rendered by psychiatrists are referred to as professional fees and are not included in the inpatient daily reimbursement rate (*\*Exception: Short-Doyle Medi-Cal Acute Psychiatric Hospitals*). Professional fee services are categorized as SMHS outpatient services and can be rendered to beneficiaries admitted to acute psychiatric inpatient, acute medical inpatient, or medical emergency rooms. Professional fee reimbursement claims are submitted to Provider Relations, Claims Processing Center (CPC), via the *Health Insurance Claim Form CMS 1500 (CMS 1500)*. See ([Appendix N](#)) for *CMS 1500 Instructions and sample*.

UM reviews inpatient admissions for Alameda County Medi-Cal beneficiaries. When the beneficiary has Alameda County Medi-Cal with private insurance or Medicare the inpatient facility may not complete a UM review. When the Medi-Cal/Medicare (Part A) beneficiary does not have Medicare Part B (outpatient), refer to Section VIII, *Billing and Claims*, of this handbook for further instructions on how to request Medi-Cal reimbursement for professional fees.

#### **A. ACUTE PSYCHIATRIC INPATIENT (In-Network and Non-Network)**

Acute psychiatric inpatient reimbursement requests are submitted to UM through a *Treatment Authorization Request (TAR 18-3)* by the inpatient facility. In accordance with California Code of Regulations (CCR), *TAR* submission to UM is required within 14 calendar days from the date of discharge. Within 14 calendar days of *TAR* receipt, to include all necessary clinical documentation, UM determines whether or not the inpatient day(s) in question meet Medi-Cal reimbursement criteria for acute or administrative days. These reimbursement authorizations are entered in a local Alameda County beneficiary database and the completed *TAR* is faxed to both the Medi-Cal Fiscal Intermediary (i.e., Xerox) and to the inpatient facility as notification.

Once the *TAR* is submitted to UM, professional fee reimbursement claims via the *CMS 1500* form can be submitted to CPC. CPC verifies in the local Alameda County beneficiary database that the inpatient days have been reviewed and authorized for either acute or administrative days. Claims will be returned if there is no record of *TAR* receipt by UM or if the inpatient day(s) are determined to not meet Medi-Cal medical necessity criteria for reimbursement.

#### **B. ACUTE MEDICAL INPATIENT/MEDICAL EMERGENCY ROOMS (Non-Network Only)**

The Provider submits a copy of the professional fee reimbursement claim via the *CMS 1500* form to UM, along with clinical documentation of the psychiatrist's assessment, to include clinical determinations and recommendations, psychiatric diagnoses, and the rationale for the attending medical physician psychiatric consult order. A copy of the psychiatric consult order

may also be included. Within 14 calendar days of receipt of all necessary documentation, UM will render a reimbursement decision, enter approval authorizations in a different Alameda County beneficiary database, and send the inpatient facility written notification of approval or denial decisions.

Upon receipt of the UM written approval decision, the inpatient facility or designated entity submits the professional fee reimbursement claim via the original *CMS 1500* to CPC. CPC verifies in the appropriate Alameda County beneficiary database that UM has completed approval authorizations for the professional fee reimbursement requests prior to remitting payment.

**To obtain professional fee reimbursement, Provider shall:**

1. Contact Network Office to become a Non-Network provider at (510) 383-2874
2. Submit to UM, the applicable payment request form (i.e., original *TAR 18-3* or copy of *CMS 1500*) and chart/clinical document to:  
Utilization Management  
2000 Embarcadero Cove, Suite 400  
Oakland, CA 94606
3. Upon receipt of UM approval, submit original *CMS 1500* to CPC:  
Provider Relations – Claims Processing Center  
P.O. Box 738  
San Leandro, CA 94577-0738

**VIII. BILLING AND CLAIMS**

Provider Relations/Claims Processing Center (CPC) is responsible for ensuring accurate and timely claims processing and prompt payment to Providers.

As a contracted provider for the BHCS MHP, Providers agree to accept a contracted fee schedule as payment in full for services provided to Mental Health Plan beneficiaries. Financial agreements between Alameda County and Providers that include but are not limited to rates, exclusions, and coordination of benefits will be written in the agreements with Alameda County and Providers, and are not affected by material presented in this manual.

Providers agree to bill the MHP FFS directly, not the beneficiary, for services provided. Beneficiaries may only be billed for the Medi-Cal Share of Cost amount. The Share of Cost amount is deducted from the MHP FFS Plan rate, not from the charge rate.

**Payments are contingent on:**

- Provider contracting with BHCS.
- An ACCESS *Referral Letter*.
- A beneficiary's continued insurance eligibility, medical necessity, and timeliness of claim submission.
- A Provider remaining in good standing (see Section III, *Provider Contract Requirements*, of this handbook).
- A Beneficiary who continues to meet *SMHS Medical Necessity Criteria*
- A Provider completing all documentation requirements (i.e. *MHP Managed Care Provider Attestation, Assessment, Client Plan, RCS*) and within the specified timelines.

**A. RATES**

Financial agreements between BHCS and Providers that include, but are not limited to, rates, exclusions and coordination of benefits will be written in contract/agreements with BHCS and Providers and are not affected by material presented in this handbook. The Exhibit B-1 in the contract reflects a Provider's contracted fee schedule and allowable procedure codes for billing.

**B. MISSED APPOINTMENTS**

BHCS does not authorize payment to Providers for beneficiary's missed appointments; nor may a beneficiary be billed.

**C. MEDI-CAL ELIGIBILITY VERIFICATION**

As a contracted State Medi-Cal Provider, BHCS as the intermediary obtains a State personal identification number (PIN) per provider agency that allows for Medi-Cal verification processes. Providers must verify beneficiary's eligibility and other primary coverage prior to rendering services and prior to claims submission. When a potential beneficiary presents him/herself as a Medi-Cal beneficiary or presents a Medi-Cal Identification Card, Providers must verify the individual's eligibility. Providers must conduct the verification at a minimum, on a monthly basis, as benefits may change. The Provider Relations unit provides Medi-Cal eligibility verification training on a monthly basis. In addition they provide a Medi-Cal Eligibility Help Desk phone support at (888) 346-0605 to assist with basic Medi-Cal benefit questions.

At a minimum, on a monthly basis, Providers must verify beneficiary's Medi-Cal eligibility and other primary coverage prior to rendering services and prior to claims submission.

**Methods for Verifying Medi-Cal Eligibility are:**

1. The DHCS online system process is the preferred method as it allows users the ability to print the verification and maintain the documentation as proof. Proof may be necessary as a beneficiary's eligibility can change throughout the month and proof may secure revenue.

Using the State DHCS web based on-line Medi-Cal eligibility system.

Providers may use the on-line system to verify beneficiary benefits utilizing their PIN. <https://www.medi-cal.ca.gov/Eligibility/Login.asp>

Prior to accessing the State on-line system, Providers must have the required information at hand. The State on-line system log-in requires:

- four-digit State Provider number (including the five preceding zeros) assigned to you
- eight-digit PIN

The Eligibility Verification for the unique beneficiary search requires:

- beneficiary's social security number or Medi-Cal identification number
- date of birth
- card issue date (or today's date)
- date of service

The DHCS online system:

- verifies an individual's Medi-Cal eligibility for the current and/or prior twelve months
- provides information on Share of Cost, Other Health Care Coverage, and Prepaid Health Plan (PHP)
- identifies any service restrictions that may exist on individual benefit plans

Or

2. Using the *Automated Eligibility Verification System (AEVS)* at (800) 456-AEVS (2387) Providers may use AEVS, a phone based system, to verify beneficiary benefits utilizing their PIN. Prior to accessing AEVS, Providers must have the required information at hand. AEVS requires:
  - an eight-digit PIN
  - the potential beneficiary's social security number or Medi-Cal identification number
  - date of birth

AEVS allows three attempts to enter the required information. Upon the third unsuccessful attempt, AEVS will terminate the call.

AEVS verifies an individual's Medi-Cal eligibility for the current and/or prior twelve months. AEVS provides information on Share of Cost, Other Health Care Coverage and PHP status. AEVS also identifies any service restrictions that may exist on individual benefit plans.

Note: Use of AEVS or the Medi-Cal online verification does not guarantee that Providers' claims will be paid.

All means of Medi-Cal verification will be used by the CPC to verify beneficiary eligibility. Provider claims for beneficiaries served without verified Medi-Cal will be returned to the Provider as denied (a few exceptions may apply).

#### **D. SHARE OF COST**

Providers may only bill the beneficiary for the Medi-Cal Share of Cost amount. BHCS is not responsible for helping to meet the Share of Cost obligation. When billing for services rendered to a beneficiary, the Share of Cost should be noted as the amount paid and the amount should be deducted from the total charges on the claim. The Share of Cost amount is deducted from the BHCS payment rate, not from Provider's customary charge rate. Documentation of charges used to meet the Share of Cost obligation must be maintained by Providers and documented on the *CMS 1500*, (Appendix N), form in Box 29 (Amount paid) when submitting claims to BHCS CPC. In addition, providers must include a completed *SOC / Spend Down Clearance Request* form with their claims submission to the CPC. See (Appendix O) for a sample of the *SOC / Spend Down Clearance Request* form.

#### **E. MEDI-CAL BENEFICIARIES WITH OTHER HEALTH INSURANCE COVERAGE (OHC)**

Providers are responsible for determining when a beneficiary has health insurance in addition to Medi-Cal. Private insurance is considered the primary plan and must be billed first. Providers must submit documentation, i.e., Explanation of Benefit or Remittance Advice, of payment or a \*valid denial from the insurance carrier attached to the claim form to the CPC. The OHC payment amount is deducted from the total charges and documented on the *CMS 1500* form in box 29 (Amount paid) when submitting claims to BHCS CPC.

The CPC will adjudicate the service(s) based on the BHCS contracted rate minus the insurance payment.

\*Only the following denials are considered "Valid" for reimbursement:

- Not a covered benefit
- Benefits have been exhausted
- Coverage has been terminated

#### **F. MEDI-CAL BENEFICIARIES WITH MEDICARE**

Providers are responsible for determining whether a beneficiary is covered by Medicare. If Providers are enrolled with Medicare they should bill Medicare as the primary payer and **not** claim any balance to BHCS (for inpatient services see Section VIII. Item K, *Special Rules*, of this handbook). Providers may contact DHCS directly to determine if they can claim the balance of services after the Medicare payment to Medi-Cal. To request Medi-Cal enrollment call the Medi-Cal Provider Service Center at (800) 541-5555 or via the DHCS webpage at <http://www.dhcs.ca.gov>. Claims received for clients with Medicare and Medi-Cal will be returned to the provider.

#### **G. CLAIMING PROCESS**

##### **1. Claim Submission**

Providers must submit all original *CMS 1500* claims to Provider Relations' CPC within 60 days from the end of the month of service. BHCS may deny claims received later than 60 days after the month of service. Payment of claims is dependent on continued insurance eligibility, medical necessity, referral or reauthorization, and timeliness of claim submission.

##### **2. Year End Claim Deadline**

June 30<sup>th</sup> is the end of the fiscal year and every year the CPC will send Providers a minimum of three letters indicating the deadline for submitting fiscal year claims. It is essential for all

Providers to meet this annual deadline for all services provided within that year. Late Claims will be denied.

### 3. Late Claim Submission

BHCS must submit claims to the state within a strict timeline based on the date of service. Thus, BHCS strictly enforces the claims submission timeline of 60 days from the month of service. Sometimes there are valid reasons for a late claim submission. In these rare instances, Providers may request a late submission exception by completing and submitting a *Late Claim Submission Exception Request* (Appendix P) form to the CPC. Claims over one year old must include a copy of the beneficiary's proof of benefits over the year letter from Social Services and must be submitted to the CPC within 10 business days from the date of the letter. Providers should contact the CPC at (800) 878-1313 with any questions.

### 4. Claim Processing and Payments

Provider Relations' CPC's goal is to adjudicate claims within 21 working days from the receipt of a claim. Claims are adjudicated for payment based on BHCS referral or re-authorization, meeting medical necessity and beneficiary monthly benefits eligibility. If or when a claim does not meet this criteria payment or processing may be delayed or denied.

All claims are subject to a comprehensive review for accuracy and audits for compliance. All claims that pass the edits and audits will be adjudicated for payment processing. The CPC will notify Providers, as time permits by mail or phone, of claims requiring further information or action.

There are several potential reasons a service may need to be repaid to BHCS. This action is referred to as a **Revert**. Circumstances may include beneficiaries who receive retroactive Medicare, beneficiaries with an unmet Share of Cost, or with other health insurance, etc. The BHCS CPC will process a revert service that reduces the payment amount from the Providers next check.

CPC will issue payments for all adjudicated claims once per week. Claim payments will be mailed to Providers with a *Remittance Advice* (RA) that will reflect all paid and/or reverted services. Providers are expected to review the RA to assist with tracking billing and payments. See (Appendix Q) for a sample *Remittance Advice*.

### 5. Claim Returns

CPC may return claims to Providers that do not pass the edits and audits or when additional information is needed in order to process the claim for payment. Providers are allowed up to 45 days from the date of the claims return letter to resubmit the claim. See (Appendix R) for a sample *Claims Return Letter*. Claims received after this deadline will be denied.

### 6. Claim Denials

CPC may deny claims to Providers that do not pass the edits and audits necessary to process the claim for payment. Denied claims may not be corrected, but may be appealed within 30 days of the denial date. See (Appendix S) for a sample *Claims Denial Letter*.

### 7. Claim Inquiries

Providers who have submitted a claim and have not received a payment, return letter or denial within 30 to 45 days should submit a *Claims Inquiry* form along with an original claim form. The CPC will research the circumstances and respond accordingly via payment, denial or request for further information. See (Appendix U) for a sample *Claims Inquiry* form.

**8. Claim Appeals**

Providers who have received a denial for services and have a valid justification for payment reconsideration may submit a *Claims Appeal* form, accompanied with a copied claim form and supporting documentation within 30 days of the denial letter to the CPC. See (Appendix T) for a sample *Claims Appeal* form.

Provider Relations (PR) will acknowledge the receipt of an appeal within 15 days by sending a letter to the Provider.

PR will respond with a final decision within 45 days of receipt of the appeal and indicate:

- The reason for the decision that addresses each issue raised in the appeal;
- Any action required by the Provider;
- Denial or payment

If the appeal is denied, Providers may submit a 2<sup>nd</sup> Level Appeal within 30 days from the appeal denial decision date when they do not agree with the appeal decision and have a valid justification for payment reconsideration.

PR Administration will respond to all 2<sup>nd</sup> Level Appeals with a final decision within 60 days of receipt of the 2<sup>nd</sup> Level Appeal.

**H. CLAIM FORMS**

Providers must submit claims for services rendered as described below.

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*OUTPATIENT PROVIDER*

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***CMS 1500***

Providers must complete all form areas using the contracted procedure codes as seen in Exhibit B-1 in your contract and Diagnostic and Statistical Manual (DSM-5) diagnosis codes. The Authorized Person’s Signature in Box 12 and 13 may be designated as “signature on file” with supporting signature documentation at kept at the Provider’s site. The rendering Provider’s NPI number must be entered in Box 24-J. Providers must sign Box 31. See (Appendix N) for instructions and a sample *CMS 1500* form..

**Mail all claims to:**

Provider Relations – Claims Processing Center  
P.O. Box 738  
San Leandro, CA 94577-0738

**I. SPECIALTY SERVICES**

1. CFS Mental Health Services

CFS may request Mental Health services to address the unique needs of Social Services through the ACCESS referral process. See (Appendix D).

Providers must adhere to all of the claim submission guidelines. Completed *CMS 1500* claim forms must be submitted to the CPC within 60 days from the month of service.

2. CFS Customized Services

CFS may request customized services which address the unique needs of Social Services. In order to be reimbursed for customized services, the Social Services CWW must obtain supervisory approval and submit a signed *Authorization Form for Customized Mental Health Services* to ACCESS. Once submitted, Providers must receive an ACCESS *Referral Letter* requesting customized services prior to rendering services to the beneficiary.

Customized services that are referred by ACCESS for Sexual Perpetrator or Dangerous Clients will be paid whether the beneficiary has Medi-Cal or not based on the CFS referral.

Providers must adhere to all of the claim submission section guidelines. Completed *CMS 1500* claim forms must be submitted to the CPC within 60 days from the month of service.

3. CalWORKs

**Providers should not provide services to CalWORKs recipients unless the Provider has received an authorization from ACCESS. If a beneficiary contacts the Provider directly, refer the beneficiary to ACCESS.** All services that are submitted prior to receiving a referral will be denied by the CPC.

Provider may submit claims for two reports associated with providing CalWORKs services. Providers will be reimbursed by BHCS MHP for completing CalWORKs reports. (Please refer to Section VI. Item C.3. *Referrals and Initial Authorizations, Services to Youth on Probation and/or CalWORKs Recipient*, of this handbook.) The Provider must complete and submit the *CMS 1500* form to the CPC within 60 days from the month of service.

4. Eating Disorder Services

Providers can become an eating disorder specialist by obtaining an Eating Disorder certificate from a credentialed university (i.e., UC Berkeley, JFK University). BHCS will consider licensed clinicians who have experience working in an Eating Disorder program and satisfactorily completes a BHCS *Eating Disorder Supplemental Questionnaire*. A Provider must receive a referral and authorization from the ACCESS department in order to provide specialty Eating Disorder Services.

Upon completion of authorized services, Providers must complete a *CMS 1500* claim form and submit it to the CPC within the established claim submission guidelines above. Providers contracted for Eating Disorder services will receive a special procedure code and rates, see Exhibit B-1 of your Provider contract.

5. Murphy Conservatorship Providers

The Public Guardian Conservators Office is responsible for processing all Murphy Conservatorship referrals to the appropriate BHCS contracted SMH FFS Provider. The Public Guardian referral letter will be accompanied with a partially completed *CMS 1500* claim form (Boxes 12, 13 and 17 will be completed). All other required fields on the *CMS 1500* form are the responsibility of the Provider to complete once services have been rendered. (Note: Providers must enter the actual date of the face-to-face visit in Box 24A of the *CMS 1500* form.) The Provider must complete the claim form and submit it to the CPC within 30 days from the evaluation completion date.

6. Competency to Stand Trial (CST)

The Guidance Clinic is responsible for processing all CST referrals to the appropriate BHCS contracted SMH FFS Provider. Upon completion of services, Providers must complete a *CMS*



1500 claim form and submit it to the CPC within the established claim submission guidelines. A *CST Psychologist Panel Provider Relations Information Sheet* must also be submitted to the CPC by the Guidance Clinic prior to processing the claim.

7. **Educationally Related Mental Health Services (ERMHS)**  
Providers contracted for ERMHS assessments will receive the client referral through Alameda County BHCS' Children Specialized Services (CSS) unit. A completed *CMS 1500* claim form must be mailed to CSS within 50 days from the referral date for CSS approval. All ERMHS claims must be mailed to:

CSS  
7700 Bancroft Ave., Suite 125C  
Oakland, CA 94605

CSS will submit the approved *CMS 1500* claim form to the CPC within the established claim submission guidelines for services rendered.

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### *INPATIENT PROFESSIONAL SERVICE PROVIDER*

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#### **J. Non-Network Providers**

Upon completion of services, with an approved Treatment Authorization Request (TAR), providers must complete a *CMS 1500* claim form and submit it to the CPC within the established claim submission guidelines above. Claims for Non-Network providers will be adjudicated for payment if a TAR is on file for the inpatient stay or in the case of a medical admission, when the medical records are reviewed by the UM and medical necessity has been established. Providers should consult with the Network Office to confirm Non-Network Provider status before submitting claims.

For IP services to be reimbursed, a Non-Network Provider has up to 60 calendar days from the date they receive a claims letter from the Claims Processing Center to complete the *Non-Network Provider Application* process. Once all information is received and all claims have been submitted and reviewed for accuracy and audit compliance, the Non-Network Provider will receive an approval letter. If all information is not received within the given timeline, the *Non-Network Provider Application* and the claims submitted for that provider will be denied.

#### **K. Special Rules**

Providers are responsible for determining whether a beneficiary is covered by Medicare. If Providers are enrolled with Medicare they should bill Medicare as the primary payer and **not** claim any balance to BHCS. Providers may contact DHCS directly to determine if they can claim the balance of services after the Medicare payment to Medi-Cal. To request Medi-Cal enrollment call the Medi-Cal Provider Service Center at (800) 541-5555 or via the DHCS webpage at <http://www.dhcs.ca.gov>. Claims received for clients with Medicare and Medi-Cal will be returned to the provider.

\*UM reviews acute psychiatric inpatient admissions for Alameda County Medi-Cal beneficiaries. When the beneficiary has Alameda County Medi-Cal with private insurance or Medicare the inpatient facility may not complete a UM review because private insurance and Medicare (Part A) is primary. Providers who are billing services for beneficiaries who have Medi-Cal/Medicare

(Part A), but do not have Medicare Part B (outpatient), must complete and submit the *Medi-Cal Review Request* form (Appendix U-1), along with the beneficiary's chart and a copy of the *CMS 1500* claim form, to the UM department directly to establish medical necessity. Please note, an original *CMS 1500* claim form must be submitted to the CPC within the specified claim submission deadline.

## **IX. QUALITY ASSURANCE (QA)**

As a condition of being a BHCS' MHP FFS Provider, Providers shall comply with applicable Federal and State regulations as well as any additional requirements set by BHCS. Refer to the Quality Assurance Manual: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm) and QA Memos and Notices: <http://www.acbhcs.org/providers/QA/memos.htm> on the BHCS Provider Website which contains applicable regulations, policies and procedures, and requirements, some of which are summarized as follows:

### **A. CONSUMER RIGHTS** **Informing Materials**

Provider shall review BHCS' *Informing Materials* packet (Appendix V) with each beneficiary at the initial session and annually and obtain the beneficiary's or legal representative's signature (initials annually) on the *Informing Materials – Your Rights & Responsibilities: Acknowledgement of Receipt* form which shall be kept in beneficiary's medical record. The Informing Materials packet includes sections on the following:

- Consent for Services
- Freedom of Choice
- Guide to Medi-Cal Mental Health Services, Member Handbook, & Provider List
- Confidentiality & Privacy
- Advance Directive Information: *Your Right to Make Decisions about Medical Treatment*
- Beneficiary Problem Resolution Information
- Maintaining a Welcoming & Safe Place
- Notice of Privacy Practices

### **Consumer Grievance and Appeal Process**

Provider shall be knowledgeable about BHCS' beneficiary grievance and appeal process and provide information to beneficiaries as needed. Provider shall post BHCS' Consumer Grievance and Appeal poster in a conspicuous place, preferably in a waiting area outside of Provider's office, and make available BHCS' Consumer Grievance and Appeal material and forms in such a manner that beneficiary does not need to ask for the material.

### **B. CONFIDENTIALITY AND BREACHES**

Providers shall comply with all applicable Federal, State, County and/or municipal laws, regulations, guidelines and/or directives pertaining to the confidentiality of individually identifiable health information including, but not limited to: the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH), and Welfare and Institutions Code requirements regarding confidentiality of patient information, and records, commencing with Section 5328. Provider shall inform and train its officers, employees and agents of the provisions for confidentiality of all information and records as set forth in those laws. Providers shall be familiar with the requirements of HIPAA/HITECH: [http://www.acbhcs.org/providers/QA/CQRT\\_General.htm](http://www.acbhcs.org/providers/QA/CQRT_General.htm).

#### **1. Breaches of Confidentiality**

As a condition of being part of BHCS' MHP FFS Provider Plan, Providers shall follow State and Federal guidelines pertaining to breaches of confidentiality. Providers agree to hold BHCS harmless for any breaches or violations arising from the action/inactions of Providers, their staff and sub-contractors. All breaches of confidentiality shall be reported to BHCS per the *HIPAA Breach Reporting Policy* which is located in the QA Manual, Section 11, at [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm).

**2. Business Associates – Sharing of Information**

As part of BHCS’ MHP FFS Provider Plan, all contracted Providers are considered Business Associates and as such, all providers shall share necessary beneficiary information with any other service provider within BHCS’ System of County-operated and County-contracted providers for:

- Treatment activities (including the need to make timely referrals among programs for purposes of providing integrated services within this system of care)
- Payment activities of said providers, and/or for
- Health care operations of said providers if each of the entities has or had a relationship with the beneficiary.

**3. Informed Consent & Informing Materials**

BHCS MHP FFS Providers shall use BHCS’ Informing Materials Packet and obtain applicable Releases of Information for all BHCS beneficiaries. Informing Materials guidelines and materials can be found at: <http://www.acbhcs.org/providers/QA/General/informing.htm>.

**C. NOTICES OF ACTION FOR MEDI-CAL BENEFICIARIES**

All Providers are required to issue Notices of Actions (NOA’s) to Medi-Cal beneficiaries in certain circumstances as outlined in BHCS’ *Notices of Action for Medi-Cal Beneficiaries* policy which can be referred to in the QA Manual, Section 10: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm). NOA templates can also be found in the QA Manual. NOAs inform beneficiaries of the action and their rights when certain actions are taken.

The following NOAs are to be issued by Providers:

Notice of Action	Providers must issue a NOA when
Notice of Action – Assessment (NOA-A)	It is determined, on the basis of an assessment, that the Medi-Cal beneficiary does not meet medical necessity criteria or is otherwise not entitled to receive a specialty mental health service (SMHS) from the Mental Health Plan. The NOA-A and the language services notices, are to be given directly to or sent to the beneficiary, or parent or legal guardian, by the Provider within three days of the action being taken and a copy of all documents to: BHCS Quality Assurance 2000 Embarcadero, Suite 400 Oakland, CA 94606 Or via FAX (510) 639-1346 Refer to the <i>Notices of Action for Medi-Cal Beneficiaries</i> policy QA Manual, Section 10: <a href="http://www.acbhcs.org/providers/QA/ga_manual.htm">http://www.acbhcs.org/providers/QA/ga_manual.htm</a> for further details.
Notice of Action – Lack of Timely Services (NOA-E)	The Provider has not provided services in a timely manner based on standards established by the Mental Health Plan. The Provider responsible for providing the services shall send the NOA-E to the beneficiary, parent, or legal guardian, and send a copy of all documents to QA (address above). Refer to the policy for further details.

**D. DOCUMENTATION STANDARDS****1. Timelines (Assessment, Client Plan, Progress Notes)**

*Assessments* (Appendix I) or (Appendix J), *Client Plans* (Appendix H), and *Progress Notes*, (Appendix W) shall be completed per timelines as established by BHCS and published in the *MHP Network Provider Documentation Standards* located in the QA Manual, Section 7: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm).

**2. Content**

Content of documentation in the medical record shall meet all State and Federal Regulations as well as BHCS' guidelines as contained in the *MHP Network Provider Documentation Standards* located in the QA Manual, Section 7: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm).

**E. MAINTENANCE AND RETENTION OF RECORDS**

Providers shall adhere to the maintenance, access, disposal and transfer of records in accordance with professional standards and all applicable Federal, State, County and/or municipal laws, regulations, guidelines and/or directives, including, if applicable, the specified regulations of the Substance Abuse and Crime Prevention Act of 2000.

Records shall be organized and contain sufficient detail to make it possible for contracted services to be evaluated and meet documentation standards; see *General Management of Clinical Record* in the *MHP Network Provider Documentation Standards* located in the QA Manual, Section 7: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm). Providers shall permit authorized BHCS personnel to make periodic inspections of the records. Providers shall furnish information and patient records such as these personnel may require for monitoring, reviewing and evaluating fiscal and clinical effectiveness, appropriateness, and timeliness of the services being rendered under this contract. Clinical records are to be destroyed in a manner to preserve and assure beneficiary confidentiality.

All Beneficiary Records must be retained as long as required by law, and until ACBHCS has finalized that fiscal year's cost settlement with DHCS (whichever is longer). Currently the last ACBHCS/DHCS finalized cost settlement was through 6/30/2008 – this will be updated as needed in the *MHP Network Provider Documentation Standards* located in the QA Manual, Section 7: [http://www.acbhcs.org/providers/QA/ga\\_manual.htm](http://www.acbhcs.org/providers/QA/ga_manual.htm). No records containing services beyond that date may be destroyed. Other requirements pertaining to records retention follows:

Clinical records must be preserved for a minimum of seven years following discharge/termination of the beneficiary from services, with the following exceptions:

- Un-Emancipated Minors: The records of un-emancipated minors must be kept for at least one year after such minor has reached age 18, and in any case, not less than seven years.
- For psychologists: Clinical records must be kept for seven years from the beneficiary's discharge/termination date; in the case of a minor, seven years after the minor reaches age 18
- Third party: If a Provider uses a third party to perform work related to their BHCS contract, the Provider must require the third party to follow these same standards
- Audit situations: Records shall be retained beyond the seven year period if an audit involving those records is pending, until the audit findings are resolved. The obligation to insure the maintenance of records beyond the initial seven year period exists only if the MHP notifies Contractor of the commencement of an audit prior to the expiration of the seven year period.

**Provider out of business**

In the event a Provider goes out of business or no longer provides mental health services, the provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of clinical records for the minimum retention time as described above. As well, the Provider must notify the BHCS Quality Assurance Office of who will be responsible for the maintenance of the records.

**F. UNUSUAL OCCURRENCE (SENTINEL EVENT) AND DEATH REPORTING**

Providers shall submit an *Unusual Occurrence/Death Reporting Form* to the BHCS QA Office within seven days of the knowledge of the Unusual Occurrence or death involving any Beneficiary. Please see the *Unusual Occurrence and Death Reporting Policy* and forms in the QA Manual, Section 6: [http://www.acbhcs.org/providers/QA/qa\\_manual.htm](http://www.acbhcs.org/providers/QA/qa_manual.htm). Reporting is used to identify and address:

- Utilization patterns that suggest issues with access to services
- Gaps within the service continuum
- Linkage with services
- Coordination of care
- Quality improvement

**G. SERVICE VERIFICATION**

BHCS regularly verifies with beneficiaries that they did, in fact, receive services claimed for by Providers. Services may be verified by BHCS via a letter to the beneficiary, a phone call to the beneficiary, or other method. Providers shall regularly verify the beneficiary's contact information with the beneficiary and update BHCS' records as needed. Please see BHCS' *Service Verification Policy* in the QA Manual, Section 15: [http://www.acbhcs.org/providers/QA/qa\\_manual.htm](http://www.acbhcs.org/providers/QA/qa_manual.htm).

**H. MEDI-CAL SITE CERTIFICATION**

All organizational MHP FFS Providers (only) shall have a valid Medi-Cal Site Certification and a valid fire clearance at all times in order to operate and to claim to Medi-Cal. See the *Medi-Cal Site Certification for Providers of Mental Health Services Policy* and Procedure located in the QA Manual, Section 16: [http://www.acbhcs.org/providers/QA/qa\\_manual.htm](http://www.acbhcs.org/providers/QA/qa_manual.htm).

**I. EXCLUSION LIST MONITORING**

Per Federal and State regulations, BHCS monitors that all providers of services, both individual provider and agencies, who receive federal funding such as Medicaid (Medi-Cal in California) are not included on any federal or state list that excludes the provider from receiving federal funds. BHCS monitors the specified lists on a monthly basis. For more information refer to *OIG and Other Exclusion List Monitoring, Oversight, and Reporting Policy* and Procedure located in the QA Manual, Section 15: [http://www.acbhcs.org/providers/QA/qa\\_manual.htm](http://www.acbhcs.org/providers/QA/qa_manual.htm).

**J. OTHER BHCS QA POLICIES**

Please see the QA Manual, [http://www.acbhcs.org/providers/QA/qa\\_manual.htm](http://www.acbhcs.org/providers/QA/qa_manual.htm), for other applicable QA policies and procedures.

**X. GLOSSARY**

Terms	Definitions
Acute Crisis Care & Evaluation for System-wide Services ( <b>ACCESS</b> )	The “front door” entry point for information, screening and referrals for outpatient mental health and substance use disorder services for Alameda County residents.
Alameda County Behavioral Health Care Services ( <b>BHCS</b> )	The public insurance (Medicaid/Medi-Cal) administrator which provides the behavioral health component of the insurance plan through its Mental Health Plan (MHP).
Assessments <ul style="list-style-type: none"> <li>• Initial Assessment</li> <li>• Annual Assessment</li> </ul>	Assessments are a collection of information and clinical analysis of the history and the current status of a beneficiary’s mental, emotional and/or behavioral health. <ul style="list-style-type: none"> <li>• The Initial Assessment is required prior to the third beneficiary’s visit.</li> <li>• The Annual Assessment is due approximately 11 months after the Initial Assessment by the first of the Episode Opening Month.</li> </ul>
Automated Eligibility Verification System ( <b>AEVS</b> ) (800) 456-2387	A state Medi-Cal verification phone line that allows providers to enter beneficiary information to obtain an automated Medi-Cal verification response.
Child and Family Services ( <b>CFS</b> )	A department of the Alameda County Social Services Agency that is focused on improving the lives of children and families in Alameda County by serving children and youth who have experienced, or are at risk of experiencing, abuse or neglect.
Child Welfare Worker ( <b>CWW</b> )	CWWs provide intensive assessment, case management and/or casework services directed toward providing the most stable home environment for children who have been or are in danger of being abused, neglected or abandoned.
Children’s Specialized Services ( <b>CSS</b> )	A BHCS clinical unit who monitors and coordinates services for children in the schools (for ERMHS, psychodiagnostic evaluations, IEP’s, coordination of care).
Client Plan	A treatment plan which includes a mental health diagnosis, current symptoms, treatment goals and interventions to address the specific mental health symptoms. The Client Plan must have measurable objectives and achievable within a 6 month authorization period. A client plan form developed by the BHCS Quality Assurance Office that is in compliance with Federal and State regulations if utilized correctly. Fee for service providers <u>must</u> utilize a BHCS Client Plan form.
Clinical Review Specialist ( <b>CRS</b> )	Licensed BHCS clinician (i.e. LCSW, MFT, PhD, PsyD, RN) who makes SMH referrals, reviews authorization requests &/or provides QA trainings and chart reviews.
<b>CMS</b>	Centers for Medicare and Medicaid Standards Department of Health and Human Services

Terms	Definitions
CMS 1500	Health Insurance Claim Form prescribed by CMS - see sample form
Credentialing and Re-Credentialing	The process by which BHCS authorizes contracts/agreements with individual and group providers who are licensed to practice independently in order to provide services to beneficiaries.
Customized Services	Mental health services that address the unique needs of Social Services, but are not billable to Medi-Cal.
Department of Health Care Services ( <b>DHCS</b> )	The California state Department of Health Care Services (the state) regulates the MH and SUD service contracts with the counties for all Medi-Cal services.
Educationally Related Mental Health Services ( <b>ERMHS</b> )	Mental Health services provided by school based providers with financial support of the school district.
Extension Package of Services	<p>26 total services in 6 month time span:</p> <ul style="list-style-type: none"> <li>• 1 session- Assessment/Treatment Plan</li> <li>• 20 Therapy sessions- Individual, Family and/or Group Therapy                             <ul style="list-style-type: none"> <li>➢ Individual (60 min) Family Therapy (60 or 90 min); Group Therapy (90 min)</li> </ul> </li> <li>• 3 hours- Brokerage/Linkage (30 and 60 min)</li> <li>• 2 hours- Collateral (10 and 45 min)</li> </ul>
Fee-for-Service ( <b>FFS</b> )	A method in which Mental Health providers are paid for each service performed. Examples of services are; evaluation, assessment and therapy.
Health Information Technology for Economic and Clinical Health ( <b>HITECH</b> )	This Act was signed into law February 17, 2009 to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information.
Health Insurance Portability & Accountability Act ( <b>HIPAA</b> )	The HIPAA Privacy regulations require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared.
Health Insurance Technician ( <b>HIT</b> )	BHCS staff who specialize in Medi-Cal enrollment and verification.
Health Program of Alameda County ( <b>HealthPAC</b> )	HealthPAC is a program created by the County to provide affordable health care to Alameda County residents without insurance. While HealthPAC provides basic health care to Alameda County residents, the program does not provide the same range of benefits as most health insurance plans. HealthPAC offers you a limited network of health care



Terms	Definitions
	providers (meaning there are only certain places that you can go for health care). If you use other services or other providers, you will likely be billed.
In-Network	Refers to providers, either as solo practitioners, group or organization, who are usually located within Alameda County and are contracted with BHCS' Mental Health Plan.
Individualized Education Program ( <b>IEP</b> )	A written document that's developed for each public school child who is eligible for special education.
Initial/Annual Package of Services	<p>26 total services in 6 month time span:</p> <p>Completed Assessment/Client Plan and MHP Managed Care Provider Attestation required prior to rendering treatment services</p> <ul style="list-style-type: none"> <li>• 2 sessions- Assessment/Treatment Plan</li> <li>• 20 Therapy sessions- Individual, Family and/or Group Therapy <ul style="list-style-type: none"> <li>➢ Individual (60 min) Family Therapy (60 or 90 min); Group Therapy (90 min)</li> </ul> </li> <li>• 2 hours- Brokerage/Linkage (30 and 60 min)</li> <li>• 2 hours- Collateral (10 and 45 min)</li> </ul>
Inpatient ( <b>IP</b> ) Group	A group of two or more licensed psychiatrists providing specialty mental health services in an inpatient facility.
Inpatient ( <b>IP</b> ) Individual	An individual licensed psychiatrist providing specialty mental health services in an inpatient facility.
Inpatient ( <b>IP</b> ) Service Provider (In-Network and Non-Network)	Psychiatrist or psychiatry group who render psychiatric evaluation and treatment services to beneficiaries who have been admitted to an acute medical or psychiatric inpatient setting or medical emergency room.
Inpatient Professional Services	Psychiatric evaluation/treatment services rendered by psychiatrists in acute psychiatric inpatient, acute medical inpatient, or medical emergency rooms.
Medicaid	A joint federal and state program that helps with medical costs for some people with limited income and resources.
Medi-Cal	California's Medicaid program
Medical Necessity Criteria	Title 9, California Code of Regulations (CCR), medical eligibility requirements for Specialty Mental Health Services.
Medi-Cal Specialty Mental Health Services ( <b>SMHS</b> )	SMHS is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act.

Terms	Definitions
Medication Evaluation and Monitoring	Providers evaluate whether medication would alleviate beneficiary’s symptoms, and if so, monitors effects of the medication. Only licensed psychiatrists, licensed psychiatric nurse practitioners, physician assistants, or clinical psychiatric pharmacists working under the supervision of a psychiatrist can provide these services.
Mental Health Plan (MHP)	An entity which enters into an agreement with the Department of Health Care Services (DHCS) to contract, arrange and/or provide Specialty Mental Health Services (SMHS) to beneficiaries. A MHP may be a county, counties jointly or another governmental or nongovernmental entity.
Mental Health Plan (MHP) Fee-For-Service (FFS) Provider	<p>Mental Health providers contracted by BHCS to provide outpatient mental health services to Alameda County residents who are eligible for mental health benefits under Medi-Cal or other funding streams within BHCS MHP.</p> <p>The MHP FFS Providers are a pool of mental health provider disciplines, including:</p> <ul style="list-style-type: none"> <li>• Licensed Clinical Social Workers (LCSW),</li> <li>• Licensed Marriage and Family therapists (MFT);</li> <li>• Licensed Professional Clinical Counselor (LPCC);</li> <li>• Licensed clinical psychologists (PhD/PsyD)</li> <li>• Psychiatrists (MD)</li> <li>• Groups</li> <li>• Organizations</li> </ul>
MH Initial Assessment – Long Form	A long mental health assessment form developed by the BHCS Quality Assurance Office that is in compliance with Federal and State regulations, if utilized correctly, and also has additional sections that considers the beneficiary’s current status in other important realms. The long assessment form <u>must be utilized for the Annual Assessment</u> and <u>may</u> be utilized for the initial assessment. Fee for service providers <u>must</u> utilize a BHCS assessment form.
MH Initial Assessment – Short Form	A short mental health assessment form developed by the BHCS Quality Assurance Office that is in compliance with Federal and State regulations, if utilized correctly. The short assessment form may be utilized for the <u>initial assessment only</u> . Fee for service providers <u>must</u> utilize a BHCS assessment form.
MH Progress Note	A mental progress note form developed by the BHCS Quality Assurance Office that is in compliance with Federal and State regulations if utilized correctly.
MHP Managed Care Provider Attestation Form (Provider Attestation Form)	Provider signed attestation document, certifying that a beneficiary currently meets Medi-Cal medical necessity criteria for Specialty Mental Health Services and that all

Terms	Definitions
	documentation is in compliance with Medi-Cal and BHCS standards; acknowledgment and agreement to submit requested documentation to BHCS for review/audit purposes.
Mild-Moderate	Beneficiaries with functional impairments in the mild-moderate range due to mental health issues receive mental health services through their managed care plan.
Moderate-Severe	Beneficiaries who meet SMH criteria with functional impairments in the moderate-severe range receive services through BHCS.
National Provider Identifier (NPI)	A unique identification number for covered health care providers. The NPI is a 10 digit number used in lieu of legacy provider identifiers in the HIPAA standards transactions. Visit the web site at <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a>
Non-Network	Usually refers to a psychiatrist or a psychiatry group who render psychiatric evaluations and treatment services to Alameda County beneficiaries who have been admitted to an acute medical or psychiatric inpatient setting or a medical emergency room while travelling outside Alameda County.
Notice of Action (NOA)	A Notice of Action is a written notification required by Federal and State regulation to be sent to the beneficiary when certain actions are taken by the Mental Health Plan (MHP) or a MHP provider. A Notice of Action informs a beneficiary of their rights to an appeal or State Fair Hearing. It is a 2-page document.
Other Health Coverage (OHC)	Beneficiary's eligible for Medi-Cal may also have other health coverage such as Medicare or private insurance. The Medicare and private insurance is also known as OHC and is considered the primary insurance plan. Medi-Cal is considered the plan of last resort.
Outpatient Provider	Provider who renders mental health services in an outpatient setting.
Outpatient Provider - Group	A group of two or more licensed clinicians who render managed care outpatient mental health services, which include assessment, therapy, collateral, and brokerage services.
Outpatient Provider - Individual	Licensed clinician (LCSW, LPCC, MFT, PhD, and PsyD) who renders managed care outpatient mental health services, which include assessment, therapy, collateral, and brokerage services. Licensed psychiatrist who renders psychiatric evaluations and treatment services, to include medication monitoring. Licensed psychologist who provides psychological testing.

Terms	Definitions
Outpatient Provider - Organization	A Medi-Cal site certified organization that includes both licensed and unlicensed clinicians who render managed care outpatient mental health services, which include assessment, therapy, collateral, and brokerage services.
Point of Authorization ( <b>POA</b> )	Function within the Mental Health Plan that receives provider communication regarding service and/or payment authorization requests.
Preauthorization	A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is necessary. Preauthorization is not a guarantee of payment.
Prepaid Health Plan ( <b>PHP</b> )	Contracts between an insurer and a subscriber or a group of subscribers whereby a specified set of health benefits is provided in return for a periodic premium, such as Kaiser.
Protected Health Information ( <b>PHI</b> )	Under US law, any information about health status, provision of health care, or payment for health care that is created or collected by a “Covered Entity” (or Business Associate of a Covered Entity), and can be linked to a specific individual. PHI includes, but is not limited to, names, geographic identifiers smaller than a state, dates, phone numbers, fax numbers, e-mail address, social security numbers, medical record numbers, health insurance beneficiary numbers, account numbers, full face photographic images, or any other unique identifying number, characteristic or code.
Provider Identification Number ( <b>PIN</b> )	DHCS issues a PIN for providers in our network so they can perform Medi-Cal verification processes.
Psychological Evaluation/Testing	Psychological testing is authorized only for the purpose of treatment and requires prior screening and approval by ACCESS. The testing may be provided by a licensed psychologist or a doctoral intern under the supervision of a licensed psychologist. The Provider collects information, reviews records and administers a battery of tests. The Provider provides diagnostic clarification, identification and treatment recommendations. The Provider conducts interviews with parents/caregivers and reviews relevant beneficiary records. The Provider’s testing report will include a mental health diagnosis, as appropriate; psychodiagnostic conclusions; and recommendations that address the treating clinician and CWW’s specific questions. Psychological testing requests from CWW’s that do not meet medical necessity criteria are paid for by Social Services (PTAR is not needed).
Psychological Testing Authorization Request ( <b>PTAR</b> )	Form that treating provider completes and sends to ACCESS (with relevant assessments, treatment plans, etc.) when requesting psychological testing.

Terms	Definitions
Psychosocial Assessment (also known as Mental Health Assessment)	Providers identify and clarify the beneficiary’s presenting problem; the psychological impact of the trauma; the beneficiary’s strengths and challenges; the beneficiary’s mental health diagnosis and recommendations regarding treatment and/or placement needs.
Psychotherapy	Providers provide treatment with the goal of decreasing beneficiary’s symptoms and improving functioning.
Quality Assurance (QA)	The BHCS Quality Assurance Office provides monitoring and oversight for the Mental Health Plan and Substance Use Disorder Treatment program to ensure compliance with Federal and State regulations.
Re-Credentialing	BHCS re-credentials individual and providers who are part of a group every three years from the initial date of credentialing.
Referral Letter	A referral letter from ACCESS notifying Providers that a beneficiary has been referred to them; the requested service, the beneficiary’s insurance plan and any special instructions that correspond with that plan.
Request for Continued Services (RCS)	BHCS form utilized by Providers to request additional outpatient service authorization, outside of the Initial Package of Service authorization.
Request for Prior Consultation	Forms that a provider may complete and send to ACCESS for screening/authorization for a beneficiary who is requesting their services. This is an alternative to calling ACCESS to request screening and authorization.
Revert	A provider’s repayment to BHCS for services paid in error or for clients with retroactive primary benefits. This results in a credit (-) on future provider checks.
Screening Form – Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary	Instrument used to determine if beneficiary’s impairments falls in the mild-moderate or moderate-severe range.
Share of Cost (SOC)	A Client’s SOC is determined by the county welfare department based on the beneficiary/family’s income and living arrangement, if these change then the SOC may change. Members of the family may have the same or different SOC amounts. SOC beneficiaries must meet their SOC for medical expenses before Medi-Cal will pay claims for services provided in that month above the SOC amount.
Specialty Services Providers	Providers designated to provide specialty services such as Eating Disorder treatment, ERMHS assessment, and Murphy Conservatorship evaluation. See Section VI. Items C and D for a complete listing.

Terms	Definitions
Supplemental Security Income ( <b>SSI</b> )	The Social Security and Supplemental Security Income disability programs are the largest of several Federal programs that provide assistance to people with disabilities. While these two programs are different in many ways, both are administered by the Social Security Administration and only individuals who have a disability and meet medical criteria may qualify for benefits under either program.
Treatment Authorization Request ( <b>TAR 18-3</b> )	Inpatient payment authorization request form. A state Medi-Cal form required for approval of inpatient days and their professional fee component. These are sent from the hospital to BHCS UM for approval for Alameda County MH Medi-Cal beneficiaries.
UB04 (CMS 1450)	The basic Uniform Billing form for institutions prescribed by CMS.
Utilization Management ( <b>UM</b> ) Program	Utilization Management Program. The BHCS Point of Authorization for any subsequent Specialty Mental Health Fee-for-Service service authorization requests and inpatient payment authorization requests.

