

# COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH LOCAL MENTAL HEALTH PLAN



## MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES *PROVIDER MANUAL* FIFTH EDITION JULY 20 14

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**LAC  
DMH**  
LOS ANGELES COUNTY  
DEPARTMENT OF  
MENTAL HEALTH

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## INTRODUCTION

Welcome to the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP).

On June 1, 1998, under a State mandate, the LMHP implemented Phase II Consolidation of Medi-Cal specialty mental health services. Phase II consolidated specialty mental health services delivered by private fee-for-service providers with the Short Doyle/Medi-Cal Community Mental Health System under the umbrella of the LMHP.

This revised County of Los Angeles Department of Mental Health Local Mental Health Plan Medi-Cal Specialty Mental Health Services Provider Manual, Fifth Edition, July 2014 replaces, in its entirety, the Provider Manual, fourth Edition, July 2009. As updates, changes and additions to the current manual are required, you will receive Provider Bulletin publications which will supersede or augment the specified content in the Provider Manual, Fifth Edition, July 2014.

The Provider Manual and all subsequent Provider Bulletins have the same authority as the Medi-Cal Professional Services Agreement which stipulates that providers shall perform specialty mental health services in accordance with the terms and conditions of the legal agreement and the requirements in the LMHP Provider Manual and Provider Bulletins.

For your convenience the Provider Manual is located on the LMHP website at <http://dmh.lacounty.gov/>. Select "Services." Then select "Provider and Contractor Info."

We trust that you will find the Provider Manual to be a valuable and useful resource. If you have any questions, or need additional information please feel free to contact the Provider Support Office at (213) 738-3311

We look forward to working with you to ensure the delivery of quality specialty mental health services to Los Angeles County Medi-Cal beneficiaries.

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
LOCAL MENTAL HEALTH PLAN**

**Important Phone Numbers**

ACCESS Center	(800) 854-7771
Central Authorization Unit	(213) 738-2466
Help Desk	(213) 351-1335
Individual and Group Provider Contracts	(213) 738-4829
Over-threshold Services	(213) 738-2465
Patients' Rights/Beneficiary Services Program	(213) 738-4949
Provider Credentialing	(213) 738-2814
Provider Reimbursement Unit	(213) 738-2309
Provider Support Office	(213) 738-3311
Psychological Testing	(213) 738-2465
Rebillable Denial Claim Report (EOB)	(213) 738-3311

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES**

**Medi-Cal Provider Telephone Service Center**

(800) 541-5555

**LOS ANGELES MEDI-CAL FIELD OFFICE**

311 S. Spring St.  
P.O. Box 60172, MS 4513  
Los Angeles, CA 90060-0172

Call (213) 897-0745  
for  
Medi-Cal Case Management  
Hospital Services Section  
Allied Health Services/Appeals

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## SECTION I – PURPOSE, PRINCIPLES AND GOALS

### PURPOSE

The purpose of the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) is to administer all Medi-Cal and State grant funds for specialty mental health services that are in compliance with the Health Insurance Portability and Accountability Act (HIPAA), and designed to ensure availability and accessibility of quality mental health care for Los Angeles County Medi-Cal beneficiaries. These services include, but are not limited to, mental health assessment; individual, group and family therapy; mental health services in inpatient, outpatient, and residential settings; medication support and psychological testing.

The LMHP is responsible for informing fee-for-service providers (network providers) of the specialty mental health services provided by the LMHP, referring Medi-Cal beneficiaries to qualified mental health network providers, maintaining a HIPAA-compliant information system, providing quality management services, processing submitted claims, reimbursement, and evaluating mental health services.

### PRINCIPLES

The LMHP is governed by the following principles:

- Services are provided to any Medi-Cal eligible beneficiary meeting medical necessity criteria for specialty mental health services;
- Culturally sensitive services are delivered to ethnically diverse populations in the communities in which they are located;
- Services are client-centered, family-focused and culturally competent;
- Treatment is provided to the greatest extent possible in the individual's own community and at the least restrictive but most effective level of care;
- Innovative treatment approaches and clinical practices are utilized to optimize the clinical outcome;
- Possibilities for relapse are reduced through the identification and coordination of ongoing mental health services; and
- Medi-Cal beneficiary's treatment preference and selection of a network provider are honored.

### GOALS

- Establish working relationships in a public-private partnership with network providers to provide quality specialty mental health services;
- Maintain a network of skilled and effective network providers selected and retained based on demonstrated clinical performance;
- Match treatment needs to a network provider with specialized skills to address the needs of the Medi-Cal beneficiary; and
- Maintain a comprehensive well-managed mental health system to relieve clinical and symptomatic distress and improve the quality of life for Medi-Cal beneficiaries.

## SECTION II – THE PROVIDER NETWORK

The Local Mental Health Plan (LMHP) Provider Network is comprised of licensed mental health professionals whose scope of practice permits the practice of psychotherapy independently. Network providers may be psychiatrists (MD/DO), psychologists (PhD/PsyD), licensed clinical social workers (LCSW), licensed marriage and family therapists (MFT), or registered nurses (RN) who are board certified with a master's degree in psychiatric/mental health nursing as a clinical nurse specialist or as a nurse practitioner. Nurses and Nurse Practitioners must be certified by the American Nurses Credentialing Center (ANCC) or the American Association of Nurse Practitioners (AANC) in behavioral health.

All mental health providers must be credentialed and contracted with the LMHP to receive reimbursement for specialty mental health services provided to Los Angeles County Medi-Cal beneficiaries. Credentialed providers may contract with the LMHP as an individual provider or render services as part of a contracted group. A group is comprised of two or more licensed, credentialed mental health providers.

### CREDENTIALING

Credentialing is the formal process of collecting and verifying the professional credentials and qualifications of licensed providers and evaluating them against the standards and requirements established by the LMHP to determine whether such licensed providers meet these standards and requirements. Before an LMHP network applicant can be offered a LAC-DMH contract, he or she must apply for enrollment in the State Medi-Cal program, and be free and clear of any Medi-Cal related adverse actions.

Network providers are required to re-credential every three years in order to continue to participate in the LMHP Provider Network. Providers will be sent an email reminder or letter and an application to re-credential approximately four months prior to the expiration of their credentials. A certified letter with return receipt will be mailed to the provider if the re-credentialing application is not submitted within a month of the expiration date

Note: It is the network provider's responsibility to maintain current credentials. A network provider's failure to maintain current credentials will result in the termination of reimbursement privileges for specialty mental health services rendered to Medi-Cal beneficiaries. Dates of service upon which a network provider has experienced a break in active credentialing status will not be subject to retroactive reimbursement. Even if a contract is in place at the time credentials lapse, the contract is considered in default, and claims will not be reimbursed until the provider's credentials are renewed.

### APPLICATION

Mental health providers may request a credentialing application by contacting the Provider Credentialing Unit at (213) 738-2814 or at (213) 738-2465. A request may also be faxed to (213) 487-9658. When requesting credentialing applications, mental health providers should provide the following information: 1) full name, discipline, mailing address, and email address (please include a 9 digit zip code); 2) telephone and fax number (applicants must provide a phone number that would allow direct contact); 3) whether the requested application is to provide specialty mental health services as an individual or as a group provider; and 4) if the provider will be providing services within the geographic boundaries of Los Angeles County. Applications will be mailed within 2-3 working days.

The application packet contains the credentialing application form entitled *Application to Participate as a Provider in the Los Angeles County Department of Mental Health Local Mental Health Plan* and all the necessary information for completing the application requirements (Attachment III).

The following documents are required in addition to the completed credentialing application form:

- General Administration Profile Self-Assessment (Attachment I)
- Outpatient Chart Review Checklist (Attachment II)
- Psychiatrist are to include a copy of their current Drug Enforcement Agency (DEA) Certificate, a current curriculum vitae, a Certificate of Professional Liability Insurance, a completed *Rendering Provider Form* (Attachment V) and a *Consent To Release Information To Biller Form*, if applicable.
- Psychiatrists must be either board certified or board eligible in order to provide services under the LMHP. Psychiatrists who are not board certified must include a copy of their certificate of completion of psychiatric residency training.
- Psychologists, LCSWs and MFTs are to include a curriculum vitae, a Certificate of Professional Liability Insurance, a completed *Rendering Provider Form* (Attachment V) and a *Consent To Release Information To Biller Form*, if applicable.
- Clinical nurse specialists and nurse practitioners are to include a curriculum vitae, a Certificate of Professional Liability Insurance, Proof of ANCC or AANP certification in behavioral health, a completed *Rendering Provider Form* (Attachment V) and a *Consent To Release Information To Biller Form*, if applicable.
- Clinical nurse specialists are also to submit proof of graduation from a master's degree program in psychiatric/mental health nursing as a clinical nurse specialist or a master's degree within a scope of practice that includes psychotherapy
- Nurse practitioners are also to submit a DEA certificate and proof of graduation from a master's degree program in psychiatric/mental health nursing as a nurse practitioner (the quality of graduate program's curriculum as well as applicant's experience will be included in the overall decision).

All affirmative answers to any professional liability or attestation questions on pages five through seven of the application require a detailed explanation including supporting documents from the court(s) or attorney(s). Documentation from the appropriate licensing board is required if disciplinary action has been taken, or is pending, against a provider. Applicants will also be required to attest that they have downloaded and read the LMHP Provider Manual. The manual can be downloaded at: [http://dmh.lacounty.gov/wps/portal/dmh/admin\\_tools/prov\\_manuals](http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals)

## GROUP APPLICATION

Group network providers must include two or more credentialed mental health providers. A group provider may request a *Group Network Provider Application Form* (Attachment IV) by contacting the Provider Credentialing Unit at (213) 738-2814 or at (213) 738-2465. A request may also be faxed to (213) 487-9658. The following information will be required on the group application:

- The name and address of the group;
- The group Medi-Cal provider and NPI numbers;
- The names of the rendering providers in the group and their Medi-Cal provider and NPI numbers; and
- The name of the person in the group authorized to enter into legal agreements on behalf of the group.

To add new group members after the group has been contracted, submit a *Group Network Provider Application Form* and include page 2 of the application with an updated list of the group members.

The completed application form for individual and group providers, including all the required documents, is to be submitted via mail or fax to:

Department of Mental Health  
Provider Credentialing Unit  
550 S. Vermont Ave., Room 703B  
Los Angeles, CA 90020  
Fax: (213) 487-9658

Note: The County shall not be responsible to provide or arrange and pay for specialty mental health services provided by federally qualified health centers, Indian health centers, or rural health centers.

## **CONTRACT WITH THE LMHP**

After completion of credentialing, the Contracts Development and Administration Division (CDAD) will send credentialed individual providers an individual provider legal agreement. The agreement is to be signed and returned to CDAD for processing with all the required documents.

Group providers will be sent a group provider legal agreement, which must be signed by the legally authorized representative of the group.

When contract processing is successfully completed the individual or group provider will be sent a signed, dated, executed legal agreement signed by the Director of the Department.

Note: Reimbursement may only occur after the legal agreement is executed and only for specialty mental health services delivered on or after the effective date of the legal agreement. Retroactive reimbursement for services delivered prior to the completion of an executed contract will not be authorized.

## **CREDENTIALING POLICIES AND PROCEDURES**

Credentialing policies and procedures are included at the end of this section to provide detail regarding credentialing, re-credentialing, due process requirements for the limitation and termination of a provider's privileges and a provider's right to an independent review of any decisions to deny or restrict participation in the Provider Network (Attachments VI to IX).

## **CREDENTIALING REVIEW COMMITTEE**

The purpose of the LMHP Credentialing Review Committee (CRC) is to ensure that the initial and ongoing credentials of the applicants and Network Providers are evaluated and maintained in accordance with the credentialing standards established by the LMHP.

New Applicants and existing Network Providers may be referred to the CRC according to established criteria. The CRC shall review cause for concern and recommend action to the Medical Director of DMH. Network Providers shall be notified and due process shall be given for any recommended adverse action.

## NATIONAL PROVIDER IDENTIFICATION AND TAXONOMY

As of 2008, all providers are required to obtain a National Provider Identifier (NPI) prior to applying to the LMHP. Providers who do not have a NPI will be unable to reimbursement for specialty mental health services. To apply to a National Provider Identifier, go to the National Provider and Plan Enumeration System (NPPES) website at:

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>

During the process of obtaining a NPI, providers will need to submit a taxonomy which is related to the license or certification they possess. It is necessary to ensure that all licensure and certification properly reflect eligibility to render specialty mental health services.

The following taxonomies are applicable to Fee-for-Service Network providers:

Discipline	Taxonomy
M.D. / D.O.	2084P0800X
Ph.D. / Psy.D	103TC0700X
L.C.S.W.	1041C0700X
M. F.T.	106H00000X
R.N.	163WP0808X
N.P.	363LP0808X
CNS (child)	364SP0807X
CNS (adult)	364SP0809X

## INDIVIDUAL VS. INCORPORATION PROVIDERS

Individual providers are considered sole practitioners whom shall have a Type I NPI in the NPPES system, and a contract and credentialing application stating as such. Incorporations are considered sole practitioners; however, they must have a Type I and Type II NPI in the NPEES system, as well as, a contract and credentialing application stating they are to be recognized as an incorporated entity. Even though a provider has a Type I and Type II NPI in NPPES, if they have not contracted with DMH and the LMHP as an incorporation, they will still be considered as an individual provider.

## REGISTRATION AS A COUNTY OF LOS ANGELES VENDOR

All newly contracted individual and group network providers who provide a Federal Tax ID Number to the LMHP must register with the County of Los Angeles as a vendor in order to receive payments.

Registration as a vender may be completed online via the internet by accessing the County of Los Angeles homepage and vendor registration website address at: <http://camisvr.co.la.ca.us/webven/>.

Provider Vendor information must be correct and current in order to continue to receive payments. Contact ISD Vendor Relations at (213) 267-2725 or (213) 323-881-3613 if assistance is needed to modify the information in the system.

## ON-LINE VENDOR REGISTRATION REQUIREMENT

In order to receive payments, network providers who have contracted with the LMHP using a Federal Employment Identification Number (FEIN) are required to register as a vendor with the County of Los Angeles, Internal Services Department (ISD) at the following website address: <http://camisvr.co.la.ca.us/webven/>.

Do not register as a vendor if the network provider contracted with the LMHP using a social security number only and did not provide a FEIN. It is recommended that network providers confirm in the system, via the "Vendor Search" link, whether a registration has already been completed before starting the registration process. Registrants should also be prepared to enter the network provider's FEIN.

Click on the "New Registration" link at the website listed above. Enter Your FEIN or SSN to begin the process.

Note: The network provider's name and address must be exactly the same as the billing address used on their credentialing application and contract to avoid reimbursement delays. In the event that a change of billing address becomes necessary, network providers must also update their ISD vendor registration by selecting "Change Registration" at the website listed above in a timely manner to avoid reimbursement delays.

Please contact ISD Vendor Relations at (323) 267-2725 or (323) 881-3613 for questions regarding vendor registration.

## **CHANGES IN PROVIDER STATUS AND CONTACT INFORMATION**

It is very important to advise the LMHP of any changes that would affect a network provider's contract or ability to receive payment, such as a request to terminate the contract; a change in corporate status; changes in mailing, billing or service location addresses; or changes in required insurance coverage. The *Contractor Address Form* (Attachment X) is to be completed to report address changes.

Submit all changes via mail or fax to:

Department of Mental Health  
Contracts Development and Administration Division  
550 S. Vermont Ave., 5<sup>th</sup> Floor  
Los Angeles, CA 90020  
Fax: (213) 381-7092  
Attn: Managed Care Section

## **CONTRACT TERMINATION**

Network providers who elect to terminate their contract are responsible for notifying current clients in writing that they are no longer a Medi-Cal provider in the LMHP Provider Network effective the date of contract termination. The notification letter is to also advise the client that they may contact the ACCESS Center or the Patients' Rights Office to receive referrals to other LMHP network providers, directly operated providers or contract providers. Network providers may elect to utilize the sample notification letter (Attachment XI). The Beneficiary Services Program Specialist will provide assistance to the client in transferring to another mental health provider.

The network provider is to send one copy of the client notification letter and a list of clients that were sent the notification letter to:

Department of Mental Health  
Patients' Rights Office  
550 S. Vermont Ave., 6th Floor  
Los Angeles, CA 90020

**COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH**

The General Administrative Profile and Chart Review Checklist are mandatory self-assessment tools sent to the Network Providers biennially. Network providers are to utilize these tools to review their administrative procedures and clinical practices to evaluate compliance with the LMHP legal agreement and Medi-Cal requirements. Please complete this assessment in its entirety and submit it with your application.

**GENERAL ADMINISTRATIVE PROFILE  
Self-Assessment  
Individual and Group Network Providers  
Page 1 of 8**

**PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_  
Provider Discipline: MD, DO, PhD, PsyD, LCSW, MFT, NP, CNS  
Provider License/Certification Number: \_\_\_\_\_

Provider Medi-Cal Number: \_\_\_\_\_  
Provider's LMHP Status:  Individual Contract  Group Contract

Primary Office Address: \_\_\_\_\_  
\_\_\_\_\_

Is this a  private residence, or  office building?

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Services provided at this location to:  Children,  Adolescents,  Adults,  Older Adults (65+)

Secondary Office Address: \_\_\_\_\_  
\_\_\_\_\_

Is this a  private residence, or  office building?

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Services provided at this location to:  Children,  Adolescents,  Adults,  Older Adults (65+)

Tertiary Office Address: \_\_\_\_\_  
\_\_\_\_\_

Is this a  private residence, or  office building?

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Services provided at this location to:  Children,  Adolescents,  Adults,  Older Adults (65+)

*(Attach additional addresses if more than three. Please complete the succeeding pages of this assessment separately for each of the addresses.)*

Name of Individual Completing Form: \_\_\_\_\_

Date Completed: \_\_\_\_\_

No Outpatient Services Provided

**A. ADMINISTRATION**

**1. PHYSICAL ENVIRONMENT**

- a. Is your office maintained in a manner that provides for the physical safety of beneficiaries, visitors and personnel? Yes No
- b. Is your office clean, sanitary and in good repair? Yes No
- c. Does your office meet federal requirements of the Americans with Disability Act? Does it have:
  - 1) Ramps for accessibility? Yes No
  - 2) Bathrooms that can accommodate wheelchairs? Yes No
  - 3) Handicapped parking: Yes No

**2. ADMINISTRATIVE PROCEDURES**

- a. In accordance with your contract, are you aware of the provisions of Article 9, Chapter 4, Section 6150 of the Business and Professions Code related to Unlawful Solicitation? Yes No
- b. Do you maintain a Drug-Free workplace? Yes No
- c. Do you maintain a smoke-free workplace? Yes No
- d. In accordance with your contract, are you knowledgeable about the child, dependent adult and elder abuse reporting laws and the reporting requirements? Yes No
- e. In accordance with your contract, do you ensure there is no evidence of discrimination on the basis of ethnic group identification, race, creed, religion, age, sex, or physical and mental disability in the provision of services to clients? Yes No
- f. Do you maintain appropriate Health Insurance Portability and Accountability (HIPAA) policies, including:
  - 1) Informing clients about HIPAA upon admission; Yes No
  - 2) Use and Disclosure of Protected Health Information Requiring Authorization; Yes No
  - 3) Use and Disclosure of Protected Health Information (PHI) without Authorization; Yes No
  - 4) Clients Right to Access Protected Health Information. Yes No
- g. Do you inform clients about the need for an Advance Health Care Directive? Yes No

**3. CONFIDENTIALITY**

- a. Are beneficiary records accessible only to authorized personnel? Yes No

- b. Describe how you protect the confidentiality of client records and govern the disclosure of information in the records. (W&I Code 5328; Calif. MH Confidentiality Laws; Title 22)
- c. Have you educated and/or trained all your office staff on maintaining beneficiary confidentiality at all times? Yes No

**1. MAINTENANCE OF RECORDS**

- a. Where are clinical records maintained?
- b. Do you fulfill your responsibility to safeguard and protect clients records against loss, unauthorized alteration or disclosure of information? Yes No
- c. Are you in compliance with the following consent standards stipulated in the current Medi-Cal Specialty Mental Health Services Provider Manual?
  - 1) A signed Consent for Services is obtained at first contact with beneficiary Yes No
  - 2) An appropriately executed Consent of Minor is obtained at first contact with a beneficiary who is a minor. Yes No
  - 3) A signed Informed Consent for Psychotropic Medication is obtained from the beneficiary when prescribing psychotropic medication. Yes No
  - 4) A signed Authorization to Release Information is obtained from the beneficiary as to what information is released from the beneficiary's record. Yes No
- d. Are you in compliance with the minimum requirement of clinical records/documentation standards stipulated in the Medi-Cal Specialty Mental Health Services Provider Manual?
  - 1) Are clinical records retained at least seven years from the time of discharge for clients who are at least eighteen years of age or legally emancipated at the time of discharge? Yes No
  - 2) Are records that have audit or legal action pending retained 3 years after the issues have been settled or seven years from the date of discharge, whichever is longer? Yes No
  - 3) If the client is a minor or not legally emancipated at the time of discharge, are clinical records retained at least one year after such minor has

reached the age of 18, but never less than seven years?

Yes No

**B. ACCESS/AUTHORIZATION**

1. How many Medi-Cal clients were referred to you last Fiscal Year, either through a DMH directly operated or contracted agency? \_\_\_\_\_

2. Of this number, how many were you able to serve? \_\_\_\_\_

3. Are you familiar with the DMH directly operated or contracted agencies in the area(s) where you practice?

Yes No

- Identify the Mental Health agencies you communicate/coordinate with the most frequently.

4. Describe the type of relationship you have with the mental health agencies in your area(s).

**C. NOTIFICATION**

Is Notice of Action-A (NOA-A) issued when services are denied based on medical necessity criteria?

Yes No

1. Are notices informing beneficiaries of their access to specialty mental health services and the LMHP complaint and grievance procedures posted in an area in ready view of the beneficiaries?

Yes No

2. Are Patients' Rights brochures in appropriate languages?

Yes No

3. Are Patients' Rights brochures in the appropriate languages, displayed in an area in ready view of the beneficiaries?

Yes No

4. Are Grievance, Appeal Procedures-and State Fair Hearing pamphlets in appropriate languages?

Yes No

5. Are Grievance Appeal Procedure and State Fair Hearing pamphlets in appropriate languages, displayed in an area in ready view of the beneficiaries?

Yes No

6. Do you provide a copy of the Beneficiary Booklet (Informing Material) to the beneficiaries upon first receiving Specialty Mental Health Services and upon request?

Yes No

**D. MEDICATION COMPLIANCE**

**Use only if you store and dispense medications.**

**1. DISPENSING DRUGS**

a. Are drugs ordered and dispensed only by persons lawfully authorized to do so?

Yes No

- b. Is the medication supply at your office under the direct responsibility of a physician or staff whose professional license include dispensing, and administration of medication ? Yes No
- c. Are medications administered only by persons whose scope of professional license include dispensing and administration of medication? Yes No
- d. For each medication administered at your office, are the following data recorded on a Medication Log Sheet?
- 1) Date Yes No
  - 2) Patient's name Yes No
  - 3) Amount dispensed Yes No
  - 4) Signature-and license of the person administering the medication Yes No
- e. Are multi-dose vials dated and initialed when opened? Yes No

**2. PHARMACEUTICAL SAMPLES**

- a. Are "Samples" stored in a locked cabinet or other storage container, under lock and key? Yes No
1. Is a log maintained for each "sample" kept and does it include the following:
- Date dispensed Yes No
  - Patient's name Yes No
  - Amount dispensed Yes No
  - Name of authorizing physician Yes No
  - Initials of person dispensing Yes No
  - Balance of remaining inventory Yes No
- b. Are medication "samples" dispensed in the original manufacturer's packaging with directions on how to take the medication affixed to the package? Yes No

**3. LABELING AND STORING OF DRUGS**

- a. Are prescription and non-prescription drugs labeled in compliance with state and federal laws? Yes No
- b. Do you ensure that prescription labels are altered only by persons legally authorized to do so? Yes No
- c. Are drugs intended for external use only stored separately? Yes No
- d. Do you have a means to monitor the room temperature of the storage area where medications are kept? Yes No
- e. Is a log maintained to show the date, time, temperature and signature of the person responsible for the weekly monitoring function? Yes No
- f. Are drugs stored at proper temperatures, i.e., room temperature drugs at 59-86 degrees F

- (15-30 degrees C)?  Yes  No  
 refrigerated drugs at 36-46 degrees F (2-8 degrees C)?  Yes  No
- g. Are drugs stored separately from foodstuff and other agents, and are drugs clearly labeled?  Yes  No
- h. Are drugs stored in an orderly manner, in a secure area with access limited to authorized personnel, and controlled by policy and practice, including "sample" drugs?  Yes  No
- i. Are drugs retained after the expiration date?  Yes  No
- j. Do you keep drug containers that are cracked soiled or poorly secured?  Yes  No

**4. DISPOSAL OF DRUGS AND INJECTABLE MATERIALS**

- a. Do you dispose of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws?  Yes  No
- b. Is a log maintained of drugs that have been disposed of, including "sample" drugs?  Yes  No
- c. Are needles and syringes disposed of in accordance with the Center for Disease Control guidelines?  Yes  No

**F. CLIENT INFORMATION (FOR MEDICAL CLIENTS SEEN THROUGH YOUR CONTRACT WITH THE DEPARTMENT OF MENTAL HEALTH ONLY)**

	Primary Location	Secondary Location	Tertiary Location
1. Indicate the total number of cases presently open at each of your provider locations	_____	_____	_____
2. How many clients are dually diagnosed, substance abuse/mentally ill?	_____	_____	_____
3. How many clients are dually diagnosed, mental retardation/mentally ill?	_____	_____	_____
4. How many clients are wards or dependents of the courts?	_____	_____	_____
5. How many forensic clients are part of your caseload?	_____	_____	_____
6. Please provide the following specific client data			
♦ The ethnicity			

percentages of clients at  
each provider location.

1)	Caucasian	_____	_____	_____
2)	Hispanic	_____	_____	_____
3)	African-American	_____	_____	_____
4)	Asian/Pacific Islander	_____	_____	_____
5)	Native American	_____	_____	_____
6)	Other (Please specify)	_____	_____	_____

Primary  
Location

Secondary  
Location

Tertiary  
Location

- 9) What is the age range of the clients you serve? \_\_\_\_\_
- 10) How many clients do you refer to an emergency room each month for psychiatric hospitalization? \_\_\_\_\_
- 11) Are beneficiary telephone numbers and addresses updated when there is a change?  Yes  No

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHART REVIEW CHECKLIST

INDIVIDUAL AND GROUP NETWORK PROVIDERS

<b>Outpatient Chart Review Checklist - Managed Care Division, Compliance Unit</b>			
<b>Client's First Name:</b>	<b>MR#</b>		
<b>Line #</b>			
<b>Provider:</b>	<b>Reviewer:</b>		
<b>Provider ID Number:</b>			
<b>Date of Admission:</b>			
<b>Section I Administration - Required Forms</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
One of these Consents is present (indicate which with a yes):			
Consent for Services signed by client/parent/guardian or refusal to sign is documented			
Medication Informed Consent has been completed			
Acknowledgement of Receipt of Privacy Practices			
Evidence that informing materials were provided to client or caregiver upon first accessing services & upon request?			
Are Patients' Rights posters, beneficiary grievance, appeal forms and LMHP self-addressed envelopes prominently displayed in the Provider's workplace where Medi-Cal beneficiaries are being seen?			
Is there a complete medical/clinical record for every beneficiary?			
<b>Section II Engagement: Beneficiary and/or Family Participation</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Is the beneficiary's ethnicity and culture identified in the clinical record?			
Is there evidence that interpreter services are provided when applicable? (N/A when English)			
Is the address of the beneficiary correctly identified in the clinical record?			
Is the current telephone number of the beneficiary correctly identified in the clinical record?			
Are efforts made to include active participation of key family members or substitute caregivers in the team meetings where service decisions are made that impact their lives? (review if client is a child)			
Are special accommodations made to encourage participation? (review if client is a child)			
If the child is over 12 years old and capable, do progress notes indicate the child's participating in planning life goals, deciding in service arrangements to support and achieve success in school and life? (N/A when under 12)			
<b>Section III Assessment</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Are all the components of an Assessment as required in the Provider Manual, Section VII completed?			
a) Presenting Problems			

b) Relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma			
c) Mental Health History: Previous tx, response, inpatient admissions			
d) Medical History: Relevant physical health condition. If child, must include prenatal and perinatal events			
e) Medications: Information on medications the beneficiary is receiving or has received to treat mental and/or physical health conditions; absence or presence of allergies or adverse reactions to medications; documentation of an informed consent to medications			
f) Substance Exposure/Substance Use			
g) Client strengths and functional impairments			
h) Risks: Includes situations that present a risk to client and/or others, including past and present trauma			
i) A mental status examination			
j) Diagnosis from the most current DSM or most current ICD-code consistent with presenting problems is the Assessment completed within the required timeframe? (within 2 months of admission; 30 days for new episode) Is there a new re-assessment every three (3) years? If there is no medical necessity for admission, is a Notice of Action- Assessment (NOA-A) form given to the client?			
<b>Section IV Medical Necessity</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Does the client meet all three of the following reimbursement criteria (1a, 1b, 1c below)?			
1a. The client has a DSM IV diagnosis contained in the CCR, Title 9, Section 1830.205(b)(1)(A-R) *			
1b. The client, as a result of a mental disorder listed in 1a. Must have at least, one of the following criteria (1-4 below) *			
1) A significant impairment in an important area of functioning.			
2) A probability of significant deterioration in an important area of functioning.			
3) A probability that the child will not progress developmentally as individually appropriate.			
4) For full-scope MC clients under the age of 21, a condition as a result of the mental health disorder that SMHS can correct or ameliorate.			
1c. Must meet each of the intervention criteria listed below:			
1) The focus of the proposed intervention is to address the condition identified in No. 1b.(1-3) above, or for full- scope MC clients under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate per No. 1b (4)			
2) The expectation is that the proposed intervention will do, at least, one of the following (A, B, C, D): *			
A. Significantly diminish the impairment.			
B. Prevent significant deterioration in an important area of life functioning			
C. Allow the child to progress developmentally as individually appropriate.			
D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.			
<b>Section V Client Treatment Plan * (If no Treatment Plan)</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Is there a treatment plan formulated within 2 months of admission? *			

Does the treatment plan have the following components?			
a) Are the goals specific, measurable, achievable, realistic, time framed and related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis?			
b) Identify proposed types of interventions, including detailed description of the intervention to be provided?			
c) Have a proposed duration and frequency of intervention?			
d) Interventions that focus and address the functional impairments and consistent with client plan goals?			
e) Consistent with the qualifying diagnosis?			
f) Is the client plan signed by one of the following discipline: Physician/Psychiatrist; Licensed Psychologist ; Licensed Social Worker; Licensed Marriage and Family Therapist; Registered Nurse (NP or CNS) *			
g) Is there a dated, client or legal guardian signature? *			
h) Is the plan updated annually? *			
Is there documented evidence that a copy of the treatment plan was offered to the beneficiary?			
<b>Section VI Tracking, Adapting, and Plan Implementation</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Are identified needs and problems being acted on in a timely manner?			
Is progress or lack thereof being identified and noted?			
Are new strategies developed if no progress is observed?			
Are detected problems being reported and addressed promptly?			
Is the plan being modified as a result of progress made, not made or changes in the client's condition or living situation?			
Are crisis situations being addressed promptly?			
<b>Section VIII - Progress Notes</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Progress notes document the following:			
a) Is there documentation of medical necessity? *			
b) Is there documentation of beneficiary encounters, including relevant decisions/interventions? *			
c) Is the beneficiary's response to the intervention(s) documented? *			
d) Is there a signature (or electronic equivalent) of the staff providing the service with professional degree, license, or job titles?*			
e) Are dates and total time of services provided accurately documented?			
f) Correct Procedure Codes?			
g) Is there a service provided? *			
h) Is the claim for a group activity properly apportioned to all clients present? *			
i) Is there a progress note found for service claimed? *			
j) Is the time claimed equal to the time documented? (Deny if amount claimed is greater than time documented)			
k) Is documentation is legible?			
<b>For Reviewers: (Include a walkthrough of the facility to ensure compliance to self-assessment tool)</b>			

## Credentialing Application Instructions

Individual providers and group rendering providers are licensed or certified (registered nurses only) to practice psychotherapy independently and must be credentialed by the Local Mental Health Plan (LMHP). Non-psychiatric physicians may not be credentialed with the LMHP.

- Credentials will be renewed every three years.
- LCSWs, MFTs and clinical nurse specialists will be reimbursed only for clients ages 20 and under.
- The credentialing application must be typed or printed legibly.
- Applicants must provide a phone number and an email address that allows direct contact
- All providers must report their DUNS (Dun & Bradstreet) number, which uniquely identifies providers in the claims submission processing. The following website allows you to register for the DUNS number: <http://www.sba.gov/content/getting-d-u-n-s-number>. In addition to including your DUNS number in the application, please submit your DUNS number via email to [CPTT@dmh.lacounty.gov](mailto:CPTT@dmh.lacounty.gov).
- Visit the National Plan & Provider Enumeration System (NPES) website and ensure your primary taxonomy matches your discipline, as illustrated in the following chart:

Discipline	Taxonomy
M.D. / D.O.	2084P0800X
Ph.D. / Psy.D	103TC0700X
L.C.S.W.	1041C0700X
M. F.T.	106H00000X
R.N.	163WP0808X
N.P.	363LP0808X
CNS (child)	364SP0807X
CNS (adult)	364SP0809X

- The provider application must be completed in its entirety.
- If the answer to any professional liability question is “yes”, provide full details on an attached separate sheet and include all pertinent documents from the court and/or attorneys.
- If the answer to any attestation question is “yes”, provide full details on an attached separate sheet. Documentation is required from the professional licensing board if any action has been taken against your license. Additionally, documentation is required from Medi-Cal or Medi-Caid authorizing final disposition on any adverse actions.
- Psychiatrists are to include a copy of their current Drug Enforcement Agency (DEA) certificates, a current *curriculum vitae*, copies of their Medical Degrees, a *Certificate of Professional Liability Insurance*, a completed *Consent to Release Information to a Biller* form (if applicable) and a completed *Rendering Provider Form*. Psychiatrists must be either board certified or board eligible in order to provider services under the LMHP. Psychiatrists who are not board certified must include a copy of their certificate of completion of psychiatric residency training.

Psychologists, LCSWs and MFTs are to include a *curriculum vitae*, copies of applicable Graduate Degrees, a *Certificate of Professional Liability Insurance*, a completed *Consent to Release Information to a Biller* form (if applicable) and a completed *Rendering Provider Form*.

- Clinical nurse specialists and nurse practitioners are to include a *curriculum vitae*, a *Certificate of Professional Liability Insurance*, Proof of ANCC or AANP certification in behavioral health, a completed *Consent to Release Information to a Biller* form (if applicable) and a completed *Rendering Provider Form*. Clinical nurse specialists are to submit proof of graduation from a master's degree in psychiatric/mental health nursing as a clinical nurse specialist. Nurse practitioners are to submit proof of graduation from a master's degree program in psychiatric/mental health nursing as a nurse practitioner and a DEA certificate.
- Malpractice insurance liability requirements are \$1,000,000 per occurrence and \$3,000,000 aggregate.
- The Credentialing Unit will query the following websites to confirm licensure/certification, and obtain information regarding limitations or sanctions and malpractice claims.
  - State licensing boards and Medical Specialty Boards
  - National Provider Data Bank and Healthcare Integrity and Protection Data Bank
  - Office of the Inspector General exclusion list
  - Department of Health Care Services Medicaid/Medicare Suspended and Excluded List

Please mail or fax the completed application with the required documents to:

Department of Mental Health  
Provider Credentialing Unit  
550 S. Vermont Avenue, Room 703B  
Los Angeles, CA 90020  
Fax: (213) 487-9658

Credentialing Unit Telephone Numbers: (213) 738-2814 or (213) 738-2465

Application To Participate As A Provider in  
The Los Angeles County Department of Mental Health  
Local Mental Health Plan

**PROVIDER INFORMATION**

Last Name:		First Name:		Middle Initial:	
Social Security Number: _____ Federal Tax Identification Number: _____					
Direct Contact Phone Number: _____			Email Address: _____		
Name Affiliated with Federal Tax Identification Number: _____					
National Provider Identifier (NPI): _____					
Medicare Number: _____ if no Medicare # did you choose not to participate: <input type="checkbox"/> Yes <input type="checkbox"/> No					
DMH MediCal Provider Billing Number: _____ (recredentialing only) <input type="checkbox"/> Yes <input type="checkbox"/> No					
Data Universal Numbering System (DUNS) number: _____					
Is /are there any other name(s) under which you have been known? Name(s): _____					
Gender:		Birth date:		Ethnicity:	
				Degree:	

**PRACTICE INFORMATION**

Solo Practice Only  Group Practice Only  
Name of Group(s): \_\_\_\_\_  
\*Group must be contracted with County of Los Angeles

Both Solo and Group Practice  
Name of Group(s): \_\_\_\_\_  
\*Group must be contracted with County of Los Angeles

Are you currently a County of Los Angeles employee?  Yes  No

If the answer is yes, please provide the following information:  Full-time  Part-time  Consultant

Name of Department: \_\_\_\_\_

Work Location: \_\_\_\_\_

Position: \_\_\_\_\_

Job Responsibilities: \_\_\_\_\_

**MAILING ADDRESS:** Address to which all official notices will be mailed

Street:	Suite Number:	Post Office Box Number:
City:	State:	Zip Code (9 digits required):
E-Mail Address (Required):		

**PRACTICE LOCATIONS and ASSOCIATED BILLING INFORMATION:** (Practice location address will be listed in the LMHP Directory of Network Provider)

<b>LOCATION #1</b> Street:		Suite Number:
City:	State:	Zip Code:
Phone:	Fax Number:	Is this office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medi-Cal Provider Billing Number: \_\_\_\_\_

**BILLING ADDRESS FOR ABOVE PROVIDER NUMBER: (Reimbursements will be mailed to this address)**

Street: \_\_\_\_\_ Suite Number: \_\_\_\_\_ Post Office Box Number: \_\_\_\_\_

City:	State:	Zip:
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<b>LOCATION #2</b> Street:		Suite Number:
City:	State:	Zip:
Phone:	Fax:	Is this office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medi-Cal Provider Billing Number: \_\_\_\_\_

**BILLING ADDRESS FOR ABOVE PROVIDER NUMBER: (Reimbursements will be mailed to this address)**

Street: \_\_\_\_\_ Suite Number: \_\_\_\_\_ Post Office Box Number: \_\_\_\_\_

City:	State:	Zip:
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<b>LOCATION #3</b> Street:		Suite Number:
City:	State:	Zip:
Phone:	Fax:	Is this office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medi-Cal Provider Billing Number: \_\_\_\_\_

**BILLING ADDRESS FOR ABOVE PROVIDER NUMBER: (Reimbursements will be mailed to this address)**

Street: \_\_\_\_\_ Suite Number: \_\_\_\_\_ Post Office Box Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PROFESSIONAL EDUCATION**

Educational Institution		Degree	From (mm/yy)	To (mm/yy)
Graduate School/ Medical School	Institution: Address: City, State, Zip:			
Internship	Institution: Address: City, State, Zip:			
Residency	Institution: Address: City, State, Zip:			
Fellowship	Institution: Address: City, State, Zip:			

If you are an international medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)?  Yes  No  
For Non-Board Certified Physicians please include Residency completion Certificate

**PROFESSIONAL LICENSE (S):**

Include a copy of your license(s) with your application materials

Licensing Board Name	State	Specify Active or Inactive	License Number	Expiration Date

**DEA CERTIFICATE: M.D.s'/D.O.'s/Nurse Practitioners**

Include a copy of your current certificate with your application materials

DEA Certificate Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**BOARD CERTIFICATION: M.D.'s/D.O.'s/R.N.s**

Name of Board	Certification Date	Expiration Date (If Applicable)

**HOSPITAL PRIVILEGES: List all hospitals at which you have privileges**

Hospital	City	Appointment Date

**PROFESSIONAL LIABILITY COVERAGE:**

Insurance Carrier	Per claim amount	Aggregate amount	Expiration Date

Please answer either "yes" or "no" after each question. If you answer "yes" to any question, please provide a detailed explanation on a separate sheet. Documentation is required if you have any malpractice actions pending or settled within the past five years. The documentation must be from an attorney or the entity that issued the judgment.

Have you ever been denied professional liability insurance?  Yes  No

Has your professional liability insurance ever been canceled, denied renewal or subject to restriction (e.g. reduced limits, surcharged)?  Yes  No

Within the past seven years have you been a party to any malpractice actions?  Yes  No

Within the past seven years has any malpractice action been settled or has there been an unfavorable judgment(s) against you in a malpractice action?  Yes  No

To your knowledge, is any malpractice action against you currently pending?  Yes  No

**ATTESTATION QUESTIONS:**

Please answer "yes" or "no" after each question. If you answer yes to any question, please provide a detailed explanation on a separate sheet. Documentation is required from the professional licensing board if any action has been taken against your license.

**LICENSURE**

- 1. Has your professional license in any state ever been limited, suspended, revoked or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you?.....  Yes  No
  - a. Have you ever voluntarily surrendered your license?.....  Yes  No
  - b. Are formal charges pending against you at this time?.....  Yes  No

**HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS**

- 2. Have you ever had an application for membership or privileges at a hospital or other health care facility denied, granted with limitations, suspended, revoked, not renewed or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you, or ever been recommended by a standing medical staff committee or governing board of a hospital, other health care facility or any medical organization? .....  Yes  No
- 3. Have you ever voluntarily or involuntarily relinquished a medical staff membership, your clinical privileges, a professional license, or a narcotics permit under threat of disciplinary action, threat of censure, restriction suspension or revocation of such privileges?.....  Yes  No
- 4. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?.....  Yes  No
- 5. Have your medical staff membership, your clinical privileges, a professional license, or a narcotics permit ever been limited or subjected to disciplinary action of any kind?.....  Yes  No
- 6. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? .....  Yes  No
- 7. Are you currently the subject of any investigation by any hospital, licensing authority, DEA, or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?.....  Yes  No
- 8. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever be revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?.....  Yes  No

**EDUCATION, TRAINING AND BOARD CERTIFICATION**

- 9. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?.....  Yes  No
- 10. Has your specialty board certification or eligibility ever been limited, suspended, revoked, denied, relinquished, not renewed, or reduced or subjected to probationary conditions, or have proceedings toward any of those ends ever been instituted? (M.D.s/O.D.s only).....  Yes  No

**DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION**

- 11. Has your DEA certificate or any other controlled substances authorization, ever been suspended, revoked, limited, denied renewal, or have any proceedings toward any of those ends ever been instituted against you?( M.D.' s/D.O.'s/ nurse practitioners only).....  Yes  No

**MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PARTICIPATION**

- 12. Do you have any pending disciplinary action, or are you currently sanctioned, expelled, or suspended from any federally funded programs, including but not limited to, Medi-Cal, or Medicare?.....  Yes  No
- 13. Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid?.....  Yes  No
- 14. Have you ever been sanctioned, expelled, suspended from, or had criminal charges brought against you by any federally funded programs, including but not limited to, Medi-Cal, or Medicare?.....  Yes  No

**PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY**

- 15. Has your professional liability insurance ever been terminated, or not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your liability insurance or its coverage of any procedure? .....  Yes  No

**MALPRACTICE CLAIMS HISTORY**

- 16. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data bank or Healthcare Integrity and Protection Data Bank?.....  Yes  No
- 17. Has any malpractice lawsuit and/or arbitration been filed against you in the last 10 years?.....  Yes  No
- 18. To your knowledge, do you have any pending malpractice suite, arbitrations or judgments?.....  Yes  No

**CRIMINAL/CIVIL HISTORY**

- 19. Have you ever been court-martialed for actions related to your duties as a medical professional?(M.D.s/O.D.s /N.P.s only) .....  Yes  No
- 20. Have you ever been a subject of charges related to moral or ethical turpitude?.....  Yes  No
- 21. Have you ever been convicted of any crime, other than a traffic violation, or pled nolo contendere?  Yes  No
- 22. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?.....  Yes  No
- 23. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last 10 years for sexual harassment or other illegal misconduct?.....  Yes  No

**ABILITY TO PERFORM JOB**

- 24. Do you have a history of alcohol and/or chemical dependency/substance abuse?.....  Yes  No
- 25. Do you have a current problem with alcohol and/or chemical dependency/substance abuse?.....  Yes  No
- 26. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?.....  Yes  No
- 27. Do you have any physical or mental impairment which would render you unable, with or without reasonable accommodations, to provide professional services within your areas of practice, without posing a direct threat to the health and safety of others?.....  Yes  No
- 28. Are you able to perform all the services required by your agreement with, or professional bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodations, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?.....  Yes  No

I do hereby certify that the information contained in this application is accurate and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission from this application constitutes cause for denial of credentialing and enrollment as a network provider in the County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP). I agree to notify the LMHP promptly if there are any material changes in the information provided in this application.

I authorize the LMHP to consult orally, electronically, and in writing with the state licensing board(s), the American Medical Association, the National Technical Information Service, educational institutions, malpractice insurance carriers, specialty boards, Educational Commission for Foreign Medical Graduates, hospitals, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my professional competence and qualifications. Applicants are hereby advised that the LMHP participates in the National Practitioner Data Bank, The Office of the inspector General, California Licensing Boards, American Board of Medical Specialties, and the Department of Health Care Services Medi-Cal Suspended and ineligible Provider list, and the Healthcare Integrity and Protection Data Bank. Applicants acknowledge that adverse actions taken by the LMHP may be reported to these agencies and/or other disciplinary boards/authorities as necessary.

I consent to the release by any person to the LMHP of all information that may be relevant to an evaluation of my professional competency and qualifications, including any information relating to any disciplinary action, suspension or curtailment of privileges. I release the LMHP and all those whom the LMHP contacts from any and all liability for their acts performed in good faith in obtaining and verifying such information and in evaluating my application.

I agree to obtain and maintain in effect all licenses, permits, registration, accreditations and certificates as required by all Federal, State and local laws, ordinances, rules and regulations, and policies of the LMHP. I agree to immediately notify the LMHP upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my DEA number, furnishing certificate, professional license, professional liability insurance, participation in federally funded programs such as Medi-Cal or Medicare or other certification and/or other credentials authorizing me to practice my profession. I also agree to immediately notify the LMHP upon termination, suspension or revocation of my staff privileges at any hospital or health care facility.

I understand that I must meet any requirements set forth in this credentialing application and that this credentialing application implements the LMHP credentialing policy, all of which apply to the application and any decision made by the LMHP with respect to it.

I certify under penalty of perjury that I have downloaded and read the LMHP Provider manual.

---

Signature of Applicant

---

Date

## PROVIDER PRACTICE PROFILE

### MEDI-CAL REFERRALS

Do you wish to receive new outpatient Medi-Cal client referrals?  Yes  No  
 Do you wish to be included in the LMHP Directory of Network providers?  Yes  No

Please notify Provider Credentialing at (213) 738-2814 or (213) 738-2465 to close or open your practice to new referrals.

**Note: The County does not guarantee referrals**

**What age groups of clients do you serve?** (Please check only those that apply) **MFTs, LCSWs and clinical nurse specialists are ONLY reimbursed by the LMHP for services to beneficiaries' age 0 through age 20.**

Children 0 through 5.....      Children 6 through 13 .....      Adolescents 14 through 17 .....  
 Transition Youth 18 through 20.....      Adults 21 through 59.....      Adults 60 and over .....

Services you provide:

Brief Psychotherapy .....      Medication Services.....  
 Inpatient.....      Consultation and Liaison .....      Psychological Testing .....  
 Family Psychotherapy.....      Neuropsychological Testing .....      Group Psychotherapy .....  
 Psychological testing that considers the influence of medication on test results .....

**Practice settings in which you provide services:** For each practice setting that you check, please indicate the Service Area (SA) in which you are available to provide these services. **Example: You have offices in both Hollywood and Santa Monica. Check Office and SA 4 and 5. You provide services to group homes, but only in Hollywood. Check Group Home and SA Area 4.** You may refer to the map attached to this application to assist you in determining which cities are in which SA.

	<b>Practice Settings</b>	<b>Service Area</b>							
		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
1.	Office <input type="checkbox"/> *For each Service Area you check, please complete the practice location information on page 2.	<input type="checkbox"/>							
2.	Inpatient <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Youth Group Home/Residential/Schools <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Residential Facilities <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Probation Facilities <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Nursing Facilities <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Clients' Homes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- SA 1    Antelope Valley
- SA 2    San Fernando/Santa Clarita Valley
- SA 3    San Gabriel Valley
- SA 4    Metropolitan/Hollywood
- SA 5    Santa Monica/ West Los Angeles
- SA 6    South Los Angeles
- SA 7    Southeast Los Angeles
- SA 8    Harbor /Long Beach

**MFTs, LCSWs, and RNs are not reimbursed by the LMHP for services in inpatient settings.**

Identify any foreign language(s) or sign language in which you are sufficiently proficient to provide competent mental health services without the assistance of a translator:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Afgan, Pashto, Pusho          | <input type="checkbox"/> Hebrew           | <input type="checkbox"/> Native American Dialects Norwegian |
| <input type="checkbox"/> Afrikaan                      | <input type="checkbox"/> Hindi            | <input type="checkbox"/> Pakistani                          |
| <input type="checkbox"/> American Sign Language        | <input type="checkbox"/> Hindustani       | <input type="checkbox"/> Pangasinan                         |
| <input type="checkbox"/> Amharic                       | <input type="checkbox"/> Hmong            | <input type="checkbox"/> Polish                             |
| <input type="checkbox"/> Arabic                        | <input type="checkbox"/> Hungarian        | <input type="checkbox"/> Portuguese                         |
| <input type="checkbox"/> Armenian                      | <input type="checkbox"/> Ibonese          | <input type="checkbox"/> Punjabi                            |
| <input type="checkbox"/> Bengali                       | <input type="checkbox"/> Igorot           | <input type="checkbox"/> Romanian                           |
| <input type="checkbox"/> Bulgarian                     | <input type="checkbox"/> Ilocano or Iloko | <input type="checkbox"/> Samoan                             |
| <input type="checkbox"/> Burman or Burmese             | <input type="checkbox"/> Ilongot          | <input type="checkbox"/> Serbo-Croatian                     |
| <input type="checkbox"/> Calo                          | <input type="checkbox"/> Indonesian       | <input type="checkbox"/> Sinhalese                          |
| <input type="checkbox"/> Cambodian                     | <input type="checkbox"/> Italian          | <input type="checkbox"/> Swahili                            |
| <input type="checkbox"/> Cantonese                     | <input type="checkbox"/> Japanese         | <input type="checkbox"/> Swatowese                          |
| <input type="checkbox"/> Cebuano                       | <input type="checkbox"/> Konkani          | <input type="checkbox"/> Swedish                            |
| <input type="checkbox"/> Chinese, other specify: _____ | <input type="checkbox"/> Korean           | <input type="checkbox"/> Russian                            |
| <input type="checkbox"/> Choctaw                       | <input type="checkbox"/> Lao              | <input type="checkbox"/> Sign Language, Specify: _____      |
| <input type="checkbox"/> Creole                        | <input type="checkbox"/> Lingata or Ngata | <input type="checkbox"/> Somali                             |
| <input type="checkbox"/> Czech                         | <input type="checkbox"/> Lithuanian       | <input type="checkbox"/> Spanish                            |
| <input type="checkbox"/> Danish                        | <input type="checkbox"/> Mandarin         | <input type="checkbox"/> Tagalog                            |
| <input type="checkbox"/> Dutch                         | <input type="checkbox"/> Marathi          | <input type="checkbox"/> Taiwanese                          |
| <input type="checkbox"/> English                       | <input type="checkbox"/> Mien             | <input type="checkbox"/> Telegu                             |
| <input type="checkbox"/> Ethiopian                     |   | <input type="checkbox"/> Temne                              |
| <input type="checkbox"/> Farsi                         |   | <input type="checkbox"/> Thia                               |
| <input type="checkbox"/> French                        |   | <input type="checkbox"/> Toisan                             |
| <input type="checkbox"/> German                        |   | <input type="checkbox"/> Tonga                              |
| <input type="checkbox"/> Greek                         |   | <input type="checkbox"/> Turkish or Ottoman                 |
|  |   | <input type="checkbox"/> Ukranian                           |
|  |   | <input type="checkbox"/> Urdu                               |
|  |   | <input type="checkbox"/> Vietnamese                         |
|  |   | <input type="checkbox"/> Visayan                            |
|  |   | <input type="checkbox"/> Yao                                |
|  |   | <input type="checkbox"/> Yiddish                            |
|  |   | <input type="checkbox"/> Yoruba                             |
|  |   | <input type="checkbox"/> Other, specify _____               |

***Cultural competence is an awareness, understanding, and acceptance of the dynamics of cultural differences. It involves the ability to adapt practices to the cultural context of the consumer. The culturally competent practitioner utilizes the universal similarities present in all of us in order to engage the individual(s) and transcend barriers.***

**Areas of Cultural Competency:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Persian                            |
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> Gay/Lesbian/Bisexual/Transgender | <input type="checkbox"/> Russian                            |
| <input type="checkbox"/> Armenian         | <input type="checkbox"/> Hispanic/ Latino                 | <input type="checkbox"/> Samoan and other Pacific Islanders |
| <input type="checkbox"/> Asian Indian     | <input type="checkbox"/> Hmong                            | <input type="checkbox"/> Turkish                            |
| <input type="checkbox"/> Cambodian        | <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Vietnamese                         |
| <input type="checkbox"/> Chinese          | <input type="checkbox"/> Korean                           | <input type="checkbox"/> Other, specify _____               |

**Clinical Expertise:** From the list below select the areas for which you have training and expertise.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abuse Survivors                          | <input type="checkbox"/> Domestic Violence Perpetrators | <input type="checkbox"/> Mobility Impaired   |
| <input type="checkbox"/> Adjustment Disorders                     | <input type="checkbox"/> Domestic Violence Victims      | <input type="checkbox"/> Mood Disorders  |
| <input type="checkbox"/> Adoption                                 | <input type="checkbox"/> Dual Diagnosis                 | <input type="checkbox"/> Norm-Referenced Psychological Testing   |
| <input type="checkbox"/> AIDS/HIV                                 | <input type="checkbox"/> Eating Disorders               | <input type="checkbox"/> Personality Disorders   |
| <input type="checkbox"/> Anxiety Disorders                        | <input type="checkbox"/> Elder Care Abuse               | <input type="checkbox"/> Psychotic Disorders   |
| <input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder | <input type="checkbox"/> Family Therapy                 | <input type="checkbox"/> Sex Offenders   |
| <input type="checkbox"/> Developmental Delays                     | <input type="checkbox"/> Gang Members                   | <input type="checkbox"/> Severe and Persistent Mental Illness  |
| <input type="checkbox"/> Disorders of Adolescence                 | <input type="checkbox"/> Gay/Lesbian                    | <input type="checkbox"/> Sexual Abuse Victim   |
| <input type="checkbox"/> Disorders of Childhood                   | <input type="checkbox"/> Gender Identity Disorders      | <input type="checkbox"/> Substance Abuse   |
| <input type="checkbox"/> Disorders of Infancy                     | <input type="checkbox"/> Grief/Bereavement              | <input type="checkbox"/> The Use of American Psychological Association<br>Guidelines in Child Protection Matters |
| <input type="checkbox"/> Dissociative Disorders                   | <input type="checkbox"/> Group Therapy                  | <input type="checkbox"/> Visually Impaired   |
|   | <input type="checkbox"/> Hearing Impaired               | <input type="checkbox"/> Other, specify _____  |
|   | <input type="checkbox"/> Homeless                       |  |

**Hours of Operation:** Select the days and indicate the hours of your practice.

- Monday \_\_\_\_\_AM to \_\_\_\_\_PM
- Tuesday \_\_\_\_\_AM to \_\_\_\_\_PM
- Wednesday \_\_\_\_\_AM to \_\_\_\_\_PM
- Thursday \_\_\_\_\_AM to \_\_\_\_\_PM
- Friday \_\_\_\_\_AM to \_\_\_\_\_PM
- Saturday \_\_\_\_\_AM to \_\_\_\_\_PM
- Sunday \_\_\_\_\_AM to \_\_\_\_\_PM



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH  
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV



MARVIN J. SOUTHARD, D.S.W.  
Director  
ROBIN KAY, Ph.D.  
Chief Deputy Director  
RODERICK SHANER, M.D.  
Medical Director

July 2, 2014

To: Group Provider Applicant

Thank you for applying to become a group provider in the County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP). In order to enroll as a group provider and receive reimbursement for specialty mental health services provided to Medi-Cal beneficiaries, the legally authorized official of your group must sign a Group Provider Contract with the LMHP.

Please provide the information requested below:

Name of Official: \_\_\_\_\_

Address: \_\_\_\_\_

Service Location Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Official Group Name: \_\_\_\_\_

Group Medi-Cal Provider Number: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Vendor Number (if already assigned): \_\_\_\_\_

NPI Number: \_\_\_\_\_

Do you wish to receive new outpatient Medi-Cal client referrals?  Yes  No

**Note: the County does not guarantee referrals**

Are you a Federally Qualified Health Center (FQHC):  Yes  No

**Note: The County shall not be responsible to provide or arrange and pay for specialty mental health services provided by FQHCs, Indian Health Centers, and Rural Health Clinics.**

Group Provider Applicant  
January 22, 2014  
Page 2

Please mail or fax or mail the requested information to:

Department of Mental Health  
Provider Credentialing Unit  
550 S. Vermont Ave., 7<sup>th</sup> Floor, Room 703A  
Los Angeles, CA 90020  
Fax: (213) 487-9658

You cannot be enrolled in the LMHP as a group provider until we have received the above information and have credentialed the individual providers in your group. If you have any questions, please contact the Provider Credentialing Unit at (213) 738-2814 or at (213) 738-2465.

Sincerely,

Nathaniel Thomas, Ph.D.  
Supervisor, Provider Credentialing Unit  
Medi-Cal Professional Services and Authorization Division

PW:NT

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR  
Medi-Cal Professional Services and Authorization**

Please return this completed form with the Group Provider Application to:

Department of Mental Health  
Provider Credentialing Unit  
550 S. Vermont Ave., Room 703A  
Los Angeles, CA 90020  
Fax: (213) 487-9658

Group Provider Name: \_\_\_\_\_

Group Medi-Cal Provider No: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please list the individual providers in the group who provide Medi-Cal specialty mental health services. Each provider must complete an individual provider application and be credentialed.

<b>Individual Provider Name</b>	<b>9 Digit Provider Number</b>	<b>NPI Number</b>

You may attach a separate sheet to list additional provider names

## Rendering Provider Form

### Notes and Instructions

**The Rendering Provider Form must be completed for all clinical staff members who are new or are not on the Integrated System. This form is also to be used for clinical staff that have terminated services from a provider location or to update information, i.e., name change, email, phone no., fax no., or expiration dates. When completing this form, please refer to the following guidelines:**

- The original form must be completed in its entirety (if applicable), with the authorized manager/designee signature. Fax, photocopies and electronic forms are not acceptable.
- EXCEPTION: Prescription writing physicians/clinicians rendering provider form may be faxed for immediate processing. To initiate this procedure, the contact person must call the CIOB/Help Desk at (213) 351-1335 for fax instructions.
- All information must be current upon submission of this form.
- Be sure all fields are completed accurately and appropriately to avoid delay in the processing of a request.

#### REQUEST TYPE:

- This section determines the type of request the rendering provider wants to initiate.

#### GENERAL INFORMATION:

- This section will serve as the rendering provider's identifier.

Last Name – Please print last name.

First Name – Please print first name (Do Not Use Nicknames)

Middle Initial – (If applicable)

Sex – Please mark the appropriate gender.

Ethnicity – This code can be found in the IS Codes Manual.

Staff Code – *For county employee:* This is your 6-digit employee number. *For NGA:* This is your 7-digit staff number consisting of 3 or 4 preceding letters followed by numbers (ex: ABC1234 or ABCD123).

FFS Individual Provider Number – This is your FFS Individual provider number that is associated with the taxpayer ID for this request.

SSN – These are the last 4 digits of your social security number.

Language Code – This code(s) can be found in the IS Codes Manual. A maximum of five language codes can be listed on the form.

DMH Classcode – This is the type of organization to which your home provider belongs.

Tax Payer ID – This is the nine digit federal tax payer ID. (FFS only)

#### CONTACT & ASSIGNED LOCATION INFORMATION:

- This section outlines the location(s) where the rendering provider is providing the service(s).

Contact Name – This is the designated person in case there are problems with the submitted form.

Contact Phone No. – This is the phone number of the designated contact person.

Contact Email- This is the contact person's email address (Do Not use personal email address)

Contact Fax No. – This is the contact person's fax number.

DMH/NGA Prov No./Rept Unit – This is the 4-digit State provider number or 5-digit (four digit provider number + the alpha code) that is assigned to the facility where services are being provided.

FFS Group/Organization Prov No. – This is the 9-digit number associated to the tax payer ID if this form is to add the rendering provider under a FFS group or organization.

Effective Date – This is the date the rendering provider began delivering services under this provider number.

Termination Date – This is the date the rendering provider stopped delivering services under this provider number.

Locum Tenum – Check this box to indicate the rendering provider is a temporary staff **assigned to a DMH facility**.

Intern – Check this box if the rendering provider is an **Intern with DMH** assigned a unique staff code.

Name of Organization – This is the name of the facility where service(s) is provided.

Service Area – This code can be found in the IS Codes Manual.

MHSA – Check this box to indicate the Mental Health Service Act funding source. **(DMH Providers Only)**

Address, City, Zip – This is the service location's complete address, city and zip code.

#### TAXONOMY AND LICENSE INFORMATION:

- This section provides evidence of the rendering provider's eligibility.

Description – This is the description associated with the taxonomy code.

Taxonomy – This is the rendering provider's discipline. (If multiple disciplines use additional space provided.) The taxonomy code(s) can be found in the IS Codes Manual.

Professional License # - This is an 8-digit alphanumeric number listed on your professional license.

Effective Date & Expiration Date – These are the effective and expiration dates of your professional license.

DEA License # - This is a 9-digit alphanumeric number listed on your DEA license (if applicable).

Expiration Date – This is the date your DEA license expires.

Medicare Prov No. This is the 6-digit facility Medicare provider number associated with a rendering provider's PPIN Medicare No. (DMH only).

PPIN Medicare No. – This is the 9-digit performing physician identification number that is assigned to a rendering provider delivering services at a specific location . (DMH only)

Expiration Date – This is the date the PPIN number expires.

NPI – This is the 10-digit National Provider Identifier. This number is a unique identifier for use to identify health care providers in HIPAA standard transactions.

NPI Effective Date – This is the data the 10-digit National Provider Identifier became effective.

#### AUTHORIZED MANAGER NAME AND SIGNATURE

- This is the manager/designee's name and signature on the Authorization to Sign CIOB Access Form for the above assigned location.



# RENDERING PROVIDER FORM

Mail to: Department of Mental Health  
Chief Information Office Bureau  
Systems Access Unit  
695 South Vermont Avenue  
Los Angeles, CA 90005

## Request Type

Submit Date: \_\_\_\_\_  New  Update  Terminate  Name Change  
License Reporting Unit Effective Date

## General Information

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Sex:  M  F Ethnicity: \_\_\_\_\_

DMH/NGA Staff Code: \_\_\_\_\_

FFS Ind Prov No.: \_\_\_\_\_

SSN (Last 4 only): \_\_\_\_\_

Language Code: \_\_\_\_\_

Select DMH Classcode:  
 DMH Prov name: \_\_\_\_\_  
 DHS Prov name: \_\_\_\_\_  
 Non-Governmental Agency (DMH Contracted)  
 L.E. #: \_\_\_\_\_  
 L.E. Name: \_\_\_\_\_  
 FFS Individual  FFS Group  FFS Org  
 Tax Payer ID (FFS only): \_\_\_\_\_

## Contact & Assigned Location Information

Contact name: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Contact phone no: ( ) \_\_\_\_\_ Contact Fax No: ( ) \_\_\_\_\_

Add this rendering provider in the service location indicated below: (please use form MH-228A for additional locations)  
 Delete this rendering provider in the service location indicated below.  Delete this rendering provider in ALL service locations within the legal entity indicated above.

DMH/NGA Prov No./Rept Unit: \_\_\_\_\_ FFS Group/Org Prov No.: \_\_\_\_\_  
(Please enter the provider no. associated to the above taxpayer ID)

Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_ Locum Tenum:  Intern:

Name of Organization: \_\_\_\_\_ Service Area:  MHSA:

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

## Taxonomy and License Information (Required if request type is NEW)

Description: \_\_\_\_\_ Taxonomy: \_\_\_\_\_

Professional License #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Description: \_\_\_\_\_ Taxonomy: \_\_\_\_\_

Professional License #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

DEA License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Medicare Prov No. (DMH directly-operated only): \_\_\_\_\_ PPIN Medicare No. (DMH directly-operated only): \_\_\_\_\_ Expiration Date: \_\_\_\_\_

NPI: \_\_\_\_\_ NPI Effective Date: \_\_\_\_\_

Authorized Manager/Designee  
 Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

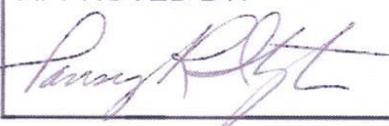
## CIOB USE ONLY

Rendering Provider IS No: \_\_\_\_\_ Ticket #: \_\_\_\_\_

Date Processed: \_\_\_\_\_ Processed by: \_\_\_\_\_



**DEPARTMENT OF MENTAL HEALTH**  
Office of the Medical Director  
**POLICY/PROCEDURE**

<b>SUBJECT:</b> <b>CREDENTIALING OF PROVIDERS</b>	<b>POLICY NO.</b>  <b>CR1</b>	<b>EFFECTIVE DATE</b> <b>1/1/09</b>	<b>PAGE</b> <b>1 of 6</b>
<b>APPROVED BY:</b> 	<b>SUPERSEDES</b>  <b>12/19/02</b>	<b>ORIGINAL ISSUE DATE</b> <b>11/1/98</b>	

**PURPOSE**

- 1.1 To outline the standards, requirements and guidelines for the credentialing of licensed mental health providers to participate as network providers in the Los Angeles County Department of Mental Health Plan Local Mental Health Plan (LMHP).

**POLICY**

- 2.1 Licensed mental health professionals whose scope of practice permits the practice of psychotherapy independently, who meet the credentialing standards and contracting requirements established by the LMHP and who have a signed and executed contract, will be approved to provide specialty mental health services to Los Angeles County Medi-Cal beneficiaries.

**DEFINITION**

- 3.1 **Credentialing:** The formal process of collecting and verifying the professional credentials and qualifications of licensed individual providers and evaluating them against the standards and requirements established by the LMHP to determine whether such individual providers meet these standards and requirements.
- 3.2 **Credentialing Timeframe:** The process of completing credentialing must occur within 180 days of the LMHP receipt of the provider's complete application.
- 3.3 **Providers:** The following mental health providers who are licensed or certified and recognized by the State of California to practice independently may apply to participate as network providers in the LMHP.
- 3.3.1 Board eligible or board certified psychiatrists
  - 3.3.2 Licensed clinical psychologists
  - 3.3.3 Licensed clinical social workers
  - 3.3.4 Licensed marriage and family therapists
  - 3.3.5 Registered nurses with a master's degree in psychiatric/mental health nursing as a clinical nurse specialist or nurse practitioner.



**DEPARTMENT OF MENTAL HEALTH**  
**Office of the Medical Director**  
**POLICY/PROCEDURE**

<b>SUBJECT:</b> <b>CREDENTIALING OF PROVIDERS</b>	<b>POLICY NO.</b> <b>CR 1</b>	<b>EFFECTIVE DATE</b> <b>1/1/09</b>	<b>PAGE</b> <b>Page 2 of 6</b>
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**PROCEDURE**

- 4.1 Upon receipt of a request for an application to participate in the LMHP, the provider's name, discipline, address, phone number and fax number are to be entered in the Application Request Log.
  - 4.1.1 Each entry in the Application Request Log is to be dated and include the initials of the Credentialing Unit staff member who recorded the request.
  - 4.1.2 The application packet will be sent to the provider within five working days of the request.
  - 4.1.3 The packet contains the application, credentialing requirements and directions for completing the application.
  - 4.1.4 The date the application is sent and the initials of the staff member who processed the application request are to be entered on the Application Request Log.
  - 4.1.5 Completed logs are to be retained for 60 days for future reference.
- 4.2 Upon receipt of a completed application, it is date stamped on page 1 of the application indicating the date of receipt of the application materials.
- 4.3 A Credentialing Unit staff member will review the application within two weeks of receipt of the application and determine if the application materials are complete and current.
  - 4.3.1 A Mental Health Provider Application Checklist is to be completed recording the outcome and date of the review.
  - 4.3.2 The application form must be completed, signed and dated. If the application form is incomplete and/or the documents required are not included or are not current, the provider will be contacted via telephone or letter. A copy of the notification letter will be retained in the provider file. The incomplete application form is returned to the provider and a copy is retained in the provider file.
  - 4.3.3 A detailed explanation is required for an affirmative answer to liability or attestation questions. A history of all professional liability claims which resulted in settlements or judgments paid on behalf of the provider is required.



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4.3.4 The following documents are required for credentialing and must be included with the application form:

- 1) A copy of the certificate of completion of psychiatric residency training (physicians who are not board-certified in psychiatry).
- 2) Documentation of completion of a graduate nursing program in psychiatric/mental health nursing (clinical nurse specialists and nurse practitioners).
- 3) A copy of a current DEA certificate (physicians and nurse practitioners only)
- 4) A current curriculum vitae
- 5) Evidence of current malpractice insurance with liability requirements of \$1,000,000 and \$2,000,000 aggregate

4.4 The Credentialing Unit staff member will complete a query of the National Provider Data Bank and the Healthcare and Integrity Protection Data Bank. A copy of the results of the query will be added to each provider's file.

4.5 The Credentialing Unit staff member will verify that the provider is not on any federal or state list excluding the provider from Medicare or Medicaid payment. The results will be documented in the provider's file.

4.6 Verification of Professional License/Physician Board Certification

4.6.1 M.D.: License status is verified directly with the Medical Board of California via the internet. The verification is printed and retained in the provider's file.

4.6.2 Board certification by the American Board of Psychiatry and Neurology is verified directly via the Internet. The search results are printed and retained in the provider's file.

4.6.3 D.O.: License status is verified with the Osteopathic Medical Board of California via the Internet. The verification is printed and kept in the provider's file.

4.6.4 Board certification by the American Osteopathic Board of Psychiatry and Neurology is verified directly via the internet. The search results are printed and retained in the provider's file.



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- 4.6.5 Psychologists: License status is verified directly with the California Board of Psychology. The verification is printed and kept in the provider's file.
- 4.6.6 Licensed Clinical Social Workers and Licensed Marriage and Family Therapists: License status is verified directly with the California Board of Behavioral Sciences via the Internet. The verification is printed and kept in the provider's file.
- 4.6.7 Registered Nurses with a master's degree: License status is verified directly with the California Board of Registered Nursing via the Internet. The verification is printed and kept in the provider's file.
- 5.1 Criteria for Accreditation into the LMHP Provider Network.
- 5.1.1 Minimum criteria must be met for an applicant to be considered for enrollment as a LMHP Network Provider. These minimal criteria are indicated in the provider application. Applicants who fail to meet the minimum criteria shall be notified by the Credentialing Unit staff member in writing of those criteria that are not met and that further consideration of the application will not occur until such criteria are met. Applicants have no right of appeal when the application is denied due to failure to meet minimum credentialing criteria. Minimum criteria are as follows:
- 1) Practice location meets the following standards for individual and group practice sites:
    - a) Practice site is maintained in a manner that provides for the physical safety of beneficiaries, visitors and personnel.
    - b) Practice site is clean, sanitary and in good repair.
    - c) Medications are securely stored and dispensed according to State and Federal regulations.
    - d) Clinical records are maintained securely and confidentially.
  - 2) Graduation from an accredited professional school at the time of attendance, and/or highest training program applicable to the academic degree, discipline, and licensure of the provider.
  - 3) Physicians must have attained Board certification or be eligible for examination to receive certification by the American Board of Psychiatry and Neurology. A copy of the certificate of completion of psychiatric residency training must be submitted with the application materials for those physicians who are not Board certified.



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- 4) Valid, current California license.
- 5) Valid, current, unrestricted Drug Enforcement Agency (DEA) Certificate, where applicable.
- 6) Submission of a completed, signed and dated application form with all required documents as indicated on the application.
- 7) Absence of falsification of the provider application or material omission of the information requested in the provider application.
- 8) Current professional liability insurance that meets or exceeds the Department's minimum limits of \$1 million per incident/ \$2 million annual aggregate per clinician. The Contracts Development and Administration Division will conduct insurance verification.
- 9) Absence of current sanctions by regulatory agencies including Medicare/Medicaid and any other regulatory agency.

6.1 Additional Credentialing Criteria: Applications that meet the minimum credentialing criteria listed in Section 5.1.1 of this policy will be reviewed by the credentialing specialist for the following additional criteria. Applications will be referred to the Credentialing Review Committee (CRC) if the additional criteria are not met which may result in a determination to deny credentialing.

- 1) Absence of a history of involvement in a malpractice suit, arbitration or settlement in the past five years in accordance with the criteria set forth below. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.
  - a) No more than three malpractice suits, arbitrations, or settlements within the last five years greater than \$100,000 in aggregate.
  - b) No single judgment, arbitration or settlement within the last five years that is greater than \$100,000.
  - c) The CRC reviews all open cases.
- 2) Absence of a history within the past 10 years of disciplinary actions affecting the applicant's professional license, Board standing, DEA certification, or other required certification. Waiver of this requirement can be made only by review of the CRC.



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Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.

- 3) Absence of felony or misdemeanor convictions, other than traffic violations. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such conviction does not adversely affect the applicant's ability to perform his/her professional duties.
- 4) Absence of a history of sanctions by regulatory agencies including Medicare/Medicaid and any other public regulatory agency. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.
- 5) Absence of a history of alcohol and chemical dependency/substance abuse. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.
- 6) Absence of a physical or mental impairment which would make the applicant/provider unable, with or without reasonable accommodations, to provide professional services within his/her area of practice, without posing a direct threat to the health and safety of others. Waiver of this requirement can be made only by review of the CRC. Evidence must exist that any such condition does not adversely affect the applicant's ability to perform his/her professional duties.
- 7) If the CRC denies waiver for one of the situations addressed in this section an applicant may not apply for a credential for two years or until such a time as the situation requiring waiver is resolved.

7.1 In situations where currently credentialed providers would be excluded by changes in credentialing policies or changes in application of the policies, such providers may be excepted from the policies and their application reviewed on a case by case basis.



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<b>APPROVED BY:</b>  	<b>SUPERSEDES</b>  <b>6/3/03</b>	<b>ORIGINAL ISSUE DATE</b> <b>2/1/99</b>	

**PURPOSE**

- 1.1 To outline the structure, composition and functions of the Credentialing Review Committee (CRC).

**POLICY**

- 2.1 The CRC will review and consider the applications of all mental health providers whose credentials present special issues that require further consideration and who do not clearly meet the standards for credentialing in the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) Provider Network.

**DEFINITIONS**

- 3.1 Credentialing is the formal process of collecting and verifying the professional credentials and qualifications of licensed providers and evaluating them against the standards and requirements established by the LMHP to determine whether such providers meet these standards and requirements.
- 3.2 The CRC is a confidential, multi-disciplinary body appointed by the Medical Director of the Department and the Medical Director of Managed Care Services. The purpose of the CRC is to ensure that the initial and ongoing credentials of applicants and network providers are evaluated and maintained in accordance with the credentialing standards established by the LMHP.

**PROCEDURE**

- 4.1 CRC Meetings
  - 4.1.1 The CRC meeting is scheduled monthly.
  - 4.1.2 Prior to each meeting the credentialing specialist will notify committee members of the scheduled meeting.



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- 4.1.3 The credentialing specialist will prepare a meeting agenda prior to each scheduled meeting.
- 4.1.4 The credentialing specialist will distribute the minutes of the previous committee meeting to the committee members for review prior to each scheduled meeting.
- 4.1.5 The credentialing specialist prepares and presents documentation for consideration by committee members. Prior to each meeting, the redacted credentialing documents scheduled for review will be distributed to the committee members. The application materials will be marked **CONFIDENTIAL**.
- 4.1.6 The credentialing specialist will prepare CRC minutes. The minutes will reflect the discussion of the relevant issues presented and consideration of the provider's credentialing documents before a credentialing decision is made. The committee minutes will be marked **CONFIDENTIAL**.
- 4.1.7 Approved committee minutes will be kept in a binder in the Medi-Cal Professional Services and Authorization Division.
- 5.1 Applicants will be referred to the CRC under the following circumstances:
  - 5.1.1 Falsification or misrepresentation of any information on the application.
  - 5.1.2 A pending or previous malpractice claim that reflects quality of care or clinical practice problems.
  - 5.1.3 More than two professional malpractice actions within the past five years.
  - 5.1.4 Applicants who are currently on probation with the professional licensing board.
  - 5.1.5 Applicants with a disciplinary action(s) pending before the professional licensing board.
  - 5.1.6 Applicants whose professional license or narcotic registration has previously been revoked, suspended or limited.
  - 5.1.7 Applicants who have been the recipient of adverse actions by Medicare, Medi-Cal or any other public program.



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- 5.1.8 Applicants who have been the recipient of adverse actions by a specialty board, professional organization, hospital medical staff, clinical group, independent practice association or other health delivery system.
- 5.1.9 Applicants who have been convicted of a felony.
- 5.1.10 Applicants who have a physical or mental impairment which might render him/her unable, with or without reasonable accommodations, to provide professional services within his/her area of practice, without posing a direct threat to the health and safety of others.
- 5.1.11 Applications that raise concerns regarding clinical practice outside the professional standard of care.
- 6.1 Network providers will be referred to the CRC under the following circumstances:
  - 6.1.1 A disciplinary action concerning a network provider is brought before the professional licensing board.
  - 6.1.2 The professional licensing board enforces a disciplinary action against a network provider.
  - 6.1.3 A malpractice claim is brought against a network provider that reflects quality of care or clinical practice problems.
  - 6.1.4 The network provider becomes the recipient of an adverse action by Medi-Cal, Medicare or any other public agency.
  - 6.1.5 The network provider becomes the recipient of an adverse action by a specialty board, professional organization, hospital medical staff, clinical group, independent practice association or other health delivery system.
  - 6.1.6 Felony criminal charges are filed against a network provider that raise concerns about clinical practice and quality of care.
  - 6.1.7 The network provider has developed a physical or mental impairment which might render him/her unable, with or without reasonable accommodations, to provide professional services within his/her areas of practice, without posing a direct threat to the health and safety of others.
  - 6.1.8 A complaint(s) raises concern regarding professional standard of care.



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7.1 Responsibilities and Functions of the CRC are as follows:

- 7.1.1 To serve as an advisory panel in the development of standards for the credentialing of mental health providers.
- 7.1.2 To serve as an advisory panel in the development of credentialing policies and procedures.
- 7.1.3 To review and evaluate the credentials of mental health providers whose application and/or credentials present special issues or indicate adverse events that require further consideration.
- 7.1.4 To review and evaluate the credentials of network providers who no longer appear to meet the established criteria for credentialing during the term of an existing contract or at the time of contract renewal.
- 7.1.5 To review and evaluate the credentials of network providers at the time of re-credentialing who no longer appear to meet the established criteria for credentialing.
- 7.1.6 To advise the Medical Director of the Department of the committee's recommendations for the denial of credentialing of mental health providers.

8.1 The CRC Evaluation of Application and Credentials are as follows:

- 8.1.1 The CRC will review all documents pertaining to the evaluation of the professional credentials of a provider presented to the committee.
- 8.1.2 The CRC may request additional information from the provider or pertinent organizations that may assist the committee in the evaluation process.
- 8.1.3 The CRC may request a personal interview with providers to clarify any questions related to the approval/denial of credentialing.
- 8.1.4 Upon completion of the review, the CRC will recommend a decision regarding the qualifications of the provider to participate in the LMHP Provider Network. Recommendations may include, but are not limited to full approval, approval with specific restrictions and monitoring and denial.
- 8.1.5 A recommendation by the CRC to deny credentialing to deny re-credentialing or to recommend the termination of an existing contract will be reviewed with the Medical Director of the Department.



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8.1.6 The Medical Director of Managed Care Services will notify providers in writing, via certified mail, of a decision to place a provider on probation, to deny credentialing, to deny re-credentialing or to recommend termination of an existing contract.

9.1 A recommendation by the CRC to deny credentialing, deny re-credentialing or recommend termination of an existing contract may be made under the following circumstances:

9.1.1 Falsification or misrepresentation of information required for credentialing or re-credentialing.

9.1.2 Failure to supply current information when requested for credentialing.

9.1.3 Failure to attest, explain or provide accurate information regarding the following:

9.1.3.1 Past and/or current professional liability claims and settlements.

9.1.3.2 Past and/or current denial, termination, restriction, or modification of professional liability insurance.

9.1.3.3 Past and/or current suspension, limitation or termination of professional license or narcotic registration.

9.1.3.4 Current sanction activity by a professional licensing board or Drug Enforcement Administration.

9.1.3.5 Past and/or current sanction activity or adverse actions by Medicare, Medi-Cal, a specialty board, hospital medical staff, health faculty, clinical group, independent practice association or other health delivery entity or system.

9.1.3.6 A felony conviction.

9.1.3.7 A physical or mental impairment, which would render the provider unable, with or without reasonable accommodation, to provide professional services within his/her area of practice, without posing a direct threat to the health and safety of others.

9.1.4 Inability to verify credentials submitted by provider.

9.1.5 Excessive or egregious past or current malpractice claims and/or settlements.



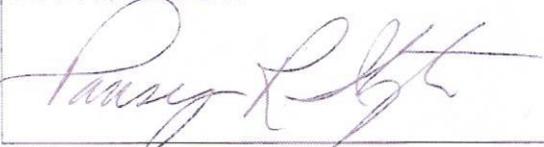
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- 9.1.6 Excessive or significant beneficiary or provider complaints as verified by primary source and/or internal quality management information.
  - 9.1.7 Excessive or egregious administrative non-compliance as determined by internal quality management information.
  - 9.1.8 Provider has stated or demonstrated practice patterns outside of professional standard of care.
  - 9.1.9 Provider is unable to provide professional services within his/her area of practice, with or without reasonable accommodation, for a physical or mental impairment, without posing a direct threat to the health and safety of others.
  - 9.1.10 The CRC determines, based upon the provider's application, credentials and information obtained from primary source verification, the provider's inability to execute the duties and obligations as assigned in the provider legal agreement.
- 10.1 The LMHP will maintain the confidentiality of all provider credentialing and re-credentialing information and files.

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<b>APPROVED BY:</b> 	<b>SUPERSEDES</b> <b>12/1/04</b>	<b>ORIGINAL ISSUE DATE</b> <b>10/19/99</b>	

**PURPOSE**

- 1.1 To ensure that the credentialing/re-credentialing, limitation, and termination decisions of the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) network providers' privileges are followed in a consistent manner and with due process.

**POLICY**

- 2.1 LMHP shall, as appropriate, deny credentialing or re-credentialing, restrict, suspend or terminate a provider's privilege to participate in the LMHP Provider Network if it is determined that a provider:
- a) Does not meet the standards enumerated in Policies CR1, CR2, or this policy;
  - b) Does not comply with the credentialing or re-credentialing procedures specified in Policies CR1, CR2 or this policy;
  - c) Fails to comply with any of the provisions set forth in the provider contract;
  - d) Poses an immediate threat to the health and safety of any individual, including current or prospective beneficiaries;
  - e) Fails to provide care in a manner consistent with professional standards or fails to provide quality patient care;
  - f) Violates LMHP rules, policies or other requirements;
  - g) Violates professional ethics;
  - h) Is convicted of a crime related to health care, substance abuse or other crime, the commission of which, demonstrates dishonesty or lack of fitness to provide care within the Provider Network;



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- i) Is subject to licensure restrictions that limit the provider's practice or require professional oversight for care provided. This provision illustrates that the requirements for credentialing in the LMHP exceed those of licensing authorities;
  - j) Is excluded or restricted by Federal, State or local authorities from participation in any program receiving public health care reimbursement;
  - k) Is subject to mandatory termination as described in Section 6.1 of this policy.
- 2.2 A decision to deny credentialing, re-credentialing, limit or terminate a provider's privilege to participate in the LMHP Provider Network, shall be subject to independent review pursuant to Policy CR4.

**PROCEDURE**

- 3.1 Denial of Initial Credentialing/Re-credentialing
- 3.1.1 Failure to pass the minimum standards established by the LMHP for credentialing as delineated in Policy CR1 Section 5.1 will result in the denial of initial credentialing/re-credentialing.
  - 3.1.2 The credentialing specialist/designee notifies the provider in writing of the failure to meet the minimum credentialing standards.
  - 3.1.3 The provider shall be given 60 days to correct the application or submit additional information to show compliance with the minimum credentialing criteria.
  - 3.1.4 If the provider does not meet criteria within 60 days, the credentialing specialist/designee shall close the applicant's file for consideration as an LMHP network provider.
- 4.1 Failure to comply with the re-credentialing process
- 4.1.1 The credentialing specialist/designee shall send a request and application for re-credentialing no less than 120 days before the expiration date of the credentials.
  - 4.1.2 If the provider fails to respond to the initial request for re-credentialing within 30 days, the credentialing specialist/designee shall submit a second request in writing to the provider.



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4.1.3 If the provider fails to respond to the second request, his or her participation in the LMHP Provider Network shall terminate upon the expiration of the period for which he or she was last credentialed.

5.1 Termination or denial of credentialing/re-credentialing:

5.1.1 A provider's participation in the LMHP shall terminate upon the expiration of the period for which he or she was last credentialed, unless he or she is re-credentialed.

5.1.2 The Credentialing Review Committee (CRC) may recommend to the Medical Director of the Department, that a provider applicant or network provider not be credentialed, not be re-credentialed or have his or her credentials terminated. Such recommendation shall be based on the CRC's full review and evaluation of all available material at a regularly scheduled or special meeting. The content of the CRC and the discussion of the issues relative to the denial recommendation shall be reflected in the meeting minutes. The recommendation shall be forwarded to the Medical Director of the Department within five business days of the decision. The Medical Director of the Department may accept, reject, or request additional action on any recommendation of the CRC.

5.1.3 If the Medical Director of the Department takes action to deny credentialing or re-credentialing based upon the recommendation of the CRC, he or she or a designee shall serve the provider in writing via certified mail with a Notice of Intended Action to deny or restrict the provider's participation in the LMHP Provider Network. The Notice of Intended Action shall include:

- 1) The nature of the action proposed to be taken;
- 2) A date not earlier than thirty days subsequent to receipt of the Notice of Intended Action on which the intended action will take place;
- 3) The specific reasons for the proposed action;
- 4) The provider's right to request an independent review of the proposed action in the manner described in Policy CR4;
- 5) The thirty day time limit within which the provider may request an independent review pursuant to Policy CR4;
- 6) A summary of the provider's rights with respect to an independent review. A copy of Policy CR4 shall be enclosed with the notice prescribed by this section.



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5.1.4 If the provider does not request an independent review pursuant to Policy CR4, the action taken by the Medical Director of the Department shall become final and not subject to further appeal or review within the LMHP. The provider will be notified in writing via certified mail that the action is final.

5.1.5 A provider who has sought an independent review pursuant to Policy CR4, and who is not subject to summary suspension or mandatory termination pursuant to Section 6.1 of this policy may participate in the LMHP pending the decision of the Credentialing Appeals Committee (CAC) for up to 120 days after receipt by the provider of the Notice of Hearing as described in Policy CR4 Section 3.3.2

5.1.6 A provider who has received a Notice of Intended Action pursuant to Section 5.1.3 of this policy may, upon written notice given to the Chair of the CRC, and as soon as practicable after receipt of the Notice, inspect and at his or her own expense, copy any non-privileged, non-confidential documentary information relevant to the intended action that the CRC has in its possession or under its control.

6.1 Provider Terminations, Suspensions, and Restrictions during the period of credentialing

6.1.1 At any time during the period of credentialing, the CRC, may make a recommendation to the Medical Director of the Department to terminate, suspend or restrict the privilege of a provider to participate in the LMHP Provider Network if it determines that a provider no longer meets the requirements of this policy or Policies CR1 and/or CR2. Any information that might lead to an action by the CRC pursuant to this paragraph shall first be reviewed by the Medical Director of Managed Care Services in order to determine the need for, or course of, further investigation. At the discretion of the Medical Director of Managed Care Services such investigation may result in informal resolution, referral to the CRC for further evaluation, summary suspension or restriction of clinical privileges as described in Sections 6.1.2, 6.1.3 and 6.1.4 of this policy.

6.1.2 Summary Suspension: The Medical Director of the Department or the designee, may at any time, immediately suspend or restrict clinical privileges of a provider where failure to take such action may result in imminent danger to the health of any individual including prospective beneficiaries. The terms of the suspension or restriction shall remain in effect pending full investigation, CRC evaluation, and final decision. In the event of such summary suspension, the case shall be forwarded immediately to the CRC and the procedures described in this policy and Policy CR4 shall be followed. Additionally, notification shall be given to the provider and the ACCESS Center to suspend referrals until a full investigation and review has been completed.



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6.1.3 Mandatory Termination: Notwithstanding other provisions of this policy or Policy CR4, a provider shall be terminated from participation in the LMHP upon the occurrence of any of the following events:

- a) Revocation, or suspension of the provider's license by the applicable licensing authority;
- b) Commitment to jail or imprisonment;
- c) Conviction of a crime related to provision of health care within the LMHP;
- d) Loss of professional liability insurance;
- e) Exclusion or restriction of participation in the Medi-Cal or Medicare programs.

6.1.3.1 The Medical Director of Managed Care Services will immediately notify the provider of the mandatory revocation in writing via certified mail. This notification shall specify the reason for which the provider was terminated and shall include a copy of any documentary proof that supports the revocation. Mandatory termination of privileges pursuant to this paragraph is not subject to a Notice of Intended Action as provided in Section 5.1.3 of this policy. However, the terminated provider shall have the right to an independent review of the termination as provided in Policy CR4 with respect to the grounds for mandatory revocation.

6.1.4 In the event of summary suspension or mandatory termination, the following actions shall take place:

6.1.4.1 The credentialing specialist or designee shall:

- a) Request a list from the provider of all clients currently in treatment with the provider which is to include the client's name, CIN #, address and phone number.
- b) Obtain a claims based report of all clients for whom claims were paid to the provider from the Medi-Cal Professional Services and Authorization Division Provider Relations Unit and reconcile the report with the provider list to establish an accurate client list;
- c) Forward the client list to the Beneficiary Services Program in the Patients' Rights Office who shall notify the clients in writing of the following:



DEPARTMENT OF MENTAL HEALTH  
Office of the Medical Director  
POLICY/PROCEDURE

<b>SUBJECT:</b> <b>DENIAL OF CREDENTIALING OR RE-CREDENTIALING AND SUSPENSION AND TERMINATION OF PROVIDER PRIVILEGES</b>	<b>POLICY NO.</b> <b>CR3</b>	<b>EFFECTIVE DATE</b> <b>1/1/09</b>	<b>PAGE</b> <b>6 of 7</b>
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1. The provider is no longer a participant in the LMHP Provider Network;
2. Due to the inactive status of the provider, the LMHP is not responsible for any aspects of the services delivered by the provider as of the date of notification;
3. The client may contact the ACCESS Center or the Beneficiary Services Program to receive referrals to other LMHP network providers, directly operated providers or contract providers;
4. The Beneficiary Services Program Specialist will assist the client in transferring to another mental health provider if he/she so chooses;
5. Confidentiality surrounding adverse actions imposed on the provider will be maintained during the course of client discussions.

6.1.5 The Credentialing Specialist or designee shall notify Contracts Development and Administration Division of the action. The Contracts Development and Administration Division shall immediately terminate the provider contract.

6.1.6 Network Providers who elect to terminate their provider contract shall be responsible for notifying the provider's current beneficiaries in writing of the termination of the contract as provided in Section 6.1.4.1(c) (1-4) of this policy and in accordance with the requirements in the LMHP Provider Manual or through Provider Bulletins.

7.1 Network Providers with Accusations against their License: The credentialing specialist may identify a provider with an accusation from the "hot sheets" or other published reports of State licensing board activities. In such occurrences, the credentialing specialist shall review the accusation with the Medical Director of Managed Care Services to determine the course of further investigation. The provider may be forwarded to the CRC for full evaluation, review and recommended action. The CRC may:

- a) Request additional information from the provider regarding the accusation;
- b) Conduct further investigation deemed necessary by the CRC;
- c) Require that the provider provide reports on the status of the accusation on a quarterly basis;
- d) Pend the case until judgment has been rendered from specific authority investigating the case (i.e., Medical Board).



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7.1.2 If upon full evaluation the CRC recommends imposing a limit, suspension, or termination to the credentialing status of the provider, the procedures delineated in Section 5.1 of this policy shall be followed.

8.1 Reporting Requirements

8.1.1 The LMHP shall comply with the provisions of California Business and Professions Code Sections 800-809 and the Federal Health Care Quality Improvement Act of 1986.

8.1.2 LMHP shall file a Section 805 report with the Medical Board of California or the other appropriate California licensing board and a report with the National Practitioner Data Bank within 15 days after the effective date of the action, when the LMHP takes the following actions:

- a) Takes a professional review action that adversely affects the clinical privileges of a provider for a period longer than 30 days;
- b) Accepts the surrender of clinical privileges of a provider while the provider is under an investigation relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation;
- c) Takes a professional review action that adversely affects the membership of the provider into the network.



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Office of the Medical Director  
**POLICY/PROCEDURE**

<b>SUBJECT:</b> <b>INDEPENDENT REVIEW OF CREDENTIALING AND RE-CREDENTIALING DECISIONS; HEARING PROCEDURES; FINAL DECISIONS</b>	<b>POLICY NO.</b>  <b>CR4</b>	<b>EFFECTIVE DATE</b> <b>1/1/09</b>	<b>PAGE</b>  <b>1 of 7</b>
<b>APPROVED BY:</b>  	<b>SUPERSEDES</b>  <b>12/4/04</b>	<b>ORIGINAL ISSUE DATE</b> <b>12/1/04</b>	

**PURPOSE**

- 1.1 To provide a fair, prompt, final and independent review of decisions made to deny provider credentialing or re-credentialing, or limit or terminate a practitioner's privilege to participate in the Los Angeles County Department of Mental Health Local Mental Health Plan (LMHP) Provider Network.

**POLICY**

- 2.1 Providers who wish to contest notices of proposed actions to deny or restrict network participation in the LMHP Provider Network may have an independent review in the fashion described in this policy. This policy is intended to comport with, and should be interpreted to apply to, the provisions of California Business and Professions Code Sections 809.1 through 809.9 and 42 United States Code Section 11112.
- 2.2 All actions taken pursuant to Policy CR3 shall be subject to final determination pursuant to this policy.

**PROCEDURE**

- 3.1 Demand for Independent Review
  - 3.1.1 Not later than 30 days after receipt of a Notice of Intended action as described in policy CR3, a provider may demand an independent review. Such demand will be served on the Medical Director of Managed Care Services.
  - 3.1.2 If the provider chooses to be represented by an attorney or other person at the Independent Review Hearing, the demand is to provide the representative's name and contact information no later than 30 days after receipt of a Notice of Intended Action as described in Policy CR3.



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3.2 Notice of Independent Review Hearing

3.2.1 Not later than 30 days after receipt of the provider's demand for an Independent Review Hearing, the Medical Director of Managed Care Services will give the provider, or if the provider so designates as provided in section 3.8 of this policy, his or her representative, a written Notice of Hearing that specifies the date, time and place of the Independent Review Hearing, as well as the names of the Hearing Officer described in Section 3.5 of this policy and members of the Credentialing Appeals Committee (CAC) described in Section 3.6 of this policy. In addition, this notice shall specify the names and qualifications of all individuals who will testify or present justification for the intended action at the Independent Review Hearing, along with a very brief summary of the information they will present.

3.2.2 Copies of all records, writings or other non-verbal materials to be presented by the Credentialing Review Committee (CRC) at the Independent Review Hearing shall be provided along with the notice. This provision is intended to facilitate the independent review process and support full opportunity for advance preparation for the Independent Review Hearing. Failure to provide information as described in this subsection shall foreclose a presentation of verbal or non-verbal materials at the Independent Review Hearing.

3.3 Objection to the Notice of Hearing

3.3.1 Not later than 15 days after physical receipt of the Notice of Hearing, the provider, or his or her representative, may submit written questions (voir dire) concerning the qualifications or impartiality of the members of the CAC or of the Hearing Officer to which written responses shall be given within 15 days of submission.

3.3.2 Not later than 30 days after physical receipt of the Notice of Hearing, the provider, or his or her representative, may object in writing to the date, time or place of the Independent Review Hearing to the Hearing Officer. The grounds for such objections shall be stated specifically. The Hearing Officer shall promptly consider and determine such objections. However, in all cases, Independent Review Hearings shall take place not later than 120 days after receipt by the provider of the Notice of Hearing described in Section 3.2 of this policy.



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3.4 Responses to the Notice of Hearing

- 3.4.1 Not later than 30 days after physical receipt of the Notice of Hearing, the provider, or his or her representative, shall give a written response to the Notice of Hearing to the Medical Director of Managed Care Services. The response shall specify the names and qualifications of all individuals who will testify or present in opposition to the intended action at the Independent Review Hearing, along with a very brief summary of the information they will present. Copies of all records, writings or other non-verbal material to be presented shall be provided along with the response. This provision is intended to facilitate the independent review process and support full opportunity for advance preparation for the Independent Review Hearing.
- 3.4.2 Except as provided in Section 3.1.4 of this policy, failure to provide information as described in this subsection shall foreclose a presentation of verbal or non-verbal materials at the Independent Review Hearing.

3.5 Role and Qualifications of the Hearing Officer

- 3.5.1 The Hearing Officer shall be an attorney or other person knowledgeable about legal process and the introduction and preservation of evidence.
- 3.5.2 The Hearing Officer shall have no interest in, or derive direct financial benefit from, the outcome of the Independent Review Hearing and shall be fair and impartial in all matters pertaining to the Independent Review Hearing process.
- 3.5.3 The Hearing Officer shall rule on requests, motions or objections made by either party; shall rule upon and regulate the introduction of evidence; shall control the proceedings of, and maintain order at, the Independent Review Hearing; and shall instruct the members of the CAC as to their role and responsibilities as decision makers.
- 3.5.4 The Hearing Officer shall not act as a prosecuting officer, defending officer or decision maker with respect to the outcome of the Independent Review Hearing. However, he or she may ask such questions, challenge such proffered evidence and make such comment as may assist the parties or the CAC or assure the effective and efficient conduct of the independent review process.

3.6 Roles and Qualifications of the Credentialing Appeals Committee



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3.6.1 The CAC will consist of three members who shall hear and consider such evidence as is presented to them and shall determine the outcome of the Independent Review Hearing. The CAC members shall have expertise sufficient to understand and decide upon the issues to be determined in the Independent Review Hearing and, where feasible, will include an individual practicing in the same specialty as the provider.

3.6.2 The members of the CAC will have no interest in the outcome of the Independent Review Hearing; shall not have acted as an accuser, investigator, fact-finder, or initial decision maker; shall be fair and impartial in all matters pertaining to the Independent Review Hearing; and may not be in direct economic competition with the provider.

**3.7 Representation of Parties**

3.7.1 In all matters pertaining to this policy, the provider may be represented by an attorney licensed to practice law in California or other person of the provider's choice. If the provider is represented, the CRC may be represented. The attorney or other representative shall comply with the requirements and constraints of this policy and of law. The Hearing Officer is empowered to make such rulings, and take such actions, as will assure such compliance.

**3.8 Pre-hearing Communications and Pre-Hearing Conference**

3.8.1 All written communication to the provider shall be made by United States mail at the address provided by him or her to the LMHP. All written communication to the LMHP shall be made to the Medical Director of Managed Care Services Department of Mental Health, 550 So. Vermont Avenue, Room 704, Los Angeles, California 90020.

3.8.2 If the provider or the LMHP is represented by an attorney or other person, each may designate that written communications and service of documents be given to the representative at an address provided.

3.8.3 Copies of all written communications and documents described in this policy will be provided to the Hearing Officer.

3.8.4 At the discretion of the Hearing Officer, pre-hearing conferences or settlement discussions may occur.

**3.9 Time, Place and Attendance at the Independent Review Hearing and Record of Hearing**



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- 3.9.1 The Independent Review Hearing will be held in a single session at the time and place specified in the Notice of Hearing, unless otherwise mutually agreed upon by the Medical Director of Managed Care Services, the Provider and approved by the Hearing Officer.
- 3.9.2 The Independent Review Hearing will take place during the period of one and one half hours unless, for good cause shown, the Hearing Officer extends the time.
- 3.9.3 Those in attendance at the hearing may be the Director of Mental Health; the Medical Director of the Department of Mental Health; the provider and his or her representative, if any; the Medical Director of Managed Care Services; the Chair and members of the CRC and their representative, if any; witnesses to be called; and such others as permitted by the Hearing Officer for good cause shown. The Hearing Officer may hear and determine objections to the attendance of anyone during all or part of the Hearing.
- 3.9.4 A record will be made of the Independent Review Hearing and a copy of will be given to the provider upon payment of charges associated with its preparation.

**3.10 Procedure at Independent Review Hearing**

- 3.10.1 The CRC and the provider will have equal time to present at the Independent Review Hearing. During such time, they may call, examine and cross-examine witnesses; present documentary evidence; rebut evidence presented; object to, or move to, strike evidence, and; make arguments, and submit written statements of any length. In no event, shall the CRC or the provider exceed its total allocated time for any such purpose.
- 3.10.2 The Hearing Officer will permit only relevant evidence at the Independent Review Hearing. For purposes of this policy, relevant evidence tends logically to prove or disprove something at issue. Evidence of the qualifications or credibility of witnesses will be permitted. A party offering documentary or demonstrative proof must establish its authenticity. Neither party shall be permitted to present evidence that was not provided pursuant to paragraphs 3.2 or 3.3 of this policy or not otherwise previously available to the opposing party and the Hearing Officer.
- 3.10.3 The Hearing Officer may exclude evidence if its probative value is substantially outweighed by the probability that it will consume undue time, create undue prejudice, confuse the issues at the Independent Review Hearing, or mislead the CAC.



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3.10.4 Except as provided in this subsection, all evidence is admissible at the Independent Review Hearing and the rules of evidence in judicial proceedings shall not apply.

3.11 Presentation of Evidence and Burden of Persuasion

3.11.1 At all Independent Review Hearings, the CRC will have the initial responsibility to present evidence sufficient to support its intended action.

3.11.2 The party bearing the burden of persuasion must persuade the CAC by a preponderance of the evidence that what it asserts is more likely to be true than not true.

3.11.3 The burden of persuasion shall be on the provider in cases where the reason for denial of credentialing is failure to meet any of the additional requirements in CR1 Section 6.1 which the CRC finds inadequate reason to waive.

3.11.4 Burden of persuasion for Initial Credentialing: If the provider is challenging a decision related to initial credentialing, he or she shall bear the burden of persuasion with respect to his or her qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning such qualifications. However, an initial applicant shall not be permitted to introduce information not provided with the completed provider application described in Policy CR1, Section 4.2, or to the CRC pursuant to Policy CR2, Section 8.1.2 or Section 8.1.3, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

3.11.5 Burden of Persuasion at Other Hearings: If the Provider is challenging a decision other than one related to initial credentialing, the CRC shall bear the burden of persuasion to establish that its intended action is reasonable and warranted under LMHP policies related to patient care and provider credentialing.

3.12 Consideration of Evidence

3.12.1 Notwithstanding the burden of presenting evidence or the burden of persuasion, the CAC may consider all evidence admitted at the Independent Review Hearing.

3.13 Submission to and Decision of the Credentialing Appeals Committee

3.13.1 After submission of all evidence and arguments, the Independent Review Hearing shall end and the procedures described below shall take place.



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3.13.1.1 Questions: After all evidence has been submitted and arguments made, the members of the CAC may ask relevant questions of the parties or their representatives or of the Hearing Officer.

3.13.1.2 Instructions: The Hearing Officer shall instruct the CAC concerning the consideration of evidence, burdens of persuasion and their responsibilities to decide the matter before the Committee.

3.13.1.3 Decision: A final determination of the provider's credentialing status shall be rendered by the CAC and communicated to the provider in writing via certified mail by the Chair of the CAC, or his or her designee, within 14 days of the Independent Review Hearing. If the determination is adverse, the communication shall include a statement of the basis for the decision.

**3.14 LMHP Participation Pending Final Determination**

3.14.1 During the periods provided in this policy for independent review, and pending the final decision by the CAC, a provider who has sought an Independent Review Hearing and who is not subject to summary suspension or mandatory termination may participate in the LMHP.

3.14.2 Consistent with the provisions of Section 3.2 of this policy, however, the provider's participation in the LMHP shall in all cases terminate 120 days after receipt by the provider of the Notice of Independent Review Hearing described in section 3.2.1 of this policy.

**3.15 Finality of Decision**

3.15.1 The decision of the CAC is final and the provider has no further right of appeal to the LMHP.

**3.16 Strict Construction of Procedures**

3.16.1 Consistent with the purposes of this policy, the procedures described herein shall be strictly applied.

3.16.2 Deviation from these procedures shall be permitted only if found by the Hearing Officer to constitute a threat of gross injustice to a party or a substantial detriment to the role and responsibilities of the CAC.

## **ADDITIONAL INFORMATION CONTRACTOR ADDRESS FORM**

PROVIDER NUMBERS are primary locations where the services are provided. Please ensure the correct Provider Numbers are reflected in this Contractor Address Form.

THE PAY TO ADDRESS is the address that will be used FOR REIMBURSEMENT. If you receive reimbursement at more than one location, please indicate in writing by placing a checkmark in the proper Pay To Address, which corresponds with the correct Provider Numbers.

### **USE THIS FORM IF YOU HAVE A CHANGE OF ADDRESS**

Complete this form and return to the address printed on the form. If you have several Provider Numbers, ensure that the correct numbers are included with the Contractor Address Form.

Be extra careful to ensure the correct Provider Numbers are on this form.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
CONTRACTOR ADDRESS FORM

- New  
 Change of Address

Contractor: \_\_\_\_\_

Private Residence NOT FOR PUBLICATION (UNLESS IT IS THE ONLY ADDRESS ON FILE)		
A.	<input type="checkbox"/> PAY TO ADDRESS	<input type="checkbox"/> MAILING ADDRESS PROVIDER #:
_____ _____ _____		
Telephone No.	( ) _____	Fax No. ( ) _____
Email: _____		
Office Service Location (published for referrals)		
B.	<input type="checkbox"/> PAY TO ADDRESS	<input type="checkbox"/> MAILING ADDRESS PROVIDER #
_____ _____ _____		
**Telephone No.	( ) _____	Fax No. ( ) _____
Email: _____		
Other Service Location (published for referrals)		
C.	<input type="checkbox"/> PAY TO ADDRESS	<input type="checkbox"/> MAILING ADDRESS PROVIDER #
_____ _____ _____		
Telephone No.	( ) _____	Fax No. ( ) _____
Email: _____		
Other Service Location (published for referrals)		
D.	<input type="checkbox"/> PAY TO ADDRESS	<input type="checkbox"/> MAILING ADDRESS PROVIDER #
_____ _____ _____		
Contact Person	_____	
Telephone No.	( ) _____	Fax No. ( ) _____

Please check appropriate **Pay to Address** (for reimbursement) and only one **Mailing Address**.

Return form with Agreement to Contracts Development and Administration Division, ATTN: Managed Care Section, 550 S. Vermont, 5<sup>th</sup> Floor, Los Angeles, CA 90020. This form is also to be used when reporting a change of address, which can be faxed to (213) 381-7092.

DATE: \_\_\_\_\_

SAMPLE BENEFICIARY NOTIFICATION LETTER

Date

Client Name

Address

City, State

Dear Client/Parent/Caregiver:

The purpose of this letter is to inform you that I am no longer a Medi-Cal provider in the County of Los Angeles Department of Mental Health provider network.

If you would like assistance locating another mental health provider or other mental health services in the provider network, you may call the Department of Mental Health ACCESS Center at 1-800-854-7771. The ACCESS Center is available for calls 24 hours a day, 7 days a week.

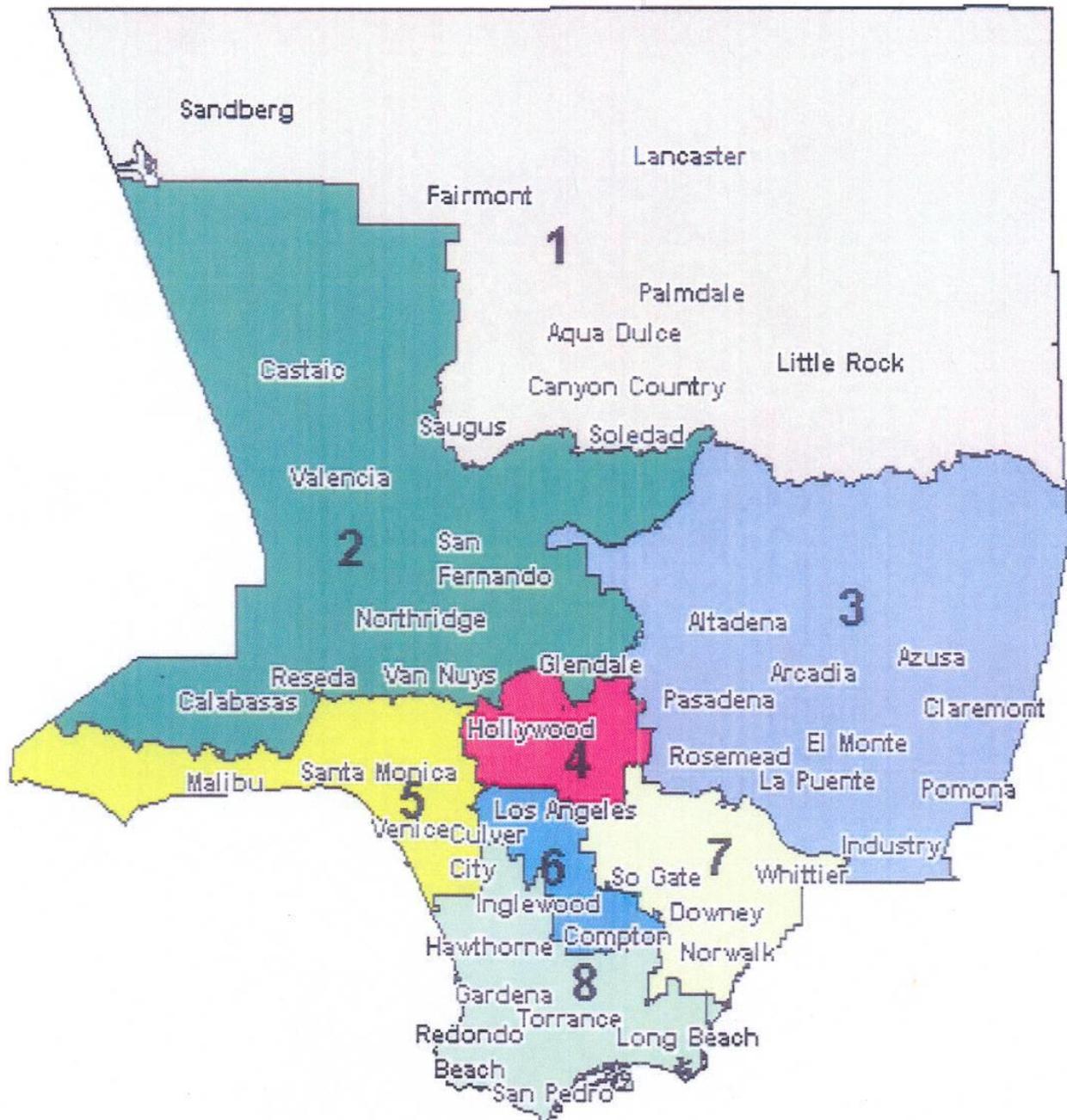
If you need additional assistance you may also contact the Beneficiary Services Program at (213) 738-4949.

Sincerely,

Provider Name

**FIGURE A:**

**COUNTY OF LOS ANGELES  
DEPARTMENT OF MENTAL HEALTH  
SERVICE AREA MAP**



## SECTION III – THE PROVIDER SUPPORT OFFICE

The Provider Support Office provides technical, administrative and clinical assistance to Local Mental Health Plan (LMHP) network providers and their authorized representative (e.g., billing agent, group provider administrator) to aid in the delivery of quality specialty mental health services. The Provider Support Office may be contacted at (213) 738-3311 during the business hours of 8:00 a.m. to 5:00 p.m., to provide the following technical, administrative, and clinical assistance:

### TECHNICAL ASSISTANCE

- Disseminate guidelines regarding changes to County's claims processing information systems technical requirements and the submission of HIPAA-compliant claims to the LMHP;
- Advise and resolve network providers' and billing agents' issues concerning electronic claiming, disputes and reports in the County's claims processing information systems;
- Provide assistance regarding electronic Medi-Cal beneficiary enrollment and MediCal eligibility transactions in the County's electronic health records systems; and
- Direct network providers and billing agents to appropriate resources, internal and external to the LMHP.

### ADMINISTRATIVE ASSISTANCE

- Provide information and assistance to mental health providers on the application, credentialing and contracting process;
- Provide information and assistance to set up and updates network providers' profiles in the County's electronic health records systems;
- Disseminate LMHP guidelines, policies and State and Federal regulations;
- Compile, prepare and post the Network Provider Manual via the Department's outpatient website;
- Distribute bulletins and other network provider informational materials;
- Provide information regarding network providers' responsibility for obtaining forms for Medi-Cal beneficiary materials;
- Develop and administer the network providers' fiscal appeal process; and
- Provide administrative assistance to network providers and billing agents regarding Notices of Action.

### CLINICAL ASSISTANCE

- Serve as liaison between Medi-Cal beneficiaries and network providers to facilitate access to services and care coordination;
- Provide guidelines regarding procedure and diagnosis codes;
- Assist with out-of-county provider services and authorization of over-threshold and psychological testing services;
- Coordinate the clinical appeal process; an

- Provide information to network providers regarding clinical records and consent standards.

If you have any questions or need additional information, please contact the Provider Support Office at the following location:

Department of Mental Health  
Provider Support Office  
695 S. Vermont Ave., 11<sup>th</sup> Floor  
Los Angeles, CA 90005  
Phone: (213) 738-3311  
Fax: (213) 352-8742

Email: [FFS2@dmh.lacounty.gov](mailto:FFS2@dmh.lacounty.gov)

## SECTION IV– ACCESS TO SERVICES

Medi-Cal beneficiaries can access specialty mental health services through the Access to Community Care and Effective Services and Support (ACCESS) Center at (800) 854-7771, 24 hours a day, seven days a week. Services are organized on a geographic basis to facilitate greater ease of access. However, Medi-Cal beneficiaries are free to request services in any geographic service area of the system, and may secure referrals to any mental health program, whether directly operated by, or contracted with, the LMHP.

The ACCESS Center (AC) is a major entry point to the LMHP for Medi-Cal beneficiaries and is staffed with multi-disciplinary, multi-cultural and multi-lingual personnel. The AC is also able to provide services to individuals with sensory impairments. The AC provides screening and triage through licensed clinicians who evaluate treatment needs and ensure expedient and appropriate access to LMHP services

The AC offers the following:

- Information and direction to Medi-Cal beneficiaries seeking specialty mental health services;
- Determination of appropriateness for specialty mental health services through the LMHP;
- Screening and triage of client calls to identify service needs;
- Crisis intervention;
- Connection to emergency services such as the Psychiatric Mobile Response Team and other urgent delivery service systems;
- Determination of programs currently providing services to a specific client;
- Referrals to network providers;
- Direction for network providers to appropriate LMHP Divisions for authorization of psychological testing and other outpatient professional services;
- Direction for out-of-county providers to client enrollment and authorization services;
- Direction for out-of-county and out-of-state provider authorization requests to the appropriate resource;
- Information regarding linkage to community resources;
- Information and referrals for other non-related mental health services;
- Linkage and referral to services provided by the LMHP;
- Information regarding client problem resolution processes; and
- Referral to the Patients' Rights Office and the Provider Support Office, previously known as Provider Relations Unit.

## SECTION V – CONFIRMATION OF MEDI-CAL ELIGIBILITY AND ELECTRONIC MEDI-CAL BENEFICIARY ENROLLMENT

### ELIGIBILITY VERIFICATION

Confirmation of Medi-Cal eligibility is a MUST by network providers, billing agents/services and clearinghouses. Network providers are required to verify client Medi-Cal eligibility prior to providing services.

Clients are required by the State to present their Benefits Identification Cards (BIC) in order to access their Medi-Cal benefits. Carrying the BIC helps providers affirm that the client is entitled to Medi-Cal benefits and facilitates checking clients Medi-Cal eligibility. The issue date can be found on the front of the card along with other information such as the recipient's name, gender, date of birth, and the Client Index Number (CIN). The CIN is a unique identifier assigned to an individual.

Each CIN begins with a 9 followed by seven (7) digits, an alpha character other than B, I, J, K, L, O, P, Q, R, or S, and ends with a "check digit." This sequence is then followed by a four (4) digit sequence (e.g., 91234567A2 **9180**). The issue date for the BIC is the sequence after the CIN in the Julian calendar date format. The first number of this sequence represents the year and the last 3 numbers represent the day of the year. For example, in the four (4) digit sequence **9180** the 9 represents the year 2009, and 180 represents the one hundred eightieth day of that year, June 29th. The BIC issue date in this example would be June 29, 2009.

Medi-Cal eligibility and share of cost information may be verified by entering the Medi-Cal beneficiary's Client Index Number (CIN) printed on the beneficiary's Medi-Cal card in one of the State eligibility systems as follows:

- Providers with a California Department of Health Care Services (DHCS) issued provider number may verify Medi-Cal beneficiary eligibility by swiping the beneficiary's Medi-Cal card through the Point of Service (POS) Network Device. Contact the Medi-Cal POS and Internet Help Desk at (800) 427-1295 for information about acquiring a POS device, or at the following website address: <https://www.medi-cal.ca.gov/Eligibility/Login.asp>.
- Providers with a DHCS issued provider number may verify Medi-Cal beneficiary eligibility by entering the CIN in the Automated Eligibility Verification System (AEVS). The AEVS is an interactive voice response system that allows the provider to verify eligibility through a touch-tone telephone. The AEVS may be accessed by calling (800) 456-2387. Please refer to the AEVS User Guide at: [http://files.medi-cal.ca.gov/pubsdoco/AEVS\\_home.asp](http://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp) for more information.
- Groups, licensed clinical social workers, marriage and family therapists and registered nurses are not issued DHCS provider numbers. These disciplines may contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 to obtain specially designated provider numbers (user ID) and personal identification numbers (pin/password) to verify Medi-Cal eligibility via the website at <https://www.medi-cal.ca.gov/Eligibility/Login.asp>, or AEVS at (800) 456-2387.

It is recommended that network providers maintain a copy of the Benefits Identification Card and a copy of Medi-Cal eligibility obtained from one of the State eligibility systems listed above.

## **BENEFICIARY ENROLLMENT**

Electronic Medi-Cal beneficiary enrollment is a process that requires network providers, billing agents/services and clearinghouses to enroll Medi-Cal eligible clients in the County's claims processing information system. The purpose of electronic Medi-Cal beneficiary enrollment is to assign unique Department of Mental Health client identification numbers and maintain a tracking system for Medi-Cal beneficiaries receiving services from network providers. Reimbursement will only be provided if Medi-Cal beneficiaries are enrolled in the County's claims processing information system.

Contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) for questions regarding Medi-Cal beneficiary enrollment and Medi-Cal eligibility transactions.

## SECTION VI – THE BENEFICIARY SERVICES PROGRAM AND REQUIREMENTS FOR PROVIDING MEDI-CAL BENEFICIARY MATERIALS TO CLIENTS

### MEDI-CAL BENEFICIARY MATERIALS

Under California Code of Regulations (CCR), Title 9, Chapter 11, the Local Mental Health Plan (LMHP) and its network providers are required to provide beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service.

The LMHP has developed user-friendly Medi-Cal beneficiary materials that provide a general understanding of services offered. All Medi-Cal beneficiary materials listed below must be posted in prominent locations where Medi-Cal beneficiaries obtain outpatient specialty mental health services, which includes the waiting areas of a network provider's place of service.

The LMHP has made an effort to ensure that the cultural and linguistic needs of the diverse populations served throughout the LMHP are met by developing Medi-Cal beneficiary materials in the LMHP's threshold languages which are: Arab, Armenian, Cambodian, Chinese Simplified, Chinese Traditional, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese. The Medi-Cal beneficiary materials available in the LMHP's threshold languages are:

- **Guide to Medi-Cal Mental Health Services:** Booklet informs Medi-Cal beneficiaries on how to access and obtain routine and emergency specialty mental health services;
- **Grievance Procedures:** Pamphlet describes the informal and formal processes for filing a grievance;
- **Beneficiary Grievance Form:** Form provides Medi-Cal beneficiaries the opportunity to register written dissatisfaction about any aspect of services offered by the LMHP; and
- **Beneficiary Poster:** A poster designed to provide Medi-Cal beneficiaries simple and user-friendly information while upholding Title 9, California Code of Regulations. The FFS Network Provider should post the Beneficiary Poster in prominent locations and/or waiting areas where Medi-Cal beneficiaries obtain outpatient specialty mental health services.

To obtain copies of the Medi-Cal beneficiary materials identified above, orders must be on the organization's letterhead. Materials will only be delivered to a street address, not a P.O. Box. The request may be faxed to (213) 252-9740 or mailed to:

Department of Mental Health – Warehouse  
550 S. Vermont Ave, 2<sup>nd</sup> Floor  
Los Angeles, CA 90020

For further assistance, the Patient's Rights Office can be reached at (213) 738-4888 or (800) 700-9996. Information is also available on the Patient's Rights Office website at [http://dmh.lacounty.gov/patient\\_rights.asp](http://dmh.lacounty.gov/patient_rights.asp).

## THE BENEFICIARY SERVICES PROGRAM

The Beneficiary Services Program is available to Medi-Cal beneficiaries and their family members or representatives primarily to provide assistance in resolving mental health service concerns. All beneficiary services are provided by the Department of Mental Health Patients' Rights Office. Beneficiary Services may be reached at (213) 738-2524. The following services are available:

### BENEFICIARY INFORMATION

- Provide information to Medi-Cal beneficiaries and/or their representatives regarding the LMHP and services offered.
- Inform Medi-Cal beneficiaries of their rights under California Code of Regulations, Title 9, Chapter 11, including the right to:
  - ♦ Use the grievance process at any time;
  - ♦ Authorize another person to act on his/her behalf;
  - ♦ Protection of confidentiality at all times;
  - ♦ Request a State Fair Hearing after the appeal process of the LMHP has been exhausted; and
  - ♦ A beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.
- Assist Medi-Cal beneficiaries with comprehension of issues related to Notices of Action.
- Develop, prepare and distribute Medi-Cal beneficiary materials.
- Provide information on the Health Insurance Portability and Accountability Act (HIPAA) investigate and resolve DMH HIPAA complaints.

### BENEFICIARY ASSISTANCE

- Assist in the problem resolution process for grievances filed with the LMHP about access to service and service delivery issues.
- Record, investigate, and coordinate resolution of grievances filed by Medi-Cal beneficiaries with the LMHP.
- Provide referrals to emergency shelter and transitional housing.
- Represent Medi-Cal beneficiaries at State Fair Hearings upon request.
- Provide all services to Medi-Cal beneficiaries in their primary language and in a culturally appropriate manner.

### CLINICAL ASSISTANCE

- Assist Medi-Cal beneficiaries in accessing specialty mental health services available through the LMHP, which can include accessing care, changing providers, requesting a second opinion when indicated, and understanding and exercising their rights.

- Serve as liaison between Medi-Cal beneficiaries and network providers during the grievance process and when requested.
- Provide outpatient clinic referrals to Medi-Cal beneficiaries and assist with coordination of transfers.
- Provide assistance to Medi-Cal beneficiaries who receive notification of their network provider contract termination with the LMHP.

### **STATISTICAL REPORTING/SYSTEM CHANGE**

- Collect and provide statistical information regarding Medi-Cal beneficiary grievances and the problem resolution process.
- Make system change recommendations to the Director of Mental Health and Executive Management Team.
- Make corrective action recommendations to directly operated and network providers.
- Develop policies and procedures to enhance the quality of services to Medi-Cal beneficiaries.

### **TRAINING AND EDUCATION**

- Provide community outreach and education to Medi-Cal beneficiaries and community stakeholders about Medi-Cal beneficiary protection-related issues and State regulations affecting specialty mental health service delivery.
- Provide on-site educational presentations to network providers regarding the Medi-Cal beneficiary resolution process.
- Provide consultation and recommendations to bureaus and other community stakeholders regarding Medi-Cal beneficiary protection-related issues as stipulated under CCR, Title 9, Chapter 11.
- Educate network providers on landlord/tenant law.

## SECTION VII – CONSENTS AND AUTHORIZATION STANDARDS FOR CLIENT ACCESS TO HEALTH INFORMATION AND USE/DISCLOSURE OF HEALTH INFORMATION

### CONSENTS

It is the responsibility of network providers to ensure compliance with minimum requirements in obtaining client consent for specialty mental health services. Copies of the Local Mental Health Plan (LMHP) consent forms are at the end of this section for your reference in developing your own unique forms. It is important to ensure that all the required information is included on your consent forms and that they do not include a reference to the LMHP.

Form deficiencies identified during reviews are frequently the result of the absence of required information. The minimum content for consents is included in this section to assist you with ensuring compliance when developing a unique form.

The following types of consents must be included in a Medi-Cal beneficiary's clinical record:

- Consent for Services (Attachment I);
- Consent of Minor (Attachment II);
- Consent of Minor in Spanish (Attachment III) when appropriate; and
- Informed Consent for Psychotropic Medication when appropriate.

### CONSENT FOR SERVICES

#### DEFINED

This process documents the Medi-Cal beneficiary's agreement to receive specialty mental health services, the mental health services provided, instructions and client rights. A *Consent for Services* form must be signed during the first contact with a client and remains in effect for the course of treatment

#### MINIMUM CONTENT REQUIRED

- Client Name
- Name of individual, group, or organizational network provider
- Type of Services Provided:
  - ◆ List in specific language the type of service(s) that may be delivered, such as an assessment, psychological testing, psychotherapy, medication, laboratory tests, and/or diagnostic procedures.
- General Information:
  - ◆ The client has a right to be informed and participate in the selection of treatment services;
  - ◆ Treatment services are voluntary;
  - ◆ The client may request a change of service provider (agency or treating clinician); and
  - ◆ The information contained in the clinical record may be released to any LMHP operated or contracted agency or provider, pursuant to Welfare and Institutions Code Section 5328, without obtaining the consent of the client.

- Signatures Required:
  - ◆ For adults: Client signature and date, or indication on the form if the client is unable/unwilling to sign the *Consent for Services* form.
  - ◆ For minors: Signature of responsible adult, relationship to client, and date.
  - ◆ For clients unwilling to sign or a minor signing without parental consent: A witness statement (which may be by the clinician) explaining the absence of the client signature with the witness' signature and date.
  - ◆ For translators: Translator signature and date.
- Additional Requirements:
  - ◆ Affirmation that the *Consent of Minor* form has been completed for under-aged child or adolescent;
  - ◆ Printed client name and the DMH Client ID number;
  - ◆ Confidentiality and disclosure statement; and
  - ◆ Date when the client or responsible adult was given or declined a copy of the *Consent for Services* form.

## CONSENT OF MINOR

### DEFINED

This process documents the right of a minor, under the age of 18, to consent to services without parental consent. This can occur only when one of the following special circumstances exists:

- Emancipated: only a court can decide this status;
- Self-sufficient: client must be at least 15 years of age, living apart from the parent or guardian (with or without their consent), and managing his/her own affairs;
- Military: client currently on active duty;
- Married: client currently or formerly married; or
- In need of mental health services:
  - ◆ client must be at least 12 years of age and mature enough to participate in the services provided;
  - ◆ there must be a danger of serious physical or mental harm if services are not provided or there is alleged incest or child abuse;
  - ◆ there is documentation that the parent(s)/guardian(s) were contacted or the reason why they were not contacted;
  - ◆ there is documentation regarding the parent(s)/guardian(s) participation or unwillingness to participate in treatment; and it is documented that the client will not be prescribed psychotropic medications without parental/guardian consent.

**MINIMUM CONTENT REQUIRED**

- Emancipated: a copy of the minor's Department of Motor Vehicles emancipated minor ID card;
- Self-sufficient: no official designated document; the network provider must consider and document evidence presented by the minor;
- Military: a copy of the minor's military ID;
- Married: a copy of the marriage certificate; or
- In need of mental health services: the network provider must note and attest to the five requirements on the *Consent of Minor* form (Attachment II).

Documentation validating at least one of the five special circumstances above must be obtained at the same time the *Consent for Services* form (Attachment I) is signed.

Documentation is required only once for minors who are emancipated or are, or have been, married.

Documentation for minors who are in the military, declare themselves to be self-sufficient, or are between the ages of 12–18 must be obtained each time a Medi-Cal beneficiary re-enters service following a discharge either by the clinician or in the IS. A new *Consent for Services* form must also be signed for the new course of treatment.

**INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION****DEFINED**

This process documents the voluntary consent of the Medi-Cal beneficiary to take psychotropic medication after the physician has reviewed all the information with the client listed below under Minimum Requirements. An *Informed Consent for Psychotropic Medication* form is required for the following:

- When a new or different type of medication, such as anti-depressant or anti-psychotic, is prescribed;
- At least annually, even if there is no medication change; and
- When the client resumes taking medication following a documented withdrawal of consent.

**MINIMUM CONTENT REQUIRED**

- Explanation of the nature of mental disorder, what the medication(s) will address and why psychotropic medication is being recommended;
- The general type of medication being prescribed (anti-psychotic, anti-depressant, etc.) and the medication's specific name;
- The dose, frequency, and administration route of the medication(s) being prescribed;
- Situations, if any, which may warrant taking additional medications;
- How long it is expected that the client will be taking the medications;
- Potential side effects; and
- Whether there are reasonable treatment alternatives.
- Signed by the beneficiary
- A statement that informs the beneficiary that the consent may be withdrawn at any time by the beneficiary

## AUTHORIZATION STANDARDS

This section, which is in compliance with the LMHP interpretation of Health Insurance Portability and Accountability Act (HIPAA) regulations, is not to be viewed as legal advice or take the place of advice provided by your legal counsel.

The LMHP authorization forms at the end of this section may be adopted by network providers or used as a reference in developing your own unique forms. If a unique form is developed, it is important to ensure that all the required information is included.

Form deficiencies identified during reviews are frequently the result of the absence of required information. To provide assistance with developing unique forms, the minimum content for the Access and Authorization forms are included in this section.

The following types of authorizations are required:

- Medi-Cal beneficiary's access to his/her health information
- Medi-Cal beneficiary's authorization to release or request information

## CLIENT ACCESS TO PROTECTED HEALTH INFORMATION

A client has the right to inspect and obtain a copy of their protected health information (PHI) in a designated record. Upon submitting a request to the network provider, any current or former adult client, any minor client authorized by law to consent to treatment and any client's legally authorized personal representative, has the right to inspect and receive copies of the PHI contained in the mental health record. A *Client's Request for Access to Health Information* form (Attachment IV) may be used to assist the client in making the request in writing, to access his/her records

There are a limited number of circumstances in which a client may not have access to all or some of his/her PHI, such as information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding.

### DEFINITIONS

- Access: to inspect, copy or arrange for copying, PHI maintained by the LMHP or its business associates.
- PHI: under HIPAA, any information about health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted to include any part of a client's clinical record or payment history.

### MINIMUM CONTENT REQUIRED

- Client name;
- Indicate if the request is to access and inspect health information or to request a copy of health information;
- Description of the information to be accessed, copied or inspected;
- Inspection period;
- Fee information;
- Statement of rights:

- ◆ To receive a copy of the signed request;
- ◆ To request a review of denial of access;
- Signature of the client or the client's personal representative; and
- Verification of identity.

## **AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION**

It is the network provider's responsibility to obtain a client's written authorization before using, requesting, or disclosing PHI for purposes other than treatment, payment or mental health care, except as permitted by the HIPAA Privacy Rule. Use and disclosure of a client's PHI must be consistent with the valid authorization obtained from the client.

A network provider may release PHI under HIPAA rules only with a valid *Authorization for Request or Use/Disclosure of Protected Health Information* form (Attachment V), unless the rules specifically allow release without an authorization. The authorization is to be documented in a standard form. The authorization form is to include required elements, which will be more extensive if the network provider, rather than the client, is requesting release of the information.

### **DEFINITIONS**

- Disclosure: to release, obtain, transfer, provide access to, or divulge in any other manner, PHI outside the entity holding the information.
- Use: the sharing, application, utilization, examination, or analysis of such PHI within an entity that maintains such information.

### **MINIMUM CONTENT REQUIRED**

- Client name;
- Name of disclosing party;
- Name of recipient of PHI;
- Information to be released;
- Purpose of disclosure;
- Expiration date;
- Statement of right to receive a copy of, and right to revoke the authorization;
- Statement that refusal to sign the authorization form will not affect the client's ability to obtain treatment; and
- Client signature and date.

In addition, an *Authorization for Request or Use/Disclosure of Protected Health Information* form must contain further elements if the network provider is requesting the information for his/her own purposes, e.g., if a network provider is seeking authorization to use/disclose PHI that is already in his/her custody or if the network provider will be receiving any remuneration as a result of use or disclosure.

### CONSENT FOR SERVICES

The undersigned client or responsible adult\* consents to and authorizes mental health services by

\_\_\_\_\_  
Name of Individual/Group/Organizational Network Provider

These services may include assessment, psychological testing, psychotherapy/counseling, rehabilitation service, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at different locations, services provided within the Los Angeles County mental health system are often coordinated by the staff of a single agency.

The undersigned understands:

1. He/she has the right to
  - a. be informed of and participate in the selection of any of the above services to be provided;
  - b. receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
2. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or treating clinician) or service coordinator or withdraw this consent at any time.
3. Information from a client's service record relative to service delivery needs may be shared with any agency within the Los Angeles County Mental Health Plans system of care (County-operated and contract) without obtaining the consent of the client.
4. To ensure treatment staff have available to them the most complete information about you when deciding on treatment appropriate to your needs and for quality of care, any information you disclose to staff which is determined by them to be important to your care, will be recorded in your clinical record.
5. Providers of mental health services are prohibited from sharing client information except as allowed under Federal, State, and Los Angeles County Mental Health Plans confidentiality laws, policies, and procedures.
6. All client names are entered into a computer-based Management Information System operated by the Local Mental Health Plan that identifies the program(s) that is (are) providing services to the client. This information is available without client consent to any representative of the Department's directly operated or contract service agency system.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Adult\*

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

Witness attests:  Client is willing to accept services, but unwilling to sign the Consent.

Witness affirms:  I have completed or have caused to be completed the Consent of Minor form for any client under the age of 18 signing without parental/guardian consent.

This consent was translated into \_\_\_\_\_ for the client and/or responsible adult.

\_\_\_\_\_  
Signature of Witness/Translator

\_\_\_\_\_  
Date

Signature  was given or  declined a copy of this Consent on \_\_\_\_\_ by \_\_\_\_\_  
Date Initials

\*Responsible Adult = Guardian, Conservator, or Parent of Minor

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.	<b>Name:</b> _____ <b>DMH Client ID#:</b> _____
	<b>Individual/Group/Organizational Provider Name:</b> _____

### CONSENT FOR SERVICES



## CONSENTIMIENTO DE MENOR / CONSENT OF MINOR

**EMANCIPATED: (To be completed by staff)** This minor has been declared emancipated from his/her parent/guardian by the courts and and has been issued an identification card by the Department of Motor Vehicles (Cal Fam Code 7120). A copy of the identification card must be filed with this form.

**CAPACITADO: (para ser completada por el paciente)** Este menor a demostrado estar suficiente capacitado para declarar todo lo siguiente (Código Familiar de California 6922):

Tengo 15 años de edad o mayor, habiendo nacido el día \_\_\_\_\_ del mes de \_\_\_\_\_ del año \_\_\_\_\_

Vivo en la dirección principiada de admision para recibir servicios; aparte de la casa/residencia de mi padres/tutores.

Manejo mis propios ingresos como lo indique en la información financiera estipulada por mi al servicio de admisión.

Entiendo que soy responsable de los cargos por los servicios de salud mental y no podria anular este consentimiento por que soy un menor de edad.

\_\_\_\_\_  
Firma del Paciente

\_\_\_\_\_  
Fecha

**ACTIVE DUTY WITH ARMED FORCES: (To be completed by staff)** This minor must be currently serving in the US Armed Forces. A copy of his/her military ID must be filed with this form (Cal Fam Code 7002).

**MARRIED: (To be completed by staff)** This minor is or has been married (Cal Fam Code 7002). A copy of the marriage certificate must be filed with this form.

**NEED OF MENTAL HEALTH SERVICES: (To be completed by licensed clinical staff).** This minor is in need of mental health services. I certify that each of the following five requirements are met (Cal Fam Code 6924) .

1. the client is 12 or older and mature enough to participate intelligently in the services provided

2.

there is danger of serious physical or mental harm if participation is not permitted or

there is alleged incest or child abuse

3. the client's parent(s)/guardian(s):

were contacted on \_\_\_\_\_ by \_\_\_\_\_ or

were not contacted because \_\_\_\_\_

4. the client's parent(s)/guardian(s)

are currently involved in the services provided

do not want or are unwilling to participate in the treatment or

are not appropriate to participation in the services provided

5. the client **WILL NOT** be prescribed psychiatric medications without his/her parent/guardian signing the *Consent for Services* form.

\_\_\_\_\_  
Clinician Signature and Discipline

\_\_\_\_\_  
Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

Name: \_\_\_\_\_ DMH Client ID #: \_\_\_\_\_

Individual/Group/Organizational Provider Name: \_\_\_\_\_

## CONSENTIMIENTO DE MENOR / CONSENT OF MINOR

# CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

**CLIENT:**

_____	_____	_____
Name of Client	Birth Date of Client	DMH Client ID#
_____		_____
Street Address		City, State, Zip

**REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION ONSITE**

**REQUEST Agency Name SEND A COPY OF MY REQUESTED HEALTH INFORMATION TO:**

_____	_____
Name	FAX Number (include area code)
_____	
Street Address	
_____	
City, State, Zip Code	

**INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INSPECTION PERIOD:** I request information regarding the following time period:

**FROM** \_\_\_\_/\_\_\_\_/\_\_\_\_ **TO** \_\_\_\_/\_\_\_\_/\_\_\_\_

Month Day Year Month Day Year

**REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION**

**COPY FEES: AGENCY NAME MAY CHARGE YOU FOR MAKING COPIES OF YOUR HEALTH INFORMATION. THE ASSOCIATED FEES MAY BE 25 CENTS PER PAGE FOR PAPER OR FAX COPY; 50 CENTS PER PAGE FOR MICROFILM.**

**YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:**

**Right to Receive a Copy of This Request** - I understand that I must be provided with a signed copy of the form.

**Right to Request Review of Denial of Access**- I understand that Agency Name may deny my request to access my health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a *Request for Review of Denial of Access*. In most circumstances, Agency Name will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

**CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION**

**SIGNATURE OF CLIENT:** \_\_\_\_\_

OR

**SIGNATURE OF PERSONAL REPRESENTATIVE:**  
\_\_\_\_\_

**If signed by other than client, state relationship and authority to do so:**

\_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**FORM(S) OF IDENTIFICATION PROVIDED:**

\_\_\_ State Driver's License \_\_\_\_\_

\_\_\_ State Identification Card \_\_\_\_\_

\_\_\_ Birth Certificate \_\_\_\_\_

\_\_\_ Military ID \_\_\_\_\_

\_\_\_ Other (Provide details) \_\_\_\_\_

**FACILITY:** \_\_\_\_\_

**PRACTITIONER:** \_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our [Notice of Privacy Practices](#). You may also obtain a copy by visiting our website at [www. Agency Name .com](http://www.Agency Name.com) or by sending a written request to:

**Patient's Rights Office**

[Agency Name](#)

[Agency Address](#)

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

**AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE  
OF PROTECTED HEALTH INFORMATION (PHI)**

**CLIENT:**

_____	_____	_____
Name of Client/Previous Names	Birth Date	DMH Client ID#
_____	_____	
Street Address	City, State, Zip	

**AUTHORIZES:**

**DISCLOSURE OF PROTECTED HEALTH  
INFORMATION TO:**

_____	_____
Name of Agency	Name of Health Care Provider/Plan/Other
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip Code	City, State, Zip Code

**INFORMATION TO BE RELEASED:**

<input type="checkbox"/> Assessment/Evaluation	<input type="checkbox"/> Results of Psychological Tests	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Medication History/	<input type="checkbox"/> Treatment
<input type="checkbox"/> Entire Record (Justify)	<input type="checkbox"/> Current Medications	
<input type="checkbox"/> Other (Specify): _____		

**PURPOSE OF DISCLOSURE:** (Check applicable categories)

Client's Request  
 Other (Specify): \_\_\_\_\_


Will the agency receive any benefits for the disclosure of this information?  Yes  No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

**EXPIRATION DATE:** This authorization is valid until the following date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE  
OF PROTECTED HEALTH INFORMATION (PHI)**

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive a Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

**Right to Revoke This Authorization** - I understand that I have the right to revoke this Authorization at any time by telling Agency Name in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

\_\_\_\_\_  
Contact person

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

I also understand that a revocation will not affect the ability of Agency Name or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

**Conditions.** I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, Agency Name may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

**I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.**

\_\_\_\_\_  
Signature of Client / Personal Representative

\_\_\_\_\_  
Date

If signed by other than the client, state relationship and authority to do so: \_\_\_\_\_

**REVOCATION OF AUTHORIZATION**

**SIGNATURE OF CLIENT/LEGAL REP:** \_\_\_\_\_

**If signed by other than client, state relationship and authority to do so:** \_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

## **SECTION VIII – DOCUMENTATION STANDARDS, TREATMENT STANDARDS AND MEDICAL NECESSITY CRITERIA**

### **DOCUMENTATION STANDARDS**

Each network provider must open and maintain his/her own clinical mental health record in order to document complete, accurate and current documentation of all services provided, including assessment activities. The record must be secured and kept confidential in a locked file.

With the exception of the services that require Local Mental Health Plan (LMHP) authorization, psychological testing and over-threshold services, network providers are not required to use the LMHP forms for documenting clinical services as long as the documentation complies with Medi-Cal requirements and meets medical necessity criteria. Minimal documentation requirements are reflected on the forms contained in this section. Network providers must adhere to the clinical records content and documentation standards of the LMHP. The minimum content includes both administrative and clinical documentation.

If a network provider uses any forms other than the forms in this Provider Manual, each page must include the Medi-Cal beneficiary's name, the Department of Mental Health (DMH) Client ID Number, the name of the individual or group network provider and a confidentiality/disclosure statement similar to the statement on the LMHP forms.

### **OUTPATIENT MEDICAL NECESSITY CRITERIA**

Every service claimed, other than those for assessment purposes, must meet the test of medical necessity; i.e., the service must be directed towards reducing or ameliorating the effect of symptoms/behaviors of an included diagnosis causing functional impairments or, minimally, preventing an increase of those symptoms/behaviors or functional impairments. Each time a service is claimed, the provider who delivered the service and submitted the claim is attesting that he/she believes that there is sufficient documentation in the medical record to support the intervention provided.

The following medical necessity criteria, as defined in the California Code of Regulations, (CCR), Title 9, Chapter 11, Section 1830.205, must be met for reimbursement by the LMHP for all outpatient services rendered by Network Providers.

1. The Medi-Cal beneficiary must have one of the included diagnoses in the most current Diagnostic and Statistical Manual of Mental Disorder (DSM) and listed in CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A through R). Network Providers must use the color-coded DSM crosswalk to ICD-9 diagnosis codes. (The diagnosis in the clinical record must be consistent with the most recent and up-to-date clinical information documented in the assessment.
2. The beneficiary, as a result of the mental disorder, must have at least one of the following impairments:
  - a) A significant impairment in an important area of life functioning;

- b) A reasonable probability of significant deterioration in an important area of life functioning;
  - c) A reasonable probability a beneficiary, under the age of 21 years, will not progress developmentally as individually appropriate.
  - d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of mental disorder that Specialty Mental Health Services (SMHS) can correct or ameliorate.
3. The intervention must meet each of the following intervention criteria:
- a) The focus of the proposed intervention is to address the condition or impairments identified in "2" above.
  - b) The expectation is that the proposed intervention will:
    - ◆ Significantly diminish the impairment, or
    - ◆ Prevent significant deterioration in an important area of life functioning, or
    - ◆ Allow a beneficiary under the age of 21 years, to progress developmentally as individually appropriate;

### **Medical Necessity Criteria for Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age**

CCR, Title 9, Chapter 11, Section 1810.215 defines Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services as mental health related diagnostic services and treatment, other than physical care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by the State Department of Health Care Services (DHCS) to meet the criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered as specialty mental health services.

For child, defined as a person under 21 years of age, who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity criteria specified on the Outpatient Medical Necessity Criteria described in this section, shall be met when all of the following exist:

1. The beneficiary meets the diagnosis criteria in CCR, Title 9, Chapter 11, Section 1830.205(b)(1);
2. The beneficiary has a condition that would not be responsive to physical health care based treatment; and
3. Persons who do not meet the medical necessity criteria listed above will meet the medical necessity criteria per EPSDT (Title 22, Section 51340(e)(3)) eligibility when specialty mental health services are needed to correct or ameliorate a defect, mental illness or condition.

The following diagnoses in the DSM-IV, Fourth Edition (1994), published by the American Psychiatric Association identifies the included and excluded diagnoses to be used for Medi-Cal reimbursement:

- A. Pervasive Developmental Disorders, except Autistic Disorders
- B. Disruptive Behavior and Attention Deficit Disorders
- C. Feeding and Eating Disorders of Infancy and Early Childhood
- D. Elimination Disorders
- E. Other Disorders of Infancy, Childhood, or Adolescence
- F. Schizophrenia and other Psychotic Disorders, **except** Psychotic Disorders due to a General Medical Condition
- G. Mood Disorders, **except** Mood Disorders due to General Medical Condition
- H. Anxiety Disorders, **except** Anxiety Disorders due to a General Medical Condition
- I. Somatoform Disorders
- J. Factitious Disorders
- K. Dissociative Disorders
- L. Paraphilias
- M. Gender Identity Disorder
- N. Eating Disorders
- O. Impulse Control Disorders Not Elsewhere Classified
- P. Adjustment Disorders
- Q. Personality Disorders, **except** Antisocial Personality Disorder
- R. Medication-Induced Movement Disorders related to other included diagnoses

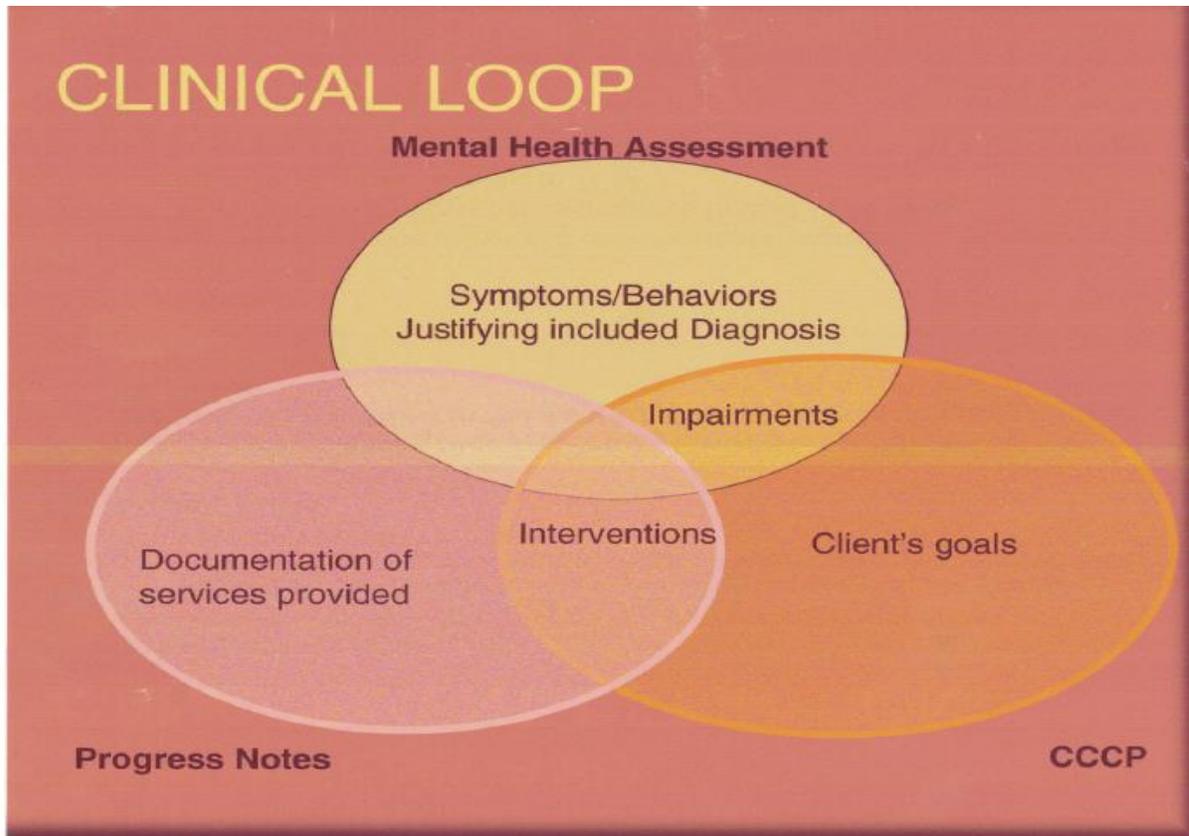
**Note:** Based on the information received from California Department of Health Care Services (DHCS) to date, no immediate changes in claiming requirements for Medi-Cal SMHS services will result from DSM-5. DHCS will issue further guidance concerning DSM 5 through future Information Notices.

### THE CLINICAL LOOP

The “Clinical Loop” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are reimbursable. All services claimed to Medi-Cal, except for emergency services, **MUST** fit into the Clinical Loop and support Medical Necessity in order to be reimbursed. The Clinical Loop is not a one-time activity. It occurs throughout the beneficiary’s treatment and should be reviewed and updated on a regular basis to ensure that current interventions are consistent with current symptoms/behaviors and impairments documented in the Clinical Record.

The sequence of documentation on which medical necessity requirements converge is:

1. **The Assessment.** The completion of an Assessment establishes the foundation for an included diagnosis and impairments in life functioning. It further documents needs, barriers and strengths which are helpful in the formulation of a treatment plan.
2. **The Beneficiary Treatment Plan.** The demonstration of medical necessity is carried forward into the Beneficiary Treatment Plan where the diagnosis and impairments are used to establish treatment goals/objectives and the proposed interventions to effect the identified objectives. It creates a “road map” for the beneficiary, family and mental health professional.
3. **The Progress Note.** Progress Note documents a service delivered that is related back to an intervention identified in the Treatment Plan and the beneficiary’s response toward the intervention.



## ASSESSMENT

An initial assessment must be completed within 60 days of intake for a new admission (No open episode in the entire system), or within 30 days when the beneficiary is being opened to a new service, but has other open episodes. An assessment must be completed on all new Medi-Cal beneficiaries unless a recent assessment equivalent to the LMHP's assessment accompanies the referral. If a comprehensive assessment has been completed by another agency or network provider in the last 6-12 months, a copy of that assessment can be filed in the clinical record and used as a baseline for the new provider's assessment. For children or certain other beneficiaries who are unable to provide a history, this information may be obtained from the parents/care-givers, etc. The assessment must clearly establish that mental health services are medically necessary. For Contractors with an Electronic Health Record System (EHRS), the relevant form with all required data elements shall be used. The assessment is to include, but is not limited to, the following:

- a. Presenting Problem: The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
- b. Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;

- c. Mental Health History: Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
- d. Medical History: Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- e. Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- f. Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
- g. Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- h. Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;
- i. A mental status examination;
- j. Complete 5 Axis psychiatric diagnosis from the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data. To meet medical necessity criteria for Medi-Cal reimbursement, the beneficiary must have one of the diagnoses specified in the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1830.205(b)(1)(A-R); and
- k. Adequate information to assess the beneficiary's needs in order to formulate a treatment plan.
- l. Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes. In addition to the staff signature, discipline/title, identification number and date shall be included.

## ASSESSMENT ADDENDUM

An Assessment addendum is required when there is additional information gathered, whether a change or an addition, after the completion of an Assessment and prior to providing any services that are not justified by the current Assessment. If using the LACDMH paper forms,

the Assessment Addendum shall be used. For Contractors with EHRS, the relevant form shall be used.

The primary assessment forms are:

- *Network Provider Child/Adolescent Assessment form (Attachment I)*
- *Network Provider Adult Assessment form (Attachment II)*

The Department of Health Care Services has set minimum standards for the content of an assessment. In order to facilitate compliance, these standards were converted into forms which when used; help ensure that the clinician covers all the required content of an assessment. The assessment forms in this section have been in use in the LMHP for several years. The LMHP prefers that its assessment forms be used. However, clinicians who have assessment formats, which are either the equivalent of, or exceed, the content of the LMHP forms, may use their own forms/formats.

The *Network Provider Child/Adolescent Assessment Addendum (Attachment III)* and the *Network Provider Adult Assessment Addendum (Attachment IV)* forms are to be used if additional writing space is needed for the initial assessment, for assessment updates, or to confirm information on the original assessment.

## **ASSESSMENT UPDATE**

The Assessment shall be completed every three years for clients receiving ongoing Specialty Mental Health Services, including Medication Support. The Assessment is required when there is a significant change in the clinical information, or at a minimum, every three years from the date of the last assessment.

## **TREATMENT PLAN**

The Treatment Plan is required for all services, including Medication Support after the completion of a client assessment and prior to the initiation of treatment services for a client. It must clearly address the problems identified in the most current assessment. It shall be completed by the end of the Intake Period (first 60 days) or within 1 month if opened elsewhere. As long as services never exceed the LMHP authorization threshold frequency of eight sessions in a four month trimester period, the Medi-Cal beneficiary's treatment plan, if clearly identified as such, can be documented in the progress note, provided all the required elements are present. The treatment plan must include the following required elements:

- Specific and observable or quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- The proposed types of interventions/modality including a detailed description of the interventions designed to address the identified functional impairments;
- The proposed duration and frequency of the interventions;

- The signature of the person providing the service (a Physician, Licensed Psychologist, Licensed Social Worker, Licensed Marriage and Family Therapist, Nurse Practitioner and Clinical Nurse Specialist); and
- Documentation of the beneficiary's participation in and agreement with the treatment plan as evidenced by the beneficiary's dated signature. (Per DMH Policy 104.9, Clinical Documentation, Section 4.3.8)
- In cases where the client is unable to sign the plan due to their mental state (e.g. agitated or psychotic), subsequent attempts to obtain the signature must be made and documented when the clinical record indicates that the situation that justified the initial absence of signature is no longer a factor or in effect.
- When the client, or other required participant in the treatment planning process, is unwilling to sign the Client Treatment Plan due to disagreement with the plan, every reasonable effort shall be made to adjust the Client Treatment Plan in order to achieve mutually agreed-upon acceptance by the client or other required participant, and the provider.
- Linguistic and interpretive needs

## TREATMENT PLAN UPDATE

The Client Treatment Plan shall be reviewed and updated as clinically appropriate when there is a change in the client's mental status or treatment or every 365 days from the start date of the first Client Treatment Plan. If the client is not available to participate in the review prior to the expiration of the 365 day period, the Treatment Plan shall be reviewed and updated with the client at the next contact with the client and prior to additional treatment services being provided.

For services that exceed the LMHP threshold frequency, the treatment plan must be documented on the *Client Plan/Authorization Request* form (Attachment VI) and submitted to the LMHP for over- threshold authorization. (Refer to Section XV: Over-Threshold Services and Inpatient Professional Services.)

## NETWORK PROVIDER PROGRESS NOTE

Service documentation should at a minimum include a recording for every service rendered on the *Network Provider Progress Note* (Attachment V). Progress notes help ensure quality and continuity of care and are required to support claims. The content of the progress note must always be consistent with the goals established in the beneficiary's treatment plan and reflect client care, clinical decisions, interventions, progress, and referrals. The progress notes must describe how the services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the beneficiary treatment plan.

The progress note must include:

- Date and time of service;
- The date the service was documented in the medical record by the person providing the service;
- The amount of time taken to provide services;
- Procedure code;

- Location of service;
- Timely documentation of relevant aspects of client care, including documentation of medical necessity;
- A description of changes in the medical necessity criteria, when they occur;
- Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Interventions applied, beneficiary's response to the interventions;
- Documentation of referrals to community resources and other agencies, when appropriate;
- Documentation of follow-up care, or if appropriate, a discharge summary;
- For family therapy, clear documentation of family therapeutic interventions shall be clearly documented. The first names of the family members in attendance must be documented; however, only one claim for the family session is to be submitted, regardless of the number of family members present.
- The discharge summary (when applicable), if not recorded on a separate form; and
- The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title and the relevant identification number; and
- Documentation for all unique services such as psychological testing, family and group therapy, medication support, etc. The type of service may be abbreviated, e.g., assessment-A, individual-I, group-G, psychological testing-PsyT, medication-Meds;

Other key features to remember regarding Progress Notes:

- Notes must be legible;
- References to other clients should only be by first name or initials;
- White-out or other forms of error correction materials are not allowed;
- If a mistake is made, place a single line through the mistake, write "mistaken entry", initial, discipline and date;
- Never skip lines when writing the note;
- Cross out all unused lines at the bottom of the entry; and
- Use black ink.

### **Timeliness/Frequency of Progress Notes**

There must be documentation on the progress notes for every Specialty Mental Health Services, Medication Support or Crisis Intervention provided.

### **Requirements for Claiming for Service Function Based on Minutes of Time**

For Fee-For-Service Providers, Mental Health Services and Medication Support are billed in minutes of time. The following requirements apply for claiming of services:

1. The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 minutes of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.

2. When the person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.
3. For the Network Provider's Family therapy services, the documentation shall include family therapeutic interventions. The first name of the family members in attendance shall be documented in the medical record. Only one claim for the family session is to be submitted, regardless of the number of family members present.

## **MEDICATION SERVICES**

Psychiatrists and nurse practitioners prescribing medications must document that the Medi-Cal beneficiary or the person responsible for the Medi-Cal beneficiary understands and agree to the administration of the psychiatric medications that are being prescribed. This understanding is known as *Informed Consent*. Informed consent must be obtained and documented when a new or different type of medication is prescribed or at least annually and if a client resumes taking medications. (Refer to Section VII: Consents and Release of Information Forms)

Elements to be documented on the *Informed Consent* shall include but not limited to:

- the reasons for taking such medications;
- reasonable alternative treatments available, if any;
- the type, range of frequency and amount, method (oral or injection), and duration of taking the medication;
- probable side effects, possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and,
- The written medication consent form must be signed by the beneficiary.
- the consent, once given, may be withdrawn at any time by the beneficiary.

When medications are prescribed, the service may be documented on either the Network Provider Complex Medication Support Service (90862) form (Attachment VII) or the Network Provider Brief Follow-Up Medication Support Service (M0064) form (Attachment VIII) instead of on a progress note. These two forms include the required documentation elements of medication support services referenced below. The Complex Medication Support Service form should be used for initial medication evaluations or when a client is unstable on his/her medications. The Brief Follow-Up Medication Support Service form should be used when a client is stable on his/her medications.

When not using the medication support forms the progress notes must include:

- Name, dosage and quantity of the medication; and
- Frequency and route of administration.

Each service claimed as a medication service must include information regarding:

- Side effects;
- Response to medication(s), both positive and negative; and
- The beneficiary's compliance with the medication regime.

When medications or dosages are changed, the reason for the change must be documented.

## **DISCHARGE SUMMARY**

A discharge summary must be written within 30 days of discharge and must include the admission date, presenting problem, a summary of the services delivered, medications (if any), referrals, recommendations, and a discharge diagnosis. As an alternative to the use of the *Discharge Summary* form (Attachment XI) a progress note may be used as long as it contains the required elements.

## Outpatient Treatment Standards

In addition to the medical necessity criteria listed above, the LMHP requires the following general standards:

### A. Network Provider

- ◆ Must be credentialed and contracted through the LMHP;
- ◆ Must render specialty mental health services to accomplish the treatment goals; and
- ◆ Must be accessible and engaged in a good working relationship with the LMHP.
- ◆ Network Providers who provide Psychiatric Inpatient Hospital Professional Services shall apply the medical necessity criteria found in CCR, Title 9, Chapter 11, Section 1820.205.
- ◆ Must maintain a complete clinical record in accordance with the structure and content specified by County DMH. All services provided to a beneficiary, for which Medi-Cal reimbursement is sought, must be documented in this record in a manner which complies with all applicable regulations and standards established by State Department of Health Care Services and County DMH.
- ◆ The Network Provider shall provide clinical records to County, and any Federal or State Department representatives having monitoring or reviewing authority, at reasonable times during normal business hours. Furthermore, the Network Provider shall provide access to and the right to monitor all work performed under the Network Agreement to evaluate the quality, ensure appropriateness and timeliness of services performed.

### B. Treatment Services

- ◆ Must be generally acknowledged as the most effective and safe treatment modality available for achieving the treatment goals specific to the diagnosis and severity of symptomatology;
- ◆ Must be delivered with a level of intensity consistent with the diagnosis and severity of symptoms;
- ◆ Must have a reasonable expectation of effectiveness in a time frame consistent with acceptable standards of treatment specific to the diagnosis; and
- ◆ Must be consistent with the wishes of the Medi-Cal beneficiary.

### A. Treatment Course

- ◆ Progress rate must be appropriate;
- ◆ Must have ongoing post-treatment and discharge planning;
- ◆ Complications must be appropriately managed;
- ◆ Medi-Cal beneficiary must have an appropriate level of satisfaction with the care.

**CLINICAL RECORD CONTENT**

<b>Clinical Minimum Record Content</b>	<b>Attachment</b>	<b>Comments</b>
Referral Information from LMHP	N/A	Referral Information from LMHP
Medication Informed Consent	Refer to Medication Services for elements of an Informed Consent	Must be signed and can be withdrawn at any time by beneficiary. Obtained annually.
Network Provider Child/Adolescent Assessment Addendum OR Network Provider Adult Assessment Addendum	Attachment I  Attachment II	An assessment must be completed for all new Medi-Cal beneficiaries within 60 days of admission.
Network Provider Child/Adolescent Assessment Addendum OR Network Provider Adult Assessment Addendum	Attachment III  Attachment IV	An assessment addendum may be used when any changes/updates are made to the assessment in the clinical record
Beneficiary Treatment Plan	Refer to Treatment Plan Elements	Must be formulated within 2 months of admission and with the beneficiary's participation, dated and signed by provider and beneficiary. Refusal to sign or unavailability must be documented.
Network Provider Progress Note	Attachment V	Required for every service rendered.
Client Plan/Authorization Request	Attachment VI	Required when requesting over-threshold services.
Network Provider Complex Medication Support Service (90862) or  Network Provider Brief Follow-Up Medication Support Service (M0064)	Attachment VII  Attachment VIII	Used for initial medication evaluations or when a client is unstable on his/her medications.  Used when a client is stable on his/her medications.
Laboratory Results	N/A	Required when laboratory tests are requested.
Psychological Testing • Authorization Request • LMHP Request Response • Raw Test Data Report	Attachment IX Attachment X N/A  N/A	Authorization request & response are required prior to the administration of tests. See the Psychological Testing Section for more information.  Raw test data may be maintained in a confidential file separate from the clinical record.
Network Provider Discharge Summary	Attachment XI	As an alternative to the use of the Discharge Summary, the summary of the course of treatment with a final diagnosis may be documented in the progress notes.



<b>III. History</b>	
Mental Health History including Meds	
Drug & Alcohol History & Treatment	
Medical History	
Family Mental Health & Medical History	
Developmental History	
School History	
Vocational History	
Juvenile Court History (Delinquency)	
Child Abuse & Protect. Services History	
Relevant Family Social History	

<b>IV. Mental Status</b>	
Appearance	
Behavior	
Expressive Speech	
Thought Content	
Cognition	
Mood/Affect	
Suicidality/Homicidality	
Attitude/Insight/Strength	

<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>	<p>Name: _____ DMH Client ID#: _____</p> <p>Individual/Group/Organizational Provider Name:                  Los Angeles County – Department of Mental Health</p>
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**V. Summary and Diagnosis**

# NETWORK PROVIDER CHILD/ADOLESCENT ASSESSMENT

**Diagnostic Summary:** (Be sure to include significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

**Admission Diagnosis** (check one Principle and one Secondary)

**Axis I**  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
(Medications cannot be prescribed with a deferred diagnosis)

Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

**Axis II**  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
 Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

**Axis III** \_\_\_\_\_ Code \_\_\_\_\_  
\_\_\_\_\_ Code \_\_\_\_\_  
\_\_\_\_\_ Code \_\_\_\_\_

**Axis IV** Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

**Primary Problem #:** \_\_\_\_

**Check all that apply:**

- |  |   |   |   |
|--|---|---|---|
| 1. <input type="checkbox"/> Primary support group            | 2. <input type="checkbox"/> Social environment      | 3. <input type="checkbox"/> Educational           | 4. <input type="checkbox"/> Occupational                  |
| 5. <input type="checkbox"/> Housing                          | 6. <input type="checkbox"/> Economics               | 7. <input type="checkbox"/> Access to health care | 8. <input type="checkbox"/> Interaction with legal system |
| 9. <input type="checkbox"/> Other psychosocial/environmental | 10. <input type="checkbox"/> Inadequate information |   |   |

**Axis V** Current GAF: \_\_\_\_\_ DMH Dual Diagnosis Code: \_\_\_\_\_  
Above diagnosis from: \_\_\_\_\_ Dated: \_\_\_\_\_

**Disposition/Recommendations/Plan:**

**Signatures**

\_\_\_\_\_  
Assessor's Signature & Discipline

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Signature & Discipline

\_\_\_\_\_  
Date

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Name: \_\_\_\_\_ DMH Client ID#: \_\_\_\_\_

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

Admit Date: \_\_\_\_\_

**I. Demographic Data**

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**II. Reason for Referral/Chief Complaint**

Describe precipitating event(s), current symptoms and impairments in life functioning, including intensity and duration, from the perspective of the client as well as significant others:

**III. Psychiatric History:**

**A. Hospitalizations** [date(s) & location(s)]. **Outpatient treatment** [date(s) & location(s)]. History and onset of current symptoms/manifestations/precipitating events (i.e., aggressive behaviors, suicidal, homicidal). Treated & non-treated history.

**B.** Describe the **impact of treatment and non-treatment history** on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

**C. Family history of mental illness**

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Name: \_\_\_\_\_ DMH Client ID#: \_\_\_\_\_

Individual/Group/Organizational Provider Name: \_\_\_\_\_

Los Angeles County – Department of Mental Health

## IV. Medical History

MD Name: \_\_\_\_\_ MD Phone: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

**Major medical problem (treated or untreated)** (Indicate problems with check: Y or N for client, Fam for family history.)

Fam Y N	Fam Y N	Fam Y N	Fam Y N
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Seizure/neuro disorder	Cardiovascular disease/symp	Liver disease	Weight/appetite chg
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Head trauma	Thyroid disease/symp	Renal disease/symp	Diarrhea
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Sleep disorder	Asthma/lung disease	Hypertension	Cancer
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Vision/glaucoma	Blood disorder	Diabetes	Sexual dysfunction
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Allergies (If Yes, specify):			Sexually trans disease
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Pap smear If yes, date: _____	Mammogram If yes, date: _____	HIV Test If yes, date: _____	Pregnant If yes, due date: _____

Comments on above medical problems, other medical problems, and any hospitalizations, including dates and reasons.

## V. Medications

List "all" past and present medications used, prescribed/non-prescribed, psychotropic, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Period Taken</u>	<u>Effectiveness/Response/Side Effects/Reactions</u>

## VI. Substance Use/Abuse

Client denies any current or past use/abuse (if not, please describe substance use/abuse below)

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Name: \_\_\_\_\_ DMH Client ID#: \_\_\_\_\_

Individual/Group/Organizational Provider Name: \_\_\_\_\_

Los Angeles County – Department of Mental Health

**VII. Psychosocial History**

- A. Family & Relationships:** Family constellation, family of origin and current family, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues (i.e., the presence of firearms.)
- B. Dependent Care Issues:** #\_\_\_\_\_ of Adults, #\_\_\_\_\_of dependent children, age(s) of child(ren), school attendance/behavior problems learning problems, special need(s), including physical impairments, discipline issues, juvenile court history, dependent care needs; any unattended needs of children, child support, child custody, and guardianship issues, foster care/group home placement.
- C. Current Living Arrangement & Social Support Systems:** Type of setting and associated problems, support from community, religious, government agencies, and other sources (i.e., Section 8 Housing, SRO, Board and Care, Semi-independent, family and transitional living, etc.)
- D. Education:** Highest grade level completed, educational goals. Skill level: literacy level, vocabulary, general knowledge, math skills, school problems, motivation.
- E. Employment History/Employment Readiness/Mean of Financial Support:** Longest period of employment, employment history, military service, work related problems, money management, source of income. Areas of strength.
- F. Legal History and Current Legal Status:** Parole, probation, arrests, convictions, divorce, child custody, conservatorship

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Name: DMH Client ID#:

Individual/Group/Organizational Provider Name:

Los Angeles County – Department of Mental Health

## VIII. Mental Status Evaluation

**Length of current treatment:** \_\_\_\_\_ **Is this part of a 5150?**  Yes  No **Medication:**  Yes  No **Client is:**  Stable  Unstable

Instructions: Check all descriptions that apply

<u>General Description</u>	<u>Mood and Affect</u>	<u>Thought Content Disturbance</u>
<p><b>Grooming &amp; Hygiene:</b> <input type="checkbox"/> Well Groomed  <input type="checkbox"/> Average <input type="checkbox"/> Dirty <input type="checkbox"/> Odorous <input type="checkbox"/> Disheveled  <input type="checkbox"/> Bizarre  Comments:</p> <p><b>Eye Contact:</b> <input type="checkbox"/> Normal for culture  <input type="checkbox"/> Little <input type="checkbox"/> Avoids <input type="checkbox"/> Erratic  Comments:</p> <p><b>Motor Activity:</b> <input type="checkbox"/> Calm <input type="checkbox"/> Restless  <input type="checkbox"/> Agitated <input type="checkbox"/> Tremors/Tics <input type="checkbox"/> Posturing <input type="checkbox"/> Rigid  <input type="checkbox"/> Retarded <input type="checkbox"/> Akathisia <input type="checkbox"/> E.P.S.  Comments:</p> <p><b>Speech:</b> <input type="checkbox"/> Unimpaired <input type="checkbox"/> Soft  <input type="checkbox"/> Slowed <input type="checkbox"/> Mute <input type="checkbox"/> Pressured <input type="checkbox"/> Loud  <input type="checkbox"/> Excessive <input type="checkbox"/> Slurred <input type="checkbox"/> Incoherent  <input type="checkbox"/> Poverty of Content  Comments:</p> <p><b>Interactive Style:</b> <input type="checkbox"/> Culturally congruent  <input type="checkbox"/> Cooperative <input type="checkbox"/> Sensitive  <input type="checkbox"/> Guarded/Suspicious <input type="checkbox"/> Overly Dramatic  <input type="checkbox"/> Negative <input type="checkbox"/> Silly  Comments:</p> <p><b>Orientation:</b> <input type="checkbox"/> Oriented  <input type="checkbox"/> Disoriented to:  <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person <input type="checkbox"/> Situation  Comments:</p> <p><b>Intellectual Functioning:</b> <input type="checkbox"/> Unimpaired  <input type="checkbox"/> Impaired  Comments:</p> <p><b>Memory:</b> <input type="checkbox"/> Unimpaired  <input type="checkbox"/> Impaired re: <input type="checkbox"/> Immediate <input type="checkbox"/> Remote <input type="checkbox"/> Recent  <input type="checkbox"/> Amnesia  Comments:</p> <p><b>Fund of Knowledge:</b> <input type="checkbox"/> Average  <input type="checkbox"/> Below Average <input type="checkbox"/> Above Average  Comments:</p>	<p><b>Mood:</b> <input type="checkbox"/> Euthymic <input type="checkbox"/> Dysphoric <input type="checkbox"/> Tearful  <input type="checkbox"/> Irritable <input type="checkbox"/> Lack of Pleasure  <input type="checkbox"/> Hopeless/Worthless <input type="checkbox"/> Anxious  <input type="checkbox"/> Known Stressor <input type="checkbox"/> Unknown Stressor  Comments:</p> <p><b>Affect:</b> <input type="checkbox"/> Appropriate <input type="checkbox"/> Labile <input type="checkbox"/> Expansive  <input type="checkbox"/> Constricted <input type="checkbox"/> Blunted <input type="checkbox"/> Flat <input type="checkbox"/> Sad  <input type="checkbox"/> Worried  Comments:</p> <p style="text-align: center;"><u>Perceptual Disturbance</u></p> <p><input type="checkbox"/> None Apparent</p> <p><b>Hallucinations:</b> <input type="checkbox"/> Visual <input type="checkbox"/> Olfactory  <input type="checkbox"/> Tactile <input type="checkbox"/> Auditory: <input type="checkbox"/> Command  <input type="checkbox"/> Persecutory <input type="checkbox"/> Other  Comments:</p> <p><b>Self-Perceptions:</b> <input type="checkbox"/> Depersonalizations  <input type="checkbox"/> Ideas of Reference  Comments:</p> <p style="text-align: center;"><u>Thought Process Disturbances</u></p> <p><input type="checkbox"/> None Apparent</p> <p><b>Associations:</b> <input type="checkbox"/> Unimpaired <input type="checkbox"/> Loose  <input type="checkbox"/> Tangential <input type="checkbox"/> Circumstantial <input type="checkbox"/> Confabulous  <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Word Salad  Comments:</p> <p><b>Concentration:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Impaired by:  <input type="checkbox"/> Rumination <input type="checkbox"/> Thought Blocking  <input type="checkbox"/> Clouding of Consciousness <input type="checkbox"/> Fragmented  Comments:</p> <p><b>Abstractions:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Concrete  Comments:</p> <p><b>Judgments:</b> <input type="checkbox"/> Intact  <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe  Comments:</p> <p><b>Insight:</b> <input type="checkbox"/> Adequate  <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe  Comments:</p> <p><b>Serial 7's:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Poor  Comments:</p>	<p><input type="checkbox"/> None Apparent</p> <p><b>Delusions:</b> <input type="checkbox"/> Persecutory <input type="checkbox"/> Paranoid <input type="checkbox"/> Grandiose  <input type="checkbox"/> Somatic <input type="checkbox"/> Religious <input type="checkbox"/> Nihilistic  <input type="checkbox"/> Being Controlled  Comments:</p> <p><b>Ideations:</b> <input type="checkbox"/> Bizarre <input type="checkbox"/> Phobic <input type="checkbox"/> Suspicious  <input type="checkbox"/> Obsessive <input type="checkbox"/> Blames Others <input type="checkbox"/> Persecutory  <input type="checkbox"/> Assaultive Ideas <input type="checkbox"/> Magical Thinking  <input type="checkbox"/> Irrational/Excessive Worry  <input type="checkbox"/> Sexual Preoccupation  <input type="checkbox"/> Excessive/Inappropriate Religiosity  <input type="checkbox"/> Excessive/Inappropriate Guilt  Comments:</p> <p><b>Behavioral Disturbances:</b> <input type="checkbox"/> None <input type="checkbox"/> Aggressive  <input type="checkbox"/> Uncooperative <input type="checkbox"/> Demanding <input type="checkbox"/> Demeaning  <input type="checkbox"/> Belligerent <input type="checkbox"/> Violent <input type="checkbox"/> Destructive  <input type="checkbox"/> Self-Destructive <input type="checkbox"/> Poor Impulse Control  <input type="checkbox"/> Excessive/Inappropriate Display of Anger  <input type="checkbox"/> Manipulative <input type="checkbox"/> Antisocial  Comments:</p> <p><b>Suicidal/Homicidal:</b> <input type="checkbox"/> Denies Ideation Only  <input type="checkbox"/> Threatening <input type="checkbox"/> Plan <input type="checkbox"/> Past Attempts  Comments:</p> <p><b>Passive:</b> <input type="checkbox"/> Amotivational <input type="checkbox"/> Apathetic  <input type="checkbox"/> Isolated <input type="checkbox"/> Withdrawn <input type="checkbox"/> Evasive <input type="checkbox"/> Dependent  Comments:</p> <p><b>Other:</b> <input type="checkbox"/> Disorganized <input type="checkbox"/> Bizarre  <input type="checkbox"/> Obsessive/compulsive <input type="checkbox"/> Ritualistic  <input type="checkbox"/> Excessive/Inappropriate Crying  Comments:</p>

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**Name:** \_\_\_\_\_ **DMH Client ID#:** \_\_\_\_\_  
**Individual/Group/Organizational Provider Name:** \_\_\_\_\_  
**Los Angeles County – Department of Mental Health**

## IX. Summary and Diagnosis

# NETWORK PROVIDER ADULT ASSESSMENT

**Diagnostic Summary:** (Be sure to include significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

**Admission Diagnosis** (check one Principle and one Secondary)

**Axis I**  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
(Medications cannot be prescribed with a deferred diagnosis)

Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

**Axis II**  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
 Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

**Axis III** \_\_\_\_\_ Code \_\_\_\_\_  
\_\_\_\_\_ Code \_\_\_\_\_  
\_\_\_\_\_ Code \_\_\_\_\_

**Axis IV** Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

**Primary Problem #:** \_\_\_\_

**Check all that apply:**

- |  |   |   |   |
|--|---|---|---|
| 1. <input type="checkbox"/> Primary support group            | 2. <input type="checkbox"/> Social environment      | 3. <input type="checkbox"/> Educational           | 4. <input type="checkbox"/> Occupational                  |
| 5. <input type="checkbox"/> Housing                          | 6. <input type="checkbox"/> Economics               | 7. <input type="checkbox"/> Access to health care | 8. <input type="checkbox"/> Interaction with legal system |
| 9. <input type="checkbox"/> Other psychosocial/environmental | 10. <input type="checkbox"/> Inadequate information |   |   |

**Axis V** Current GAF: \_\_\_\_\_ DMH Dual Diagnosis Code: \_\_\_\_\_  
Above diagnosis from: \_\_\_\_\_ Dated: \_\_\_\_\_

**Disposition/Recommendations/Plan:**

**Signatures**

\_\_\_\_\_  
Assessor's Signature & Discipline                      Date                      Co-Signature & Discipline                      Date

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Name: \_\_\_\_\_ DMH Client ID#: \_\_\_\_\_  
Individual/Group/Organizational Provider Name: \_\_\_\_\_  
Los Angeles County – Department of Mental Health







COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
 OFFICE OF THE MEDICAL DIRECTOR  
 MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION  
**CLIENT PLAN/  
 OVER-THRESHOLD AUTHORIZATION REQUEST (OTAR)**

Desired outcome(s) as stated by:  Client and/or  Parent/Responsible Adult Initial Date of Service \_\_\_\_\_

Major Barriers/Impairments to attaining outcome(s):

Diagnosis Code: \_\_\_\_\_ Nomenclature: \_\_\_\_\_

Need for additional services and risk factors (Attach progress notes from current trimester period, most recent assessment if this is a first OTAR, and any other relevant documentation):

Check one or more of the following boxes and describe:

- Severe life crisis: \_\_\_\_\_
- Decompensation/marked decline in functioning: \_\_\_\_\_
- Use of more costly/restrictive setting: \_\_\_\_\_
- Other: \_\_\_\_\_

Goal(s) (must be specific, observable and quantifiable):

Intervention Plan for requested services (must be consistent with diagnosis and client goals):

Provider's Intervention Plan:

Client's Role:

Participation of Significant Other:

Not desired by client Medication Evaluation:  Yes  No Date: \_\_\_\_\_

Intervention Partner(s) (Note any other professionals currently providing services and their role(s)):

Progress toward goals since date of last client plan (OTAR):

**Service Request**

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Procedure Code: \_\_\_\_\_ No.: \_\_\_\_\_  
 (date of anticipated 9<sup>th</sup> visit) (last date of trimester)  
 Procedure Code: \_\_\_\_\_ No.: \_\_\_\_\_ Procedure Code: \_\_\_\_\_ No.: \_\_\_\_\_

**Signatures**

\_\_\_\_\_  
 Client and/or Parent/Guardian/Responsible Adult Date \_\_\_\_\_ Significant Other or Minor

If client is unwilling/unable to sign, give reason \_\_\_\_\_  
 \_\_\_\_\_  
 Provider's Signature and Discipline Date

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**Client Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_  
**Medi-Cal #:** \_\_\_\_\_ **DMH Client ID#** \_\_\_\_\_  
**Facility/Provider:** \_\_\_\_\_  
**MC Provider #:** \_\_\_\_\_

Los Angeles County – Department of Mental Health

**NETWORK PROVIDER COMPLEX  
MEDICATION SUPPORT SERVICE (90862)**

MH 670  
Revised 05/05/09

(For Use by MD/DO and NP)

For use with client not yet stable on medication which requires detailed history, assessment and decision-making for prescribing medication using 90862. If psychotherapy is provided, a separate Progress Note should be used.

Date: \_\_\_\_\_

Procedure Code: M0064

Time

**Target Symptoms/Emergent Issues/Client Goals:**

**History** [Include any changes or additions to the [Initial Assessment](#)]:

**Treatment Response/Medication Side Effects:**

**Adherence to Medication:**

**Current/Changes in Medical Status:**

**Mental Status:**

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Name:

DMH Client ID#:

Individual/Group/Organizational Provider Name:





COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR  
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Client Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone No(s): \_\_\_\_\_

Social Worker's Name: \_\_\_\_\_ Contact No: \_\_\_\_\_  
(Form 5005 is **required** if under DCFS supervision. Please fax directly to the Psychological Testing Authorization Unit)

Psychological Testing Referral by: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Primary Therapist/Physician: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Prior Psychological Testing  No  Yes Date tested: \_\_\_\_\_ By Whom: \_\_\_\_\_

**Specific referral questions:**

Test referral questions must relate to psychological treatment. Attach additional pages if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Select One  Assign to psychologist selected by Psychological Testing Authorization Unit  
 Name of psychologist suggested for testing: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- Please note:**
- The Psychological Testing Authorization Unit reserves the right to assign specific psychologists
  - Fax this request to 213-487-9658 or 213-351-2023. Please use HIPPA compliant faxing procedures.
  - This client should be tested only after written authorization from the Psychological Testing Authorization Unit

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**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)**

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR  
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST RESPONSE (PTAR-RESPONSE)**

Date: \_\_\_\_\_

**Medi-Cal status must be verified prior to performing psychological testing.**

Request for Testing of:

Client Name: \_\_\_\_\_ DMH Client ID: \_\_\_\_\_ MEDS ID number: \_\_\_\_\_

Client Address: \_\_\_\_\_

Assigned Psychologist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

I agree to:

- 1) Test this beneficiary only after receiving written authorization;
- 2) Consult with beneficiary's therapist/DMH Case Manager prior to testing, and to provide documentation of the consultation in the psychological report;
- 3) Conduct a comprehensive psychological evaluation that includes: history, test behavior, mental status examination, along with individually administered measures of intelligence, achievement, neuropsychological screening, diagnosis, and personality;
- 4) Provide a report to the referring source that integrates current test results and prior test results, as well as directly answering the referral questions which are specific and unique to this beneficiary; and
- 5) Forward a copy of the test report to the Psychological Testing Authorization before a copy is given to the referring party.

Signature of Testing Psychologist: \_\_\_\_\_ Date: \_\_\_\_\_

**DMH USE ONLY BELOW THIS LINE**

**Psychological Testing Authorization**

- Testing request approved for \_\_\_\_\_ hours of psychological testing between \_\_\_\_ - \_\_ - \_\_\_\_ and \_\_ - \_\_ - \_\_\_\_  
 (1 additional hour for scoring via computer service)

**Request Pending**

- Testing request pending (testing authorization withheld till the following conditions are met):
- Receipt of Form 5005 **directly** from CSW with SCSW signature.
  - Receipt of permission to test from conservator.
  - Client must be examined by a medical specialist prior to psychological testing. Please inform this office when the exam has occurred.
  - Other \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

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**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST RESPONSE (PTAR RESPONSE)**

# NETWORK PROVIDER DISCHARGE SUMMARY

Admission Date: \_\_\_\_\_

Discharge Date\*: \_\_\_\_\_

**Presenting Information:**

**Services Received and Response:**

**Medication(s):** (Include Dosage & Response)  None

**Disposition and Recommendations:** [if referred, include name of agency(s) or practitioner(s)]

**Referral Out Code:** \_\_\_\_\_

**Discharge Diagnosis:**

Axis I  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Axis II  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Axis III \_\_\_\_\_ Code \_\_\_\_\_

\_\_\_\_\_ Code \_\_\_\_\_

\_\_\_\_\_ Code \_\_\_\_\_

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis (Check all that apply)

1.  Primary support group 2.  Social environment 3.  Educational 4.  Occupational 5.  Housing 6.  Economics

7.  Access to health care 8.  Interaction with legal system 9.  Other psychosocial/environmental 10.  Inadequate information

Axis V Discharge GAF: \_\_\_\_\_ Prognosis: \_\_\_\_\_

\*Discharge Date: last service date or last cancelled or missed appointment

\_\_\_\_\_  
Signature & Discipline

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Signature & Discipline

\_\_\_\_\_  
Date

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Name: \_\_\_\_\_ DMH Client ID#: \_\_\_\_\_

Individual/Group/Organizational Provider Name: \_\_\_\_\_

Los Angeles County – Department of Mental Health

## SECTION IX – PROCEDURE CODES, DIAGNOSIS CODES AND RATES

### PROCEDURE CODES

Network Providers and their designated billing agents must ensure that the correct procedure and diagnosis codes are appropriately submitted on electronic claims. When choosing the appropriate procedure code and diagnosis codes, Network Providers must select the appropriate set of codes that are identified according to the published guides on the Department Web site.

*A Guide to Procedure Codes for Claiming Mental Health Services* is available at [http://lacdmh.lacounty.gov/hipaa/ffs\\_UIS\\_Manuals.htm](http://lacdmh.lacounty.gov/hipaa/ffs_UIS_Manuals.htm). Select “*A Guide to Procedure Codes for Claiming Specialty Mental Health Services*” and look up definitions of procedure codes applicable to Network Medi-Cal Rendering Provider.

One of the objectives of the Health Insurance Portability and Accountability Act (HIPAA) is to enable health care providers throughout the country to be able to conversant with each other about the services they are providing through the use of a single coding system. Health care claiming has also been improved and simplified as a result of HIPAA.

The two nationally recognized coding systems approved for use are the Current Procedural Terminology (CPT) codes and the Health Care Procedure Coding System (HCPCS). The CPT codes are five digit numeric codes, such as 90791. The HCPCS are a letter followed by four digits, such as H0032.

CPT code definitions come from the CPT Codes Manual. HCPCS codes are almost exclusively simply code titles absent definition. Therefore, the definitions for HCPCS codes were established either exclusively or in combination from one of these sources - 1) California Code of Regulations (CCR), Title 9, Chapter 11, Medi-Cal Specialty Mental Health Services; 2) California Department of Health Care Services (DHCS) Letters and Information Notices; or 3) program definitions such as the Clubhouse Model.

Network providers must ensure that procedure codes documented in the client record and submitted to the County’s claims processing information system on electronic claims accurately reflect the specialty mental health services provided to the client. .

### CLARIFICATION OF FAMILY THERAPY, GROUP AND PLAN DEVELOPMENT PRODEDURE CODES

#### FAMILY THERAPY

Family therapy is defined as a specialty mental health service provided to an individual or multiple individuals **within a family**. The service must include the client’s significant others, whether or not related by marriage or blood, such as a partner or spouse, parents, siblings, children, grandparents, etc. The client must be present when family therapy is provided.

A client’s significant other(s) may be involved in the client’s treatment with or without the client present, if the network provider determines that this would be of therapeutic value to the client. If the client is not present the service is to be claimed as collateral.

It is not appropriate to open a case for the client's significant other(s) for the sole purpose of providing family therapy to the client. Each clinical case that is opened must meet medical necessity criteria and meet all Medi-Cal requirements for the delivery of specialty mental health services.

In no case will family therapy be reimbursed if the family is present only to observe the intervention of the therapist. Family observation of individual therapy is not considered an acceptable therapeutic intervention.

When family therapy is provided, **only one claim is to be submitted** regardless of the number of clients in the session. The name of any one client is to be selected and claimed once for the entire family session. That is, provider cannot bill for three separate family therapy sessions if there are three family members in the session. There are no exceptions to this rule.

Claiming for multiple units of family therapy is allowed only when the parents/caregivers/significant others are seen with a particular client at a different time from another client. There must be clinical justification clearly documented in the clinical record when multiple family therapy sessions are claimed.

## GROUP THERAPY

Group therapy is therapy delivered to more than one family unit, each with at least one enrolled client. Multi-family group therapy is to be claimed as group therapy and not family therapy. This includes insight oriented, behavior modifying, supportive services delivered at the same time to **more than one non-family client**.

**Only one claim is to be submitted** regardless of the number of clients and family units in the session. Documentation for each group service claim must include how many clients were present/presented, who the facilitators were, and how long the group therapy lasted. That is, provider cannot bill for three separate group therapy sessions if there are three non-family clients in the session. There are no exceptions to this rule.

## PLAN DEVELOPMENT

Plan Development, also known as Team Conferences/Case Consultations are meetings with other professionals to plan for the treatment of a client. This service is part of the treatment planning process and is to be used only as an adjunct to ongoing psychotherapeutic interventions.

Team conference/case consultation claims must be clearly documented in the clinical record and include a summary of the client treatment planning process. The names of all attendees are to be included in the progress note.

## PROCEDURE CODE RATE

The network provider rates associated with the procedure codes are included in the procedure code lists on Attachment I.

## DIAGNOSIS CODES

Assessments are to include a five axis *Diagnostic and Statistical Manual* (DSM) (current edition) diagnosis which is consistent with the client's presenting problems, history, mental status and other assessment data. To meet medical necessity criteria for Medi-Cal reimbursement the client must have one of the diagnoses specified in the CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R).

The DSM IV Crosswalk to ICD 9 is available at [http://lacdmh.lacounty.gov/hipaa/ffs\\_UIS\\_Manuals.htm](http://lacdmh.lacounty.gov/hipaa/ffs_UIS_Manuals.htm). Select "DSM IV Crosswalk to ICD 9" and the diagnosis codes reimbursed by the Local Mental Health Plan (LMHP) are those listed without yellow background in the right column of the document.. The LMHP will deny claims submitted with the diagnosis codes highlighted in yellow.

ICD-10 will be the HIPAA standard code set for dates of service and dates of discharge on and after October 2014. The exact transition strategy will be determined by the DHCS and efforts to select the optimal approach are underway. LACDMH will update the Network Providers on the implementation.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES**

**ASSESSMENT**

This is an activity that may include a clinical analysis of the history and current status of a client’s mental, emotional, or behavioral disorder; relevant cultural issues and history; and diagnosis. These codes should be used when completing an Initial Assessment form or when performing subsequent assessment activities that are documented on an assessment form. An “Evaluation by Physician” form, when completed as part of an evaluation for medication by an MD/DO, should be claimed as Medication Support.

<b>Service</b>	<b>Code</b>	<b>Duration of Face- to- Face</b>	<b>Rate for PhD/PsyD, MFT, LCSW &amp; NP/CNS</b>	<b>Rate for MD/DO</b>
Psychiatric diagnostic interview	99311 or 99261	1-19 min.	\$0.00	\$0.00
Psychiatric diagnostic interview	90791	20-39 min.	\$20.00	\$32.00
		40+ min.	\$40.00	\$53.00

**Notes:**

- These services are recorded in the clinical record and reported into the County’s claims processing information system in minutes.
- LCSW, MFT and authorized CNS can only provide these services to clients under age 21.

INDIVIDUAL AND GROUP NETWORK PROVIDERS  
PHD/PSYD AND MD/DO

PSYCHOLOGIST SERVICES - PSYCHOLOGICAL TESTING

All psychological testing performed by network providers must have prior authorization.

Service	Code	Duration of Face-to-Face	Rate for PhD/PsyD	Rate for MD/DO
<p><b>Psychological Testing</b>                      Psycho-diagnostic assessment (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg. MMPI, Rorschach, WAIS).</p> <p>For children, referrals are made to clarify symptomology, rule out diagnoses and help delineate emotional from learning disabilities.</p>	96101	60-1200 min for MD/DO  60-900 min. for PhD/PsyD	\$36.00 per hour or \$0.60 per minute	\$45.00 per hour or \$0.75 per minute
<p>Neuropsychological Testing (eg. Halstead-Reitan Neuropsychological Batter, Wechsler Memory Scales and Wisconsin Card Sorting Test)</p>	96118	60-1200 min for MD/DO  60-900 min. for PhD/PsyD	\$36.00 per hour or \$0.60 per minute	\$45.00 per hour or \$0.75 per minute

**Notes:**

- Testing is recorded in the clinical record and reported into the IS in minutes.
- Providers must document and submit a claim for the administration of tests on the day of the administration indicating which tests were administered. On the day interpretation and report writing is performed, a separate claim must be submitted.
- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES**

**INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)**

<b>Service</b>	<b>Duration of Face-to-Face</b>	<b>Code</b>	<b>Rate for PhD/PsyD, MFT, LCSW &amp; NP/CNS</b>	<b>Rate for MD/DO</b>
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	1-19 min.	No Code	\$0.00	\$0.00
	20-39 min.	90832	\$20.00	\$32.00
	40 and over	90834 or 90837	\$40.00	\$53.00

**Note:**

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

**Documentation:**

- Clinical interventions must be included in the progress note and must be consistent with the client's goals/desired results identified in the treatment plan.
- The service focuses primarily on symptom reductions as a means of improving functional impairments.

**INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)**

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

<b>Service</b>	<b>Code</b>	<b>Duration of Face- to-Face</b>	<b>Rate for PhD/PsyD, LCSW, MFT, NP/CNS &amp; RN</b>	<b>Rate for MD/DO</b>
<b>Psychotherapy in Crisis:</b> Implementation of psychotherapeutic interventions to minimize the potential for psychological trauma while a client is in a crisis state.	<b>90839</b>	<b>40+ minutes</b>	<b>\$40.00</b>	<b>\$53.00</b>

**Notes:**

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- There must be an objective on the Client Care Plan related to the services provided during Psychotherapy in Crisis or documented discussion of whether or not an objective on the Client Care Plan is needed.

**FAMILY AND GROUP SERVICES (EXCEPT MED SUPPORT GROUP)**

Service	Code	Duration of Face- to-Face	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
<p><b>Family Psychotherapy with One or <u>More</u> Client(s) Present</b> Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client(s). *</p> <p><b>Note:</b> Family Psychotherapy without the client present is not a reimbursable service through the LMHP.</p> <p>Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the "Collateral" service definition below may be claimed to 90887.</p>	90847	20-39 min.	\$24.00	\$42.00
		40-59 min.	47.00	\$70.00
<p><b>Collateral (one or more clients represented)</b> Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist client.</p>	90887	60 + min.	\$71.00	\$70.00
<p><b>Multi-family Group Psychotherapy</b> Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.</p>	90849	30 minutes minimum with 2 clients minimum to 9 clients maximum	\$14.00 per client per hour. Maximum billable session is \$126.00	\$15.00 per client per hour. Maximum billable session is \$135.00
<p><b>Group Psychotherapy</b> Insight orientated, behavior modifying, supportive services delivered at the same time to more than one non-family client.</p>	90853			

**Notes:**

- If 2 or more clients within a family are seen together, only one family therapy claim can be reimbursed regardless of the number of clients in the family therapy session. Use the name of any one client to bill for the entire session. (See Clarification of Family Therapy in this Section for more information.)
- When group therapy is provided, only one claim is to be submitted. (See Clarification of Group Therapy in this Section for more information.)
- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO AND NP SERVICES

MEDICATION SUPPORT

Service	Code	Duration of Face- to-Face	Rate
<p><b>Individual Medication Service (Face-to-Face)</b> This service requires expanded problem-focused or detailed history and medical decision-making of low to moderate complexity for prescribing, adjusting, or monitoring meds.</p> <p><b>Note:</b> If more than minimal, supportive psychotherapy is provided; the service must be claimed as an E&amp;M Individual Psychotherapy service.</p>	99201	15+ min.	\$20.00
<p><b>Brief Medication Visit (usually Face-to-Face)</b> This service typically requires only a brief or problem-focused history including evaluation of safety &amp; effectiveness with straightforward decision-making regarding renewal or simple dosage adjustments. The client is usually stable.</p>	M0064	7+ min.	\$20.00

**Notes:**

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- Medi-Cal Lockout: Medication Support services are reimbursable up to a maximum of 4 hours a day per client.

INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO, PHD/PSYD, LCSW, MFT AND NP/CNS SERVICES

PLAN DEVELOPMENT

Service	Code	Duration of Face-to-Face	Rate for PhD/PsyD, LCSW, MFT, NP/CNS & RN	Rate for MD/DO
<p><b>Plan Development</b> A stand-alone service that includes developing Client Care Plans, approval of Client Care Plans and/or monitoring of a client's progress. Plan development may be done as part of an interdisciplinary inter/intra-agency conference and/or consultation in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contact with the client in order to develop and/or monitor the client's mental health treatment.</p>	<p><b>H0032</b></p>	<p><b>1+ minutes</b></p>	<p><b>\$36.00</b></p>	<p><b>\$53.00</b></p>

**Notes:**

- These services are recorded in the clinical record and reported into the County's claims processing information system in minutes.
- The time of the Team Conference/Case Consultation determines the code selection.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO SERVICES**

**ELECTROCONVULSIVE THERAPY (ECT)**

This service may only be delivered in an Outpatient Hospital (Place of Service Code 22)

<b>Service</b>	<b>Type</b>	<b>Code</b>	<b>Duration</b>	<b>Rate</b>
<b>ECT including monitoring</b>	Single seizure	90870	20+ min.	\$89.25
	Multiple seizures/day	90871		

**Note:**

- These services are categorized in the data system as Medication Support Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO SERVICES

EVALUATION AND MANAGEMENT - HOSPITAL INPATIENT SERVICES

These services may only be delivered in service location: Inpatient (Place of Service Code 21)

Service	Components	Severity of Condition	Duration of Face-to-Face or on Unit	Procedure Code	Rate
<p><b>Initial Care</b> The first hospital encounter the admitting physician has with a client on the inpatient unit for the management and evaluation of a new client that requires <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.</p>	<ul style="list-style-type: none"> <li>Detailed history</li> <li>Detailed or comprehensive exam</li> <li>Straight-forward or low complexity decision-making</li> </ul>	Low	1-29 min.	99221	\$0.00
	<ul style="list-style-type: none"> <li>Comprehensive history</li> <li>Comprehensive examination</li> <li>Decision-making of moderate complexity</li> </ul>	Moderate	30-69 min.	99222	21+ years of age: \$78.00 20 years of age and under: \$85.00
	<ul style="list-style-type: none"> <li>Comprehensive history</li> <li>Comprehensive examination</li> <li>Decision-making of high complexity</li> </ul>	High	70+ min.	99223	21+ years of age: \$78.00 20 years of age and under: \$85.00
<p><b>Subsequent</b> Care, per day, for the evaluation and management of a client that requires at least <u>two</u> of <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.</p>	<ul style="list-style-type: none"> <li>Problem focused history</li> <li>Problem focused examination</li> <li>Straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	1-24 min.	99231	\$20.00
	<ul style="list-style-type: none"> <li>Expanded problem focused history</li> <li>Expanded problem focused exam</li> <li>Decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	25-34 min.	99232	21+ years of age: \$40.00 20 years of age and under: \$44.00
	<ul style="list-style-type: none"> <li>Detailed history</li> <li>Detailed examination</li> <li>Decision making of moderate to high complexity</li> </ul>	Unstable, Significant complication, or new problem	35+ min.	99233	21+ years of age: \$40.00 20 years of age and under: \$44.00
	<p><u>All</u> services on day of discharge</p>	N/A	1-24 min.	99238	\$20.00
Discharge			25+ min.	99239	21+ years of age: \$40.00 20 years of age and under: \$44.00

**Note:**

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO SERVICES**

**EVALUATION AND MANAGEMENT - NURSING FACILITY**

These services may be delivered at any of these locations:

- Skilled Nursing Facility (POS\* Code 31)
- Nursing Facility (POS Code 32)
- Intermediate Care Facility/Mentally Retarded (POS Code 54)
- Residential Substance Abuse Treatment Facility (POS Code 55)
- Psychiatric Residential Treatment Center (POS Code 56)

Service	Components	Severity of Condition and/or Plan Requirements	Duration of Face-to-Face or on Unit	Procedure Code	Rate
<b>Assessment</b> Annual assessment for the evaluation and management of a new or established client that requires <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>• Detailed history</li> <li>• Comprehensive examination</li> <li>• Straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving; Affirmation of plan of care required	20-39 min.	99301	\$32.00
	<ul style="list-style-type: none"> <li>• Detailed history</li> <li>• Comprehensive examination</li> <li>• Decision-making of moderate to high complexity</li> </ul>	Significant complication or new problem; New plan of care required	40-49 min.	99302	\$53.00
	<ul style="list-style-type: none"> <li>• Comprehensive history</li> <li>• Comprehensive examination</li> <li>• Decision-making of moderate to high complexity</li> </ul>	Creation plan of care required	50+ min.	99303	53.00
<b>Subsequent</b> Care, per day, for the evaluation and management of a new or established client that requires <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs	<ul style="list-style-type: none"> <li>• Problem focused history</li> <li>• Problem focused examination</li> <li>• Straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	1-19 min.	99311	\$0.00
	<ul style="list-style-type: none"> <li>• Expanded history</li> <li>• Expanded examination</li> <li>• Decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	20-39 min.	99312	\$32.00
	<ul style="list-style-type: none"> <li>• Detailed history</li> <li>• Detailed examination</li> <li>• decision making of moderate to high complexity</li> </ul>	Unstable, Significant complication or new problem	40+ min.	99313	\$53.00
<b>Discharge</b>	All services on day of discharge	N/A	20-39 min.	99315	\$32.00
			40+ min.	99316	\$53.00

\* Place of Service

**Note:**

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO SERVICES**

**EVALUATION AND MANAGEMENT  
DOMICILIARY, BOARD, & CARE, OR CUSTODIAL CARE FACILITY**

These services may only be delivered at a custodial care facility (Place of Service Code 33).

Service	Components	Severity of Presenting Problem	Procedure Code	Duration of Face-to-Face	Rate
<p><b><u>New Client</u></b> Service for the evaluation and management of a new client that requires <u>three</u> components.</p> <p>Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.</p>	<ul style="list-style-type: none"> <li>• Problem focused history</li> <li>• Problem focused examination</li> <li>• Straight-forward or low complexity decision making</li> </ul>	Low	99321	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> <li>• Expanded history</li> <li>• Expanded examination</li> <li>• Decision-making of moderate</li> </ul>	Moderate	99322	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> <li>• Detailed history</li> <li>• Detailed examination</li> <li>• Decision-making of high complexity</li> </ul>	High	99323	20-39 min.	\$32.00
				40+ min.	\$53.00
<p><b><u>Established Client</u></b> Services for the evaluation and management of an established client that requires at least <u>two of three</u> components.</p> <p>Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.</p>	<ul style="list-style-type: none"> <li>• Problem focused history</li> <li>• Problem focused examination</li> <li>• Straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	99331	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> <li>• Expanded history</li> <li>• Expanded examination</li> <li>• Decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	99332	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> <li>• Detailed history</li> <li>• Detailed examination</li> <li>• Decision making of high complexity</li> </ul>	Significant complication or new problem	99333	20-39 min.	\$32.00
				40+ min.	\$53.00

**Note:**

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

**EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES**

These services may only be delivered in an Office (Place of Service Code 11).

<b>Service</b>	<b>Components</b>	<b>Severity of Presenting Problem(s)</b>	<b>NEW CLIENT Duration of Face-to-Face w/Client and/or Family and Code</b>	<b>NEW CLIENT Rate</b>	<b>ESTAB. CLIENT Duration of Face-to-Face w/Client and/or Family and Code</b>	<b>ESTAB. CLIENT Rate</b>
Evaluation and management of a client that includes at least the three components noted in the next column.	<ul style="list-style-type: none"> <li>• Problem focused history</li> <li>• Problem focused examination</li> <li>• Straightforward medical decision making</li> </ul>	Minor	1-19 min. No Code	\$0.00	No Code	\$0.00
	<ul style="list-style-type: none"> <li>• Expanded problem focused history</li> <li>• Expanded problem focused exam</li> <li>• Straightforward medical decision making</li> </ul>	Low to Moderate	20-29 min. 99202	\$32.00	1-19 min. 99212	\$0.00
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>• Detailed history</li> <li>• Detailed examination</li> <li>• Medical decision making of low complexity</li> </ul>	Moderate	30-39 min. 99203	\$32.00	20-24 min. 99213	\$32.00
	<ul style="list-style-type: none"> <li>• Comprehensive history</li> <li>• Comprehensive examination</li> <li>• Medical decision making of moderate complexity</li> </ul>	Moderate to High	40-59 min. 99204	\$53.00	25-39 min. 99214	\$32.00
	<ul style="list-style-type: none"> <li>• Problem focused history</li> <li>• Problem focused examination</li> <li>• Medical decision making of high complexity</li> </ul>	Moderate to High	60+ min. 99205	\$53.00	40+ min. 99215	\$53.00

**Note:**

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO AND ADMITTING PHD/PSYD SERVICES

EVALUATION AND MANAGEMENT – CONSULTATIONS

These services may only be delivered at an outpatient hospital (Place of Service Code 22).

Service	Components	Severity of Presenting Problem	Initial Consult Code	Confirmatory Consult	Rate PhD/PsyD	Rate MD/DO
Initial Inpatient or Nursing Facility Service for the evaluation and management of a new or established client that requires three components.  Confirmatory Service to a new or established client to confirm an existing opinion regarding services. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	Problem focused history <ul style="list-style-type: none"> <li>Problem focused examination</li> <li>Straightforward decision making</li> </ul>	Self limited or minor	20-39 min. 99251	20-39 min. 99271	\$20.00	\$32.00
	Expanded problem focused history <ul style="list-style-type: none"> <li>Expanded problem focused exam</li> <li>Straightforward decision making</li> </ul>	Low	40-54 min. 99252	40+ min. 99272	\$40.00	\$53.00
	Detailed history <ul style="list-style-type: none"> <li>Detailed examination</li> <li>Decision making of low complexity</li> </ul>	Moderate	55-79 min. 99253	40+ min. 99273	\$40.00	\$53.00
	Comprehensive history <ul style="list-style-type: none"> <li>Comprehensive examination</li> <li>Decision making of moderate complexity</li> </ul>	Moderate to high	80-109 min. 99254	80+ min. 99274	\$40.00	\$53.00
	Comprehensive history <ul style="list-style-type: none"> <li>Comprehensive examination</li> <li>Decision making of high complexity</li> </ul>	High	110+ min. 99255	80+ min. 99275	\$40.00	\$53.00
Follow –up Inpatient Service to an established client to complete a consultation, monitor progress, or recommend modifications to management or a new plan of care based on changes in client status. At least <u>2 of 3</u> components are required. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	Problem focused history <ul style="list-style-type: none"> <li>Problem focused examination</li> <li>Straightforward or low complexity decision making</li> </ul>	Stable, recovering, or improving	1-19 min. 99261	1-19 min. 99261	\$0.00	\$0.00
	Expanded problem focused history <ul style="list-style-type: none"> <li>Expanded problem focused exam</li> <li>Decision making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	20-39 min. 99262	20-39 min. 99262	\$20.00	\$32.00
	Detailed history <ul style="list-style-type: none"> <li>Detailed examination</li> <li>Decision making of high complexity</li> </ul>	Significant complication or new problem	20-39 min. 99263	20-39 min. 99263	\$20.00	\$32.00

**Note:**

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the County's claims processing information system in minutes.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS  
MD/DO SERVICES**

**EVALUATION AND MANAGEMENT – CONSULTATIONS, OFFICE OR OTHER OUTPATIENT**

These services may be delivered in any setting other than Inpatient Hospital:

- Office (POS\* 11)
- Home (POS 12)
- Urgent Care (POS 20)
- Outpatient Hospital (POS 22)
- Hospital Emergency Room (POS 23)
- Ambulatory Surgical Center (POS 24)
- Skilled Nursing Facility (POS\* Code 31)
- Nursing Facility (POS Code 32)
- Custodial Care Facility (POS Code 33)
- Hospital (POS Code 34)

Service	Components	Presenting Problems	Duration of Face-to Face w/Client and/or Family	Code	Rate
New or Established Client  Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs	Problem focused history <ul style="list-style-type: none"> <li>• Problem focused examination</li> <li>• Straightforward decision making</li> </ul>	Self Limited or Minor	20-29 min.	99241	\$32.00
	Expanded problem focused history <ul style="list-style-type: none"> <li>• Expanded problem focused exam</li> <li>• Straightforward decision making</li> </ul>	Low Severity	30-39 min.	99242	\$32.00
	Detailed history <ul style="list-style-type: none"> <li>• Detailed examination</li> <li>• Decision making of low complexity</li> </ul>	Moderate Severity	40-59 min.	99243	\$53.00
	Comprehensive history <ul style="list-style-type: none"> <li>• Comprehensive examination</li> <li>• Decision making of moderate complexity</li> </ul>	Moderate to High Severity	60-79 min.	99244	\$53.00
	Comprehensive history <ul style="list-style-type: none"> <li>• Comprehensive examination</li> <li>• Decision making of high complexity</li> </ul>	Moderate to High Severity	80+ min.	99245	\$53.00

\* Place of Service

**Note:**

- Services are recorded in the clinical record and reported into the County's claims processing information system in minutes.

## SECTION X – QUALITY IMPROVEMENT

The Local Mental Health Plan (LMHP) has a responsibility and shared commitment with network providers, to maintain and improve the quality of the service delivery system. It is a function of the LMHP to support this commitment by establishing processes for the resolution of service and system issues and the continuous improvement of the delivery of specialty mental health services.

The LMHP quality improvement activities focus on each of the following areas:

- ◆ Service accessibility
- ◆ Service delivery capacity
- ◆ Medi-Cal beneficiary satisfaction
- ◆ Network provider satisfaction
- ◆ Appropriateness of care
- ◆ Continuity of care
- ◆ Coordination with health care
- ◆ Utilization management
- ◆ Adverse outcomes
- ◆ Credentialing and peer review

### NETWORK PROVIDER RESPONSIBILITIES

- ◆ Compliance with the terms and conditions of the LMHP Medi-Cal Professional Services Legal Agreement, Exhibit A of the Legal Agreement (Service Provisions) and the requirements in the LMHP Provider Manual and Provider Bulletins;
- ◆ Compliance with all relevant Federal, State and County statutes, rules and regulations;
- ◆ Maintenance of the clinical record for at least seven years following the discharge date of the client. Clinical records of minors are to be maintained at least one year after the minor has turned 18 years of age, but in any case, not less than seven years;
- ◆ Ensuring availability of all clinical records during normal business hours to authorized representatives of the Federal, State and County government for the purposes of inspection, program review and audit;
- ◆ Coordination of care with other treating mental and physical health care providers which should, at a minimum, include information exchange regarding treatment planning and medications;
- ◆ Emergency coverage at all times;
- ◆ Reporting of adverse incidents to the LMHP;
- ◆ Prompt response to requests from the LMHP Credentialing Review Committee; and
- ◆ Immediate notification to the LMHP of any accusations or actions against the network provider's clinical license, including, but not limited to, license suspension or termination.

### MANDATORY SELF-ASSESSMENT TOOLS AND SITE VISITS

The Medi-Cal Professional Services Legal Agreement mandates a review of individual and group network providers on not less than an annual basis to determine compliance with the LMHP legal agreement; State, Federal and County statutes, rules and regulations; and LMHP policies, procedures and guidelines. This Agreement stipulates under "*Monitoring, Quality Improvement, Records, and Audits*", that Contractors shall establish clinical records and all

services provided to a beneficiary for which Medi-Cal reimbursement is sought must be documented in this record in a manner which complies with all applicable regulations and standards established by DHCS and County DMH.

The *General Administrative Profile* is a mandatory self-assessment tool sent to network providers triennially to coincide with the re-credentialing process, refer to Section II: Provider Network (Attachment I). Network providers are to utilize this tool to review their administrative procedures and clinical practices to evaluate compliance with the LMHP legal agreement and Medi-Cal requirements. Network providers are required to return the self-assessment tools to the Credentialing Unit upon completion. The information contained in this form shall be validated for accuracy during compliance reviews. A Plan of Correction shall be issued for non-compliance to the following:

1. Physical Environment;
2. Confidentiality;
3. Maintenance of Records;
4. Notification; and
5. Medication Compliance, if applicable.

## **COMPLIANCE PROGRAM REVIEWS AND PROGRAM INTEGRITY**

Pursuant to the Medi-Cal Professional Services Agreement with Individual and Group Providers, the Compliance Unit of the Managed Care Division, has a right to access, review and to copy any records and supporting documentation pertaining to the performance of the Agreement during normal business hours. The purposes of the site visits and outpatient clinical chart reviews are:

1. To validate the information provided on the self-assessment tools—through site inspection;
2. To review the quality of specialty mental health services provided to beneficiaries, including access to services;
3. To ensure compliance with the LMHP legal agreement, and Medi-Cal documentation requirements;
4. To help identify fraud, waste and abuse issues; and
5. To help identify quality of care issues that need further improvement to better meet the needs of the beneficiaries.

Another part of the clinical chart review is the beneficiary interview. This process may be conducted either telephonic or through survey questions sent to the beneficiaries addresses. The questions include verification whether services were actually furnished to beneficiaries. This process helps the LMHP in meeting its obligation under Code of Federal Regulations (CFR), Title 42, Section 455.1(a) (2) and the Program Integrity requirement found in the LMHP Contract with DHCS.

The Compliance Unit will send a letter informing the providers of the date of the site visit at least three (3) weeks prior to the review. The letter includes copies of Reasons for Recoupment Outpatient Chart and Review Worksheet. A list of the clinical charts for review will be sent to the provider at least four (4) business days prior to the review. Within two months of the site visit, the provider will receive a report summarizing the site visit and clinical chart review findings. Documentation on the medical record that does not conform to the published county,

state and federal rules and regulations will be denied and payment already made will be recouped using the "Reasons for Recoupment". The reason(s) for recoupment and the dollar amount(s) of the denied service date(s) will be identified in the "Line List of Disallowances", which is a part of the review report. When actions are required to correct deficiencies, a request for a Plan of Correction (POC) will be included in the report. The POC is due from the providers within sixty (60) days of the receipt of the written review findings, whether the provider is accessing the appeal process or not. The POC will state how the provider will correct the deficiencies and a timeframe for application to service provisions. A follow-up site visit may be scheduled to confirm implementation of the POC.

Review findings regarding credentialing issues will be referred to the Credentialing Unit in addition to the issuance of a POC.

The LMHP Compliance Program Office (CPO) also conducts reviews and audits of LMHP programs, providers and contractors. The Managed Care Division, Compliance Unit may refer cases to the CPO when egregious over utilization of services, suspected fraud or abuse has occurred, or if the findings are beyond the scope or capacity of the Compliance Unit to pursue. The provider should be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code, Section 10115.10.

A memo from the Director of Mental Health to network providers dated February 14, 2008 (Attachment I) provided notification that the CPO would be conducting audits of network providers to ensure quality of care is being upheld and to determine compliance with billing requirements.

The payment threshold established for psychiatrists is total payments, equal to or in excess of, \$100,000 in a fiscal year. The payment threshold established for psychologists, social workers, marriage and family therapists, clinical nurse specialists and nurse practitioners is total payments, equal to or in excess of, \$25,000 in a fiscal year.

## **PROBLEM RESOLUTION PROCESSES**

The LMHP's Patients' Rights posters explaining the grievance and appeal processes, together with informing materials, are required to be posted in provider's offices or locations of service. In addition to the posters, informing materials and self-addressed envelopes from the LMHP shall be available to the beneficiaries without the beneficiary having to make a verbal or written request to anyone.

Problem resolution processes like grievance, appeals and expedited appeals regarding the clinical quality of care rendered by network providers received from beneficiaries will be thoroughly evaluated by the LMHP. The LMHP's Patients' Rights Office (PRO) shall acknowledge receipt of each grievance and appeal to the beneficiary in writing. The PRO shall notify the beneficiary and the provider identified by the beneficiary, in writing, of the final disposition of the problem resolution process, including the reason for the disposition. For questions regarding Notice of Action (NOA), refer to Section XVII: Notice of Action, Section VI: Beneficiary Services and Section XIII: Resolving Fiscal and Authorization Request Appeals.

## PROVIDER APPEAL RELATED TO QUALITY OF CARE

When a dispute arises from a decision of the Managed Care Division (MCD), Compliance Unit staff during clinical chart reviews, the provider shall seek resolution following the procedure outlined below:

### First Level appeal process

1. If the provider does not agree in whole or in part with the report of review findings, then notification in writing shall be addressed and received by the office of the Mental Health Clinical District Chief, Managed Care Division within 15 calendar days of the provider's receipt of the report. The date that the notification is received by the MCD will be the verification of receipt for the appeal.

The appeal letter shall include the following:

- a). The appeal shall state the reason(s) for the dispute;
- b). The LMHP's reason for the denial of reimbursement;
- c). The remedy sought.

The provider shall include copies of supporting evidence or documentation to refute the LMHP's findings and support the appeal.

2. The Mental Health Clinical District Chief shall assign the appeal to a clinical person not involved with the clinical chart review.
3. MCD staff shall review and make a decision based on the documentation submitted and the original documents obtained during the chart review. This written decision shall be in writing and sent to the provider within sixty days of the receipt of the appeal. If the appeal is not granted in full, the provider shall be notified of any right to submit a second level appeal.

### Second Level appeal process

2. When resolution is not to the provider's satisfaction, the provider may file a request for a second level appeal. The appeal correspondence shall be directed to the MCD Mental Health Clinical District Chief. It shall be received within 30 calendar days after the receipt of the first level appeal decision. The letter will be stamped date as verification of LMHP receipt.

The appeal packet shall include the reason for disagreement along with supporting evidence or documentation to support the appeal and a copy of the first level appeal decision.

3. The appeal will be reviewed by a clinical staff not involved with the chart review or the first level appeal. If the appeal is granted in part, a decision letter signed by the Mental Health Clinical District Chief will be sent to the provider within thirty (30) calendar days of the receipt. The decision is final.

If the LMHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by the LMHP.

First and second level appeals may be forwarded to:

Name of District Chief  
Mental Health Clinical District Chief  
Managed Care Division  
550 South Vermont Avenue, 7<sup>th</sup> Floor  
Los Angeles, CA 90020

**NOTE:**

If the appeal is for financial decisions, the appeal shall be forwarded to: Program Support Office, 695 South Vermont Avenue, 11<sup>th</sup> Floor, Los Angeles, CA 90020. Refer to Section XIII: Resolving Fiscal and Authorization Request Appeals.

**REPORTING CLINICAL INCIDENTS**

The LMHP has established reporting of clinical incidents through the Policy/Procedure No. 202.18, Reporting Clinical Incidents Involving Intentional Injuries, Deaths, Alleged Client Abuse and Possible Malpractice.

Clinical Incident is defined as incidents that include any event which threatens or causes actual damage to the health, welfare and/or safety of Medi-Cal beneficiaries, staff or the community, including, but not limited to, the following:

- ◆ deaths (unknown cause, suspected or known medical cause or suspected or known suicide);
- ◆ suicide attempts requiring emergency medical treatment;
- ◆ client sustained intentional injury requiring emergency medical treatment;
- ◆ injury to others caused by a client and requiring emergency medical treatment;
- ◆ homicide by a client;
- ◆ alleged client abuse;
- ◆ adverse medication events including medication errors; and
- ◆ threats of a malpractice lawsuit.

Clinical Incidents may either be:

- a) non-critical or
- b) critical

**NON-CRITICAL CLINICAL INCIDENT**

Non-critical clinical incident is an event that does not generate governmental and/or immediate community-wide attention and, does not require a report by the Mental Health Director to the Board of Supervisors.

If the incident is considered a non-critical clinical incident, the network provider is to complete and send Page 1 of the Clinical Incident Report within 48 hours of the incident to:

Department of Mental Health  
Office of the Medical Director  
Roderick Shaner, M.D.  
550 S. Vermont Ave, 12<sup>th</sup> Floor  
Los Angeles, CA 90020  
Fax: (213) 386-1297

## CRITICAL CLINICAL INCIDENT

Critical clinical incident is an event generating governmental and or immediate community-wide attention and, thus, may require a report by the Mental Health Director to the Board of Supervisors. All network providers must report critical clinical incidents to the LMHP.

If the incident is a critical incident, the network provider is to call the Office of the Medical Director immediately at (213) 738-4603 during normal business hours or the Access Center immediately at (800) 854-7771 after hours. For critical incidents, as well as reports containing time-sensitive information, Incident Report form (Attachment II), is to be faxed, as well as mailed, to the Office of the Medical Director within 24 hours of the incident to:

Department of Mental Health  
Office of the Medical Director  
Roderick Shaner, M.D.  
550 S. Vermont Ave, 12<sup>th</sup> Floor  
Los Angeles, CA 90020  
Fax: (213) 386-1297

Before the Critical Clinical Incident Report is faxed, a telephone call is to be made to the Office of the Medical Director to provide notification that the material will be transmitted.

## CLINICAL INCIDENT REPORTING ELEMENTS

Network providers are to adhere to the clinical incident reporting elements on the Incident Report form (Attachment II). If the form is not used, the report is to contain the following information:

- ◆ Medi-Cal beneficiary name, date of birth, address, phone number(s), sex, patient file number, diagnosis; medications prescribed, and whether or not the prescribed medications were within the LMHP parameters for the use of psychotropic medications ; network provider's name, address, telephone number; incident date and time; report date. The medication parameters can be accessed at <http://www.rshaner.medem.com>. Scroll down to "LAC DMH Parameters for Medication Use".
- ◆ A complete description of the incident, including outcome/status of the Medi-Cal beneficiary;
- ◆ Efforts to contact the Medi-Cal beneficiary's significant others and their reactions;
- ◆ Medi-Cal beneficiary attitude;
- ◆ Name, address, relationship and phone number of the Medi-Cal beneficiary's family contact or witness; and
- ◆ Equipment involved.

Note: Clinical Incident Reports should not be filed or referenced in the Medi-Cal beneficiary's record. A copy of the Clinical Incident Report may be kept by the network provider in a separate file.

Network providers may contact the Clinical Risk Manager at (213) 637-4588 for additional information and questions regarding Clinical Incident Reporting.

**COUNTY OF LOS ANGELES**

MARVIN J. SOUTHARD, D.S.W.  
Director

ROBIN KAY, Ph.D.  
Acting Chief Deputy Director

RODERICK SHANER, M.D.  
Medical Director



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**DEPARTMENT OF MENTAL HEALTH**<http://dmh.lacounty.gov>

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: (213) 738-2466  
Fax: (213) 351-2024

February 14, 2008

**CERTIFIED MAIL**

TO: Individual Fee-For-Service Network Providers

FROM: Marvin J. Southard, D.S.W.  
Director of Mental Health

SUBJECT: **COMPLIANCE AUDITS**

The Medi-Cal Professional Services Legal Agreement mandates the Department of Mental Health (DMH) conduct a review of individual network providers' performance not less than once every two years. Such an evaluation includes assessing compliance with all contract terms and performance standards; evaluating the quality, appropriateness and timeliness of services performed; and the examination and audit of all records and documents necessary to determine compliance with relevant Federal, State and local statutes, rules and regulations.

The purpose of this memo is to provide notification that the DMH Compliance Program Office will be conducting audits to determine compliance with billing requirements. As you may be aware, over the past several years, the Department of Justice (DOJ) and the Department of Health and Human Services Office of Inspector General (HHS OIG) have launched a number of detection and enforcement initiatives that are national in scope. These efforts typically involve investigations stemming from an analysis of national claims data that indicates a pattern of improper billing to government health care programs by similarly situated health care providers across the country.

DMH has analyzed payment data to determine what the expected annual payment range should be for our Fee-For-Service (FFS) providers. Further, using this payment data DMH has also established a payment limit or threshold. All providers that were paid equal to, or in excess of, the threshold amount as of June 2007, will be audited. The payment threshold established for psychiatrists is total payments, equal to, or in excess of \$100,000. The payment threshold for psychologists, social workers, marriage and family therapists, nurse practitioners and clinical nurse specialists is total payments equal to or in excess of \$25,000.

<b>Revised 11-27-07</b> <b>LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH</b> <b>CLINICAL INCIDENT REPORT (DMH Policy #202.18 Attachment I, Pg. 1)</b> <b>You may complete this report on a computer or print, but <u>do not e-mail</u> this report.</b>					
1. Client's Name:		2. Date of Birth		3. Sex:	4. MIS #:
7. Provider #	8. Clinic/Program Name: (Include address if contractor)		9. Incident Location:		10. Treating Psychiatrist/Psychiatric Mental Health Nurse Practitioner (PMHNP.)
11. List the frequency and dosages of <u>all</u> current medications:					12. Diagnosis
13. Is the medication regimen within DMH Parameters? Y <input type="radio"/> N <input type="radio"/> (Please note: The treating MD/PMHNP and reviewing psychiatrist should determine this response and also reply to No. 24 on pg. 2 should the incident fall in categories *3-*10 I in No. 14 below. DMH parameters for medication use are posted on <a href="http://dmh.lacounty.gov/Clinical_Issues.asp">http://dmh.lacounty.gov/Clinical_Issues.asp</a> .)					
14. Clinical Incident Type: (Check number) Note : *Asterisked numbers require the completion of pg. 2 by the manager					
<input type="radio"/> 1. Death-Other Than Suspected or Known Medical Cause or Suicide		<input type="radio"/> *4. Suicide Attempt Requiring Emergency Medical Treatment (EMT)		<input type="radio"/> *7. Homicide By Client	
<input type="radio"/> 2. Death Suspected or Known Medical Cause		<input type="radio"/> *5. Client Sustained Intentional Injury by Self or Another Client (not suicide attempt) Requiring EMT		<input type="radio"/> *8. Medication Error or Adverse Medication Event Requiring EMT	
<input type="radio"/> *3. Death-Suspected or Known Suicide		<input type="radio"/> *6. Client Injured Another Person Who Required EMT		<input type="radio"/> *9. Suspected Client Abuse by Staff	
				<input type="radio"/> *10. Possibility or Threat of Legal Action	
15. Description of the Incident: Include important facts. If needed, use an additional sheet(s) that includes a statement of confidentiality, i.e., the last sentence <sup>4</sup> at the bottom of this page.					
16. Is the family aware of this event? Y <input type="radio"/> N <input type="radio"/>		17. Client/Family Attitude:		18. Name/Title or Reporting Staff:	19. Signature:
20. Tel. # of reporting staff:		21. Date of Report:		22. Agency Manager's Name:	23. Manager' Telephone #:

Send Pg. 1 (sealed securely) to Roderick Shaner, MD, LAC DMH Medical Director, 550 S. Vermont Ave., 12<sup>th</sup> Floor, Los Angeles, CA 90020 within 1 business day. Make only 1 other copy to be kept in a separate file at the clinic. Do not file this report or make reference it or to communication with the Clinical Risk Mgr. in the client's chart. **\*To allow sufficient time for a clinical review of significant events, the Manager's Report of Clinical Review (Pg. 2) should be completed and sent within 30 days to the Clinical Risk Manager for asterisked (\*) categories 3-10 above.** Please call 213-637-4588 for questions. Thank you for reporting.

This information is privileged and confidential under Evidence Code Section 1157.6 and Government Code 6254 [c.]

Please Type or Print      LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH      MIS: #: \_\_\_\_\_  
Revised 11-27-07      MANAGER'S REPORT OF CLINICAL REVIEW      (DMH Policy #202.18 Attachment 1 – Pg. 2

Submit this page within 30 days of the clinical incident after completing a clinical review for incidents in asterisked categories 3-10 on Pg. 1. If item 13, on page 1 is "N," please complete item 24, and submit with Pg. 1. Send Pg. 2 (Sealed securely) to: Mary Ann O'Donnell, LAC DMH Clinical Risk Mgr., 550 S. Vermont Ave., 12<sup>th</sup> Fl. Los Angeles CA 90020.

<p>Manager's Name: _____ Date: _____ Date of Clinical Incident Report: _____ Date and Type of Last Contact: _____          _____ Check Y or N if indicated. Please use additional page(s) if needed, referring to the number and include the disclaimer on the last line of this page. Please attach the Clinical Case Review if conducted</p>
<p>24. If item 13, on pg. 1 is N, i.e. the medication regimen was outside of DMH parameters, is supportive documentation present in the medical record? Y <input type="radio"/> N <input type="radio"/>. If N, please explain. (Please note: The treating or reviewing psychiatrist/PMHNP should determine this response.)</p>
<p>25. Was this a suspected suicide or a suicide attempt requiring emergency medical treatment (EMT)? Y <input type="radio"/> N <input type="radio"/>          If Y, please describe relevant factors, e.g. prior attempt requiring EMT, recent discharge from inpatient for a suicide attempt, date of the first out-patient visit post hospital admission for suicide attempt.</p>
<p>26. If substance abuse (SA) was a factor in this event, was the client receiving SA/Dual DX RX? Y <input type="radio"/> N <input type="radio"/> If N, please explain.</p>
<p>27. List any pre-disposing factor(s) or root cause(s) that may be relevant in this type of event, e.g. include, if relevant, factors in the transfer of care between providers, e.g., medications supplied for transition to the receiving provider.</p>
<p>28. List any recommendations for operational changes or managerial actions that may be considered to lessen the impact or likelihood of this type of event occurring in the future:</p>
<p>29. List any current or new systems, parameters, policies &amp; procedures or training in your agency or through DMH, that may help your staff deal more effectively with the clinical or other issues inherent in this type of event:</p>

Do not e-mail this report or the client's name. Make only 1 other copy to be kept in a separate file at the clinic. Do not file this report or make reference it or to communication with the Clinical Risk Mgr. in the clients chart.  
 This information is privileged and confidential under Evidence Code Section 1197 and Government Code 6254 [c.]

## SECTION XI – FINANCIAL SCREENING

### FINANCIAL FOLDERS

Network providers are required to maintain a financial folder for each Medi-Cal beneficiary receiving services at their facility. The financial folder should contain all financial information regarding the Medi-Cal beneficiary and a detailed history of contacts and conversations with the Medi-Cal beneficiary/payor. The following are examples of the types of information that should be filed in the financial folder:

1. Payor Financial Information (PFI) form
2. Verification of employment, income, allowable expenses and assets
3. Photocopy of identification, Social Security Card, paycheck stubs and health insurance cards
4. Financial Obligation Agreement
5. Photocopy of the Medi-Cal beneficiary's Benefit Identification Card (BIC)
6. Department of Public Social Services/Social Security Administration (SSA) Referral Card
7. Insurance Authorization and Assignment of Benefits
8. Lifetime Extended Signature Authorization
9. Authorization for Request or Use/Disclosure of PHI
10. Any correspondence to or from the Medi-Cal beneficiary/payor
11. Re-evaluation Follow-Up Letter

Financial screening is the process of evaluating a Medi-Cal beneficiary or a responsible party's ability to pay for services. This includes the individual's ability to personally contribute, the individual's ability to access third-party benefits and the individual's ability to qualify for benefits from social welfare programs.

Medi-Cal beneficiary/payors have the right to refuse to provide financial information. However, if the beneficiary refuses to provide financial information they then become liable for the actual cost of care. There can be only one annual liability period for each Medi-Cal beneficiary/payor and their resident dependent family members regardless of the number of service providers within the state or county.

The objective of the financial screening interview is to obtain complete and accurate billing information on each Medi-Cal beneficiary/payor. It is imperative that all third-party billing sources are identified and Medi-Cal beneficiaries are appropriately referred to social welfare programs for which they are potentially eligible.

It is the goal of the LMHP to interview all Medi-Cal beneficiaries at the time of their first visit. If this goal is not attained, measures must be taken to ensure an interview takes place during a subsequent visit. Basic billing information, e.g., name, address, telephone number and Social Security Number is to be obtained on all Medi-Cal beneficiaries during their first visit, including those Medi-Cal beneficiaries receiving emergency services.

In the absence of adequate information to determine the UMDAP liability amount, the Medi-Cal beneficiary should be billed the actual cost of care. The actual cost of care amount can be rescinded once the information is provided.

## UNIFORM METHOD OF DETERMINING ABILITY TO PAY

The Uniform Method of Determining Ability to Pay (UMDAP) liability applies to services extended to the Medi-Cal beneficiary and dependent family members. It is valid for a period of one year. The UMDAP liability amounts can be adjusted should the Medi-Cal beneficiary's financial condition change during the liability period. Under no circumstances should a Medi-Cal beneficiary be billed the UMDAP liability amount if the Medi-Cal beneficiary has not incurred that amount in actual services. The Medi-Cal beneficiary is responsible for the actual cost of care or the annual liability amount (whichever is less).

DHCS requires that all Short/Doyle providers employ the UMDAP when assessing a Medi-Cal beneficiary's ability to personally pay for services rendered.

Third-party benefits are separate and aside. They apply first to the actual cost of care, then to the annual UMDAP liability. Third-party payments do not lessen the established UMDAP liability except in instances when the combined third-party payment and the UMDAP liability exceed the actual cost of care. Assisting Medi-Cal beneficiaries in understanding this process is often one of the most difficult tasks a financial screener encounters. See the following examples:

The actual cost of care is \$1,000 and the UMDAP liability amount is \$100. If the Medi-Cal beneficiary has insurance that paid \$500, nothing is applied to the UMDAP liability because the amount paid by the insurance did not reach or go below the UMDAP liability of \$100.

Insurance Payment	\$500
Medi-Cal beneficiary's obligation is the entire UMDAP liability amount	\$100
County Cost:	\$400
Actual Cost of Care:	<u>\$1,000</u>

The actual cost of care is \$1,000 and the UMDAP liability amount is \$100. If the Medi-Cal beneficiary has insurance that paid \$950, then \$50 would be applied to the UMDAP liability. The Medi-Cal beneficiary would be liable for the remaining \$50 liability.

Insurance Payment	\$950
Medi-Cal beneficiary's obligation is the remaining portion of the actual cost of care	<u>\$50</u>
Actual Cost of Care:	\$1,000

The UMDAP process that occurs during a Medi-Cal beneficiary's financial screening may be waived for those full-scope Medi-Cal beneficiaries with no share-of-cost. However, network providers are still required to complete the PFI Form for all Medi-Cal beneficiaries during the financial screening. The waiver only applies to the UMDAP Liability Determination Sections 19, 20 and 21. All other sections of the PFI Form must be completed.

If a Medi-Cal beneficiary is identified as being Medi-Cal eligible only after meeting their Medi-Cal share-of-cost, technically they are not Medi-Cal eligible and must interface with the UMDAP process.

## PAYOR FINANCIAL INFORMATION FORM

The financial screener is to base the financial interview on obtaining the information required to complete the Payor Financial Information (PFI) form (Attachment I). The PFI Form is used to capture Medi-Cal beneficiary/payor financial information in order to determine a Medi-Cal beneficiary's ability to pay. It is also used to identify and document third-party payor sources for billing purposes. All information recorded on the PFI Form is confidential per Welfare and Institutions Code Section 5328.

The PFI Form is mandated by the DHCS for content, but not for format. A PFI Form must be completed for each Medi-Cal beneficiary treated in the county mental health care system. Each provider/clinic should provide a written request for a copy of the PFI Form completed at another facility. Each clinic should provide a copy of the PFI Form when a written request for information is received. The following provides detailed instructions for the completion of the PFI Form:

### CLIENT INFORMATION

#### Line 1:

- **CLIENT NAME:** First, middle and last name
- **CLIENT INDEX NUMBER:** Enter the client's CIN number
- **DMH CLIENT ID NUMBER:** Enter the DMH Client ID number

#### Line 2:

- **MAIDEN NAME:** If applicable
- **DOB:** Date of Birth: Month, Day, and Year
- **MARITAL STATUS:** Circle one
  - M - Married
  - S - Single
  - D - Divorced
  - W - Widowed
  - SP- Separated
- **SPOUSE NAME:** If applicable

### THIRD-PARTY INFORMATION

#### Line 3:

- **NO THIRD-PARTY PAYOR:**  Check the applicable box to indicate whether or not the client has a Third-party Payor

Line 4:

- **MEDI-CAL:**  Yes  No Check the appropriate box to indicate whether the client has Medi-Cal benefits
- **MEDI-CAL COUNTY CODE/AID CODE/CLAIM NUMBER**
- **MEDI-CAL PENDING:**  Yes  No Check the appropriate box to indicate whether a Medi-Cal application is pending through the DPSS and/or a Supplemental Security Income (SSI) application is pending through Social Security Administration (SSA)
- **REFERRED FOR ELIGIBILITY:**  Yes  No Check the applicable box to indicate whether the client was referred to DPSS to apply for Medi-Cal benefits and/or referred to SSA to apply for SSI. (See the Medi-Cal Eligibility Requirements and SSI Requirements following the PFI Form instructions).
  - **DATE REFERRED:** Enter the date the client was referred

Line 5:

- **SHARE OF COST:**  Yes  No Check the appropriate box to indicate whether the client has a Share of Cost amount.
- **SHARE OF COST AMOUNT:** Enter the amount of the client's Share of Cost.
- **SSI PENDING:**  Yes  No Check the appropriate box to indicate whether an SSI application is pending through SSA.
- **SSI APPLICATION DATE:** Enter the SSI application date.
- **IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON:** If the client appeared eligible for Medi-Cal benefits and not referred to DPSS, indicate why the client was not referred. In addition, if the client appears eligible for SSI and not referred to SSA, indicate why the client was not referred.

Line 6: Check the appropriate box for the following:

- **MEDI-CAL HMO**  Yes  No
- **CalWORKs**  Yes  No
- **AB3632**  Yes  No
- **GROW**  Yes  No
- **HEALTHY FAMILIES**  Yes  No
- **HEALTHY FAMILIES CIN** Enter the Client Identification Number.
- **OTHER FUNDING** If applicable, enter other funding sources.

Line 7:

- **MEDICARE:** A Federal Health Insurance Program for people who have attained the age of 65 or over, or have received SSD for two or more years.  
 Yes  No Check the applicable box to indicate if the client is eligible for Medicare.
- **MEDI-GAP INSURANCE:** A private insurance policy that pays for some of the items that Medicare does not cover such as deductible, co-payment, prescription drugs and dental.  
 Yes  No Check the applicable box to indicate whether or not the client is covered by Medi-Gap insurance

- **CHAMPUS:** Insurance for retired military service personnel, their dependents, and the dependents of active duty service personnel.  
 Yes  No Check the applicable box to indicate whether or not the client is covered by CHAMPUS.

- **VET/ADM (Veterans Administration):** Veterans should obtain all medical care at VA facilities. Refer to the DMH Policy identified below regarding exceptional instances such as emergency care when clinics may treat veterans and bill the VA the cost of care.

**401.4.1** Procedures for Screening Veterans and Referring Veterans to the U.S. Department of Veteran Affairs.

Yes  No Check the applicable box to indicate if the client is a veteran.

- **PRIVATE INS**  Yes  No Check the appropriate box to indicate whether the client is covered by an indemnity, private, or group health/medical insurance policy.
- **HMO (Health Maintenance Organization):** To clarify who is eligible for treatment refer to the appropriate DMH policy identified below:

**401.6** Medi-Cal Prepaid Health Care Treatments and Billing

**401.7** Medicare Prepaid Health Care Treatment and Billing

**401.8** Private Prepaid Health Care Treatment and Billing

Yes  No Check the applicable box to indicate whether or not the client is covered by an HMO.

- Enter the applicable **CLAIM NUMBER**.

Line 8:

- **NAME OF CARRIER:** Enter the name of the insurance policy carrier.
- Enter the applicable **GROUP/POLICY/ID NUMBER**.
- **NAME OF INSURED:** Enter the name of the primary client of the policy.

Line 9:

- Enter the insurance **CARRIER'S ADDRESS**.
- Check the applicable box to indicate whether an **ASSIGNMENT/RELEASE OF INFORMATION** was OBTAINED.  
 Yes  No

**PAYOR PREFERENCES**

LINE 10:

- **NAME OF PAYOR:** (responsible person) if different from client.
- **RELATION TO CLIENT**
- **DOB:** Date of Birth: Month, Day and Year
- **MARITAL STATUS:** Circle one  
M - Married  
S - Single  
D - Divorced  
W - Widowed

SP - Separated

- **PAYOR CDL/CAL ID:** California Drivers License or California Identification Number. (This information is not required in the event of a conservator or foster parent.)

LINE 11:

- Client or payor residence **ADDRESS, CITY, STATE** and **ZIP CODE.** (A post office box is not acceptable as a residence address.)
- **TELEPHONE NUMBER** where client or payor may be reached. When necessary this can be the telephone number of a neighbor or relative where the client regularly receives messages.

LINE 12:

- **SOURCE OF INCOME**
  - Salary
  - Self-Employed
  - Unemployment Insurance
  - Disability Insurance
  - SSI
  - GR
  - VA
  - Other Public Assistance
  - In-Kind
  - Unknown
  - Other: \_\_\_\_\_

Check the box(es) for the appropriate source(s) of income. Clarification must be provided if "Other" is selected for how the client/payor is supported. "In-Kind" should be checked for a client receiving room and board from another person. Check "Other" and enter "unemployed" when the client/payor or spouse is no longer employed.

- Client/Payor **CIN NUMBER**

Line 13:

- Client/Payor **EMPLOYER** name
- Client/Payor **POSITION**, payroll title, or occupation
- **IF NOT EMPLOYED, INDICATE DATE LAST WORKED**

Line 14:

- **EMPLOYER'S ADDRESS:** (Include City, State & Zip Code.)
- Enter the employer's **TELEPHONE NUMBER.**

Line 15:

- **SPOUSE:** If applicable, enter spouse's name.
- Enter spouse's **ADDRESS:** (Include City, State & Zip Code.)
- Enter Client/Payors **SPOUSE'S SOCIAL SECURITY NUMBER**

Line 16:

- Enter Client/Payor **SPOUSE’S EMPLOYER** name
- Enter Client/Payor **POSITION**, payroll title, or occupation
- **IF NOT EMPLOYED, INDICATE DATE LAST WORKED**

Line 17:

- **SPOUSE’S EMPLOYER’S ADDRESS:** (Include City, State & Zip Code)
- Enter spouse’s employers **TELEPHONE NUMBER.**

Line 18:

- **NEAREST RELATIVE AND THE RELATIONSHIP**
- Enter **ADDRESS** of nearest relative and the relationship. (Include City, State & Zip Code)
- Enter **TELEPHONE NUMBER** of nearest relative/relationship

**COMPLETION OF PAYOR FINANCIAL INFORMATION FORM FOR CALWORKS MEDI-CAL BENEFICIARIES**

The Medi-Cal program **California Work Opportunities and Responsibilities to Kids (CalWORKs)** replaced Medi-Cal Aid for Dependent Children on January 1, 1998. Therefore, all Medi-Cal beneficiaries identified as CalWORKs are Medi-Cal beneficiaries.

DHCS has directed that Medi-Cal beneficiaries receiving full-scope Medi-Cal with no share-of-cost do not have an annual liability. CalWORKs Medi-Cal beneficiaries receive full-scope Medi-Cal with no share-of-cost. During the financial screening process, a PFI Form is completed for all CalWORKs Medi-Cal beneficiaries. However, the annual liability amount will be zero. The UMDAP Liability Determination sections 19, 20, and 21 on the PFI Form may be disregarded (crossed out and not completed).

**SECTION 19**

<b>LIQUID ASSETS</b>	
<b>Savings</b>	\$ _____
<b>Checking Accounts</b>	\$ _____
<b>IRA, CD, Market Value of stocks, bonds and mutual funds.</b>	\$ _____
<b>TOTAL LIQUID ASSETS</b>	\$ _____
<b>Less Asset Allowance</b>	\$ _____
<b>Net Asset Valuation</b>	\$ _____
<b>Monthly Asset Valuation (Divide Net Asset By 12)</b>	\$ _____
<b>(5) VERIFICATION OBTAINED [ ] YES [ ] NO</b>	

1. Enter the combined total of liquid assets (those easily converted into cash) of the Medi-Cal beneficiary/payor and their spouse if applicable. Network providers are not limited to those indicated on the PFI Form. Liquid assets also include Individual Retirement Accounts (IRAs), deferred compensation plans, trust funds, etc.
2. Subtract the asset allowance amount. The asset allowance is the dollar amount of liquid assets (savings, stocks, bonds, etc.) a family is allowed to retain without it being added into their income for purposes of determining their annual liability. (The chart identified in this training guide indicates the asset allowances for 1988 and 1989. The 1989 data should be used to determine the asset allowance. This is the most current chart issued by the DHCS and is still in use. When an update becomes available, it will be issued to all network providers.)
3. Enter the **NET ASSET VALUATION** (the total liquid assets less the asset allowance).
4. The **MONTHLY ASSET VALUATION** is determined by dividing the Net Asset Valuation by twelve (12). The amount entered here is to be carried forward to Section 21 - **ADJUSTED MONTHLY INCOME**, and entered on the line identified as **ADD MONTHLY ASSET VALUATION**.
5. **VERIFICATION ATTACHED.** ( YES  NO ) The Medi-Cal beneficiary must be charged the actual cost of care if verification is not attached or available in the Medi-Cal beneficiary's financial folder.

**SECTION 20**

<b>ALLOWABLE EXPENSES</b>	
<b>Court ordered obligations paid monthly</b>	\$ _____
<b>Monthly child care payments (necessary for employment)</b>	\$ _____
<b>Monthly dependent support payments</b>	\$ _____
<b>Monthly medical expense payments</b>	\$ _____
<b>Monthly mandated deductions from income for retirement plans. (Do not include Social Security)</b>	\$ _____
<b>TOTAL ALLOWABLE EXPENSES</b>	<b>\$ _____</b>
<b>VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO</b>	

1. Monthly obligations include court ordered child support and alimony obligations that are to be verified with a copy of the certified court order and receipts or canceled checks verifying payment.
2. Monthly childcare payments (necessary for employment) are to be verified with receipts or canceled checks.

3. Monthly medical expense payments include all health, medical and dental premiums as well as expenses and regular monthly payments, i.e., installments on a hospital or dental bill. Payments are to be verified with invoices, receipts, or canceled checks.
4. Monthly mandated deductions from income for retirement plans are those that are required by the employer. **DO NOT INCLUDE SOCIAL SECURITY** (identified as Federal Insurance Contribution Act on paycheck stubs). Verification of deductions is available from the Medi-Cal beneficiary's/payor's or their spouse's paycheck stubs.
5. The total expense amount entered here is to be carried forward to section 21 - **ADJUSTED MONTHLY INCOME**, and entered on the line identified as **SUBTRACT TOTAL EXPENSES**.
6. **VERIFICATION ATTACHED. ( [ ] YES [ ] NO )** All allowable expenses must be substantiated. Do not include the expense in the determination of the Medi-Cal beneficiary's/payor's annual UMDAP liability if verification is not attached or available in the Medi-Cal beneficiary's financial folder.

**SECTION 21**

<b>ADJUSTED MONTHLY INCOME</b>	
Gross Monthly Family Income	\$ _____
<b>Self/Payor</b>	\$ _____
<b>Spouse</b>	\$ _____
<b>Other</b>	\$ _____
<b>TOTAL</b>	\$ _____
<b>Add monthly asset valuation</b>	\$ _____
	_____
<b>Subtract total expenses</b>	\$ _____
<b>Adjusted monthly income</b>	\$ _____
<b>VERIFICATION OBTAINED [ ] YES [ ] NO</b>	

1. Enter the Medi-Cal beneficiary's/payor's gross monthly income.
2. Enter the Medi-Cal beneficiary's/payor's spouse's gross monthly income.
3. Enter any additional monthly income.
4. Enter the total monthly income identified above.
5. The amount identified on this line is to be added to the total monthly income amount. (See section 19 - **LIQUID ASSETS** for information regarding the determination of the **MONTHLY ASSET VALUATION**.)

6. Enter the **TOTAL** monthly income plus the **MONTHLY ASSET VALUATION**.
7. The amount identified on this line is to be subtracted from the combined totals of the monthly income plus the monthly asset valuation. (See section 20 - **ALLOWABLE EXPENSES** for information regarding the determination of monthly allowable expenses.)
8. Enter the balance of the following equation: Total gross monthly income plus monthly asset valuation minus total expenses = adjusted monthly income.
9. **VERIFICATION ATTACHED:** ( YES  NO) The Medi-Cal beneficiary must be charged the actual cost of care if verification is not attached or available in the Medi-Cal beneficiary's financial folder.

Line 22:

- **NUMBER DEPENDENT ON ADJUSTED MONTHLY INCOME:** Enter the number of dependents applicable to the adjusted monthly income. Dependents are those persons claimable as dependents on the Medi-Cal beneficiary's/ payor's Federal Income Tax Return. Child support, which is paid, but does not qualify Medi-Cal beneficiary/payor to claim the child as a dependent may be claimed in section 20 - **Allowable Expenses**. Child support must be court ordered and verification of payment must be provided.
- **ANNUAL LIABILITY:** Enter the amount of the annual liability. The annual liability is determined by using the adjusted monthly income amount and the number of dependent on the adjusted monthly income. The Uniform Patient Fee Schedule provides the annual UMDAP liability based on income and number of dependents. The shaded Medi-Cal eligible area on the Uniform Patient Fee Schedule identifies income levels presumed eligible if the Medi-Cal beneficiary meets Medi-Cal eligibility requirements. Medi-Cal beneficiary/payor income levels falling into the shaded Medi-Cal eligible area are to be assessed an annual UMDAP liability of zero. If the Medi-Cal beneficiary meets the Medi-Cal eligibility requirements, the Medi-Cal beneficiary is to be referred to the DPSS to apply for Medi-Cal benefits. (See Medi-Cal Eligibility Requirements following the PFI Form instructions.)
- **ANNUAL CHARGE PERIOD:** FROM \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_ . The annual liability period runs from the date of the Medi-Cal beneficiary's first visit (regardless of when the PFI Form is completed or of an adjustment) until the last day of the eleventh subsequent month. For example, the Medi-Cal beneficiary was admitted to a county mental health facility on October 22, 1996. The UMDAP annual charge period would be 10/22/96 through 9/30/97.
- There is only one circumstance that would warrant a change in the annual charge period. If a provider fails to financially screen a Medi-Cal beneficiary and later discovers that a PFI Form was completed at another facility, the Network Provider may contact that facility requesting that the annual charge period be changed to include their dates of service. The facility that originated the PFI Form is the only Network Provider authorized to change the annual charge period.
- **PAYMENT PLAN:** \$ \_\_\_\_\_ per month for \_\_\_\_\_ months

Line 23:

- **PROVIDER OF FINANCIAL INFORMATION:** (If Other Than Patient or Responsible Person)

**OTHER**Line 24:

- **PRIOR MH TREATMENT:** (Only applicable to current Annual Charge Period)  
 YES  NO If Yes, where?
- **FROM:** Enter the date prior mental health treatment began.
- **TO:** Enter the date prior mental health treatment ended.
- **PRESENT ANNUAL LIABILITY BALANCE:** Enter the amount of the client's current annual liability balance.

Line 25:

- **ANNUAL LIABILITY ADJUSTED BY:** Enter the signature of the person changing the deductible or payment plan for financial need during a liability and service period. (See Liability Adjustment and Therapeutic Fee Adjustment [TFA] following the PFI Form instructions.)  
**Date:** Enter the date an adjustment was made.
- **ANNUAL LIABILITY ADJUSTED APPROVED BY:** Enter the signature of the person approving the adjustment of the deductible or payment plan for financial need during a liability and service period.  
**Date:** Enter the date an adjustment was made.
- **REASON ADJUSTED:** Enter the reason an adjustment was made. Any verification must be kept in the client's financial folder.

Line 26:

- **SIGNATURE OF INTERVIEWER:** Enter the signature of the person preparing the PFI Form. The interviewer acknowledges by signature and date that an explanation of liability and payment responsibility was given to the client or payor.
- **PROVIDER NAME AND NUMBER:** Enter the name and provider number of the mental health facility where the PFI Form was completed.

Line 27:

I AFFIRM THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

- **SIGNATURE OF CLIENT OR RESPONSIBLE PERSON:** The client shall be asked to sign affirming that the statements made are true and correct.
- **DATE:** Enter the date signed.

**DISTRIBUTION**

Once the PFI Form is completed, copies are to be distributed as follows:

- **FINANCIAL FOLDER**
- **CLINIC** (Medical chart)
- **MEDI-CAL BENEFICIARY** (Medi-Cal beneficiary/payor/responsible person)

## VERIFICATION

Verification of Social Security Number, employment, current address, liquid assets, allowable expenses and income are **mandatory**. Copies of verification should be attached to the PFI Form or placed in the Medi-Cal beneficiary's financial folder. Until verification is received, the Medi-Cal beneficiary/payor is responsible for the actual cost of care.

Some sources available for verification of income are: pay check stub, tax return form, or bank statements showing direct deposits.

Care must be exercised to maintain confidentiality in making inquiries to sources other than the Medi-Cal beneficiary or payor. Letterhead stationery that identifies the network provider as a mental health clinician must not be used.

## FINANCIAL OBLIGATION AGREEMENT

A Financial Obligation Agreement is a written agreement between the Medi-Cal beneficiary/payor and the provider, and is required whenever a Medi-Cal beneficiary/payor has been determined to have an annual liability. This agreement must detail the maximum liability amount and the monthly payment amounts. The agreement must be signed by the Medi-Cal beneficiary/payor and acknowledged by a clinic representative.

Payment plans should allow the Medi-Cal beneficiary/payor to pay off their debt in the shortest time possible. The payment plan should rarely exceed the anticipated length of treatment, and under no circumstances should the plan exceed one year.

## MEDI-CAL ELIGIBILITY REQUIREMENTS

Individuals age 65 or older, blind, disabled, or meeting the family circumstances required for Temporary Assistance for Needy Families (TANF), are probably eligible for Medi-Cal benefits. Anyone falling into these categories must be referred to their local DPSS office to apply. The Medi-Cal beneficiary is to be provided with a completed DPSS SSA Referral Card when referred to DPSS.

TANF replaces Aid to Families with Dependent Children (AFDC), which provides support to eligible families when children are deprived of support due to death, incapacity, unemployment, or the absence of one or both parents.

## SUPPLEMENTAL SECURITY INCOME REQUIREMENTS

SSI is a program funded with Federal and State funds and administered by the SSA. Disabled persons meeting eligibility requirements would be entitled to monthly cash grant to assist them with living expenses. Individuals who are entitled to Social Security disability benefits lower than the SSI amount will be supplemented with an SSI payment up to the SSI amount.

SSI beneficiaries receive Medi-Cal benefits automatically. Social Security work credits are not required to qualify for SSI. The Medi-Cal beneficiary should be provided with a completed DPSS SSA Referral Card when referred to SSA.

Eligibility requirements for SSI are:

1. Age 65 or older, disabled adult or child, or blind;
2. A resident of the United States, a citizen, permanent resident alien, or resident under color of law; and
3. Income and resources within SSI limits

## **LIABILITY ADJUSTMENT**

An annual UMDAP liability amount may be adjusted when properly supported by additional financial data justifying such change. An adjustment may be made for the time remaining in the period at any time during the liability period. Reasons for such action may be for any significant change in a person's financial circumstances. Since a Medi-Cal beneficiary/payor is responsible for prompt notification of a change in financial circumstances, an adjustment cannot be retroactive, but is effective on the date of notification. An adjustment to lower the annual liability cannot be made once a Medi-Cal beneficiary has incurred services that equal or exceed the amount of the annual liability. Verification documentation supporting the adjustment must be kept in the Medi-Cal beneficiary's financial folder.

## **THERAPEUTIC FEE ADJUSTMENT**

It is the policy of the DMH to allow UMDAP liability fee adjustments for therapeutic value only. No other basis or rationale for fee adjustments will be accepted.

In the event the provider finds a Medi-Cal beneficiary's treatment would benefit by an increase or decrease in the annual liability, a therapeutic fee adjustment is indicated. The financial screener may not initiate a therapeutic fee adjustment.

Refer to the DMH Policy 404.3 Therapeutic Fee Adjustments regarding the requirements and procedures for initiating a therapeutic fee adjustment.

## **INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

The Insurance Authorization and Assignment of Benefits is to be signed and dated by all Medi-Cal beneficiaries. The authorization allows network providers to submit insurance claims for reimbursement without obtaining original Medi-Cal beneficiary signatures on each claim form. A photocopy is attached to the insurance claim, but the original should be kept in the Medi-Cal beneficiary's financial folder.

## **LIFETIME EXTENDED SIGNATURE AUTHORIZATION**

The Lifetime Extended Signature Authorization is a statement to permit payment of Medicare benefits to a supplier or physician. The authorization is to be completed, signed and dated by the Medi-Cal beneficiary. The original is to be maintained in the Medi-Cal beneficiary's financial folder.

## **AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PHI**

The Authorization for Request or Use/Disclosure of PHI is a form that grants permission to the provider/clinic to use client PHI, or disclose specific client PHI to another provider/clinic. The

authorization is to be completed, signed, and dated by the Medi-Cal beneficiary. The original is to be maintained in the Medi-Cal beneficiary's financial folder.

### **ANNUAL RE-EVALUATION**

The Medi-Cal beneficiary is to be re-evaluated on an annual basis. The Re-evaluation Follow-Up Letter may be used to facilitate the re-evaluation process. Telephone re-evaluations are acceptable, however, missing information and verification of income and expenses are still required. The Medi-Cal beneficiary/payor signature is to be obtained during the next visit. Medi-Cal beneficiaries/payors that have not been re-evaluated are responsible for the actual cost of care until the re-evaluation is completed.

The UMDAP liability period for a Medi-Cal beneficiary who is still in treatment is continuous regardless of when the PFI Form is completed. The re-evaluation date to be recorded on the PFI Form shall be from the first day of the month to the end of the eleventh succeeding month. For example, if the original UMDAP liability period was 10/22/97 through 9/30/98 then the re-evaluation date will be 10/1/98 through 9/30/99.

### **DEPARTMENT OF MENTAL HEALTH POLICY MANUAL**

The DMH Policy Manual should be accessed regarding specific policies addressed in this manual. The DMH Policy Manual may be downloaded from the following website address: [http://dmh.lacounty.gov/wps/portal/dmh/admin\\_tools](http://dmh.lacounty.gov/wps/portal/dmh/admin_tools). Click the "Policies, Parameters & Guidelines" link, and then click the "DMH Policy and Procedures for Contractors" link to view the DMH Policy Manual.

**GLOSSARY OF TERMS**

AB 3632	Synonymous with Special Education Pupils (SEP).
Actual Cost of Care	The actual cost of delivering services to the Medi-Cal beneficiary. The cost is determined by a provisional billing rate, a negotiated rate, or a cost reimbursement rate.
AFDC	Aid to Families with Dependent Children. AFDC is a public welfare program for needy families and pregnant women. County of Los Angeles administers the program based on requirements set by Federal and State laws and regulations. Temporary Assistance has replaced this program for Needy Families. (See TANF.)
Annual Charge Period	Synonymous with Annual Liability Period.
Annual Liability Amount	The annual liability amount applies to services extended to the Medi-Cal beneficiary and dependent family members and is determined by using the adjusted monthly income amount and the number dependent on the adjusted monthly income.
Annual Liability Period	The annual liability period runs from the date of the Medi-Cal beneficiary's first visit until the last day of the eleventh subsequent month.
BIC	Medi-Cal Beneficiary Identification Card. Medi-Cal beneficiaries are issued a permanent white plastic identification card by DPSS. The card is not a guarantor of eligibility.
Medi-Cal beneficiary	The person receiving services is synonymous with consumer.
CHAMPUS	Civilian Health and Medical Program of the Uniformed Armed Services. Insurance for retired service personnel, their dependents and the dependents of active duty service personnel.
CIN	Client Identification Number. Medi-Cal beneficiaries are assigned the Client Identification Number by DPSS.
Consumer	Synonymous with Medi-Cal beneficiary.
Dependents	Those persons within a family unit dependent upon the payor's income for support as well as members outside the family group that payor claims as dependents when filing income tax.
DPSS	Department of Public Social Services.
Family Unit	Payor and his/her dependents.
FCC	Full Cost of Care is synonymous with actual cost or care.

**GLOSSARY OF TERMS (cont.)**

Homeless	A Medi-Cal beneficiary who does not have an address. The SDHS required entries on the PFI Form are name, SSN if known and the word "Homeless" or "Transient" to indicate the financial condition of the Medi-Cal beneficiary. In addition to the SDHS requirements, the LMHP is requiring that the annual liability dates and annual liability amount be completed. The annual liability amount for homeless Medi-Cal beneficiaries will be zero.
Liquid Assets	Any possessions easily converted into cash, i.e., IRAs, 401Ks, or savings bonds.
Managed Care	A term coined originally to refer to the prepaid health care sector (e.g., HMOs and PHPs). In general, the term refers to a means of providing health care services within a defined network of health care providers who are given the responsibility to manage and provide quality cost-effective health care.
Medi-Cal	California's medical assistance program for eligible low-income persons to pay for needed medical care.
Medicare	A Federal Health Insurance Program for people who have attained the age of 65 or over, or have received SSD for two years or more.
Medi-Gap	Insurance companies that contract with a Medicare carrier that allows the carrier to directly cross-over your claims to an insurance company. A Medi-Gap policy would pay for some of the items that Medicare does not cover such as deductible, co-payment, prescription drugs and dental.
Payor	Person legally responsible for payment of Medi-Cal beneficiary's bills.
PFI	Patient Financial Information. The PFI Form is used to capture Medi-Cal beneficiary/payor financial information in order to determine a Medi-Cal beneficiary's ability to pay. It is also used to identify and document third-party payor sources for billing purposes.
PHP	Prepaid Health Plan. A managed care plan.
SEP	Special Education Pupils. Parents of Special Education Pupils receiving mental health services pursuant to an Individualized Education Program (IEP) are not liable for the costs of those services. The Medi-Cal beneficiary information data, Medi-Cal information (if applicable) and insurance information (if applicable) should be completed on the PFI Form. Services to Medi-Cal beneficiaries may be billed through the Short-Doyle/Medi-Cal program. Insurance or other third-party payors may only be billed in the usual manner with parental consent. The PFI Form

	should have written or stamped on it the following notation which describes the parent's exempt status:
	Pursuant to Public Law 94-142, services are provided at no charge to the parent or adult pupil, and in accordance with Section 7582 of the Government Code, they are exempt from financial eligibility requirements.
SSA	Social Security Administration
SSD	Social Security Disability. Workers who qualify for disability income when they cannot work or are diagnosed with a condition that is expected to last for a year or result in death. A spouse of a disabled worker is entitled to benefits at age 62 (including some divorced spouses) or at any age if they have children under 16 years of age. A widow(er) at any age with children under age 18 is eligible. A child including adopted or stepchild may receive monthly benefits. Normally, children's benefits may continue indefinitely or start at any age if the child has a severe physical or mental disorder, which began before age 22 and keeps the child (or adult child) from gainful employment.
SSI	Supplemental Security Income. A national program for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled.
SSP	State Supplementary Payments. SSP are any payments made by a State to a recipient with SSI benefits. The payments are made as a supplement to the Federal benefit amount, thereby increasing the amount of income available to the recipient.
TANF	Temporary Assistance for Needy Families. TANF replaced AFDC and provides support to eligible families when children are deprived of support due to death, incapacity, unemployment, or absence of one or both parents.
TFA	Therapeutic Fee Adjustment.
UMDAP	Uniform Method of Determining Ability to Pay. UMDAP is a sliding payment scale that reflects variations in the cost of living by family size and income by geo-economic areas of the State. They are based on the U.S. Bureau of Labor Statistics Consumer Price Index.
VET/ADM	Veterans Administration

LOS ANGELES COUNTY  
DEPARTMENT OF MENTAL HEALTH  
**PAYOR FINANCIAL INFORMATION**

CONFIDENTIAL CLIENT INFORMATION  
See W & I Code, Section 5328

**CLIENT INFORMATION**

1	CLIENT NAME	SS#	CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS M S D W SP
			SPOUSE NAME

**THIRD PARTY INFORMATION**

3	<b>NO THIRD PARTY PAYOR</b> <input type="checkbox"/>			
4	MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-CAL COUNTY CODE/AID CODE/ CLAIM #	MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REFERRED
			REFERRED FOR ELIGIBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	
5	SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE
				IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON
6	MEDI-CAL HMO <input type="checkbox"/> YES <input type="checkbox"/> NO	CAL WORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO
				HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO
7	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO	VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO
				PRIVATE INS <input type="checkbox"/> YES <input type="checkbox"/> NO
				HMO <input type="checkbox"/> YES <input type="checkbox"/> NO
8	NAME OF CARRIER		GROUP/POLICY/ID #	NAME OF INSURED
9	CARRIER ADDRESS			ASSIGNMENT/RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO

**PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)**

10	NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS M S D W SP	PAYOR CLD/CAL ID
11	ADDRESS	CITY	STATE	ZIP CODE	TEL #
12	SOURCE OF INCOME <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____				PAYOR SS #
13	EMPLOYER	POSITION	IF NOT EMPLOYED, DATE LAST WORKED		
14	EMPLOYER ADDRESS (Include City, State & Zip Code)			TEL #	
15	SPOUSE	ADDRESS (Include City, State & Zip Code)		SPOUSE'S SS #	
16	SPOUSE'S EMPLOYER	POSITION	IF NOT EMPLOYED, DATE LAST WORKED		
17	SPOUSE'S EMPLOYER ADDRESS (Include City, State & Zip Code)			TEL #	
18	NEAREST RELATIVE/RELATIONSHIP	ADDRESS (Include City, State & Zip Code)		TEL #	

**UMDAP LIABILITY DETERMINATION**

19	LIQUID ASSETS	20	ALLOWABLE EXPENSES	21	ADJUSTED MONTHLY INCOME
	Savings \$ _____		Court ordered obligations paid monthly \$ _____		Gross Monthly Family Income
	Checking Accounts \$ _____		Monthly child care payments (necessary for employment) \$ _____		Self/Payor \$ _____
	IRA, CD Market value of stocks, bonds and mutual funds \$ _____		Monthly dependent support payments \$ _____		Spouse \$ _____
	TOTAL LIQUID ASSETS \$ _____		Monthly medical expense payments \$ _____		Other \$ _____
	Less Asset Allowance \$ _____		Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____		TOTAL \$ _____
	Net Asset Valuation \$ _____		<b>Total Allowable Expenses</b> \$ _____		Add monthly asset valuation \$ _____
	<b>Monthly Asset Valuation (Divide Net Asset by 12)</b> \$ _____		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		TOTAL \$ _____
	VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO				Subtract total expenses \$ _____
22	Number Dependent on Adjusted Monthly Income	<b>ANNUAL LIABILITY</b>	<b>ANNUAL CHARGE PERIOD</b> FROM TO	PAYMENT PLAN \$ _____ per month for _____ months.	
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)				

**OTHER**

24	PRIOR MH TREATMENT (Only applicable to current Annual Charge Period) <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		

26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER	PROVIDER NAME AND NUMBER
27	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON <span style="float: right;">DATE</span>	

## SECTION XII – CLAIMING INFORMATION

### BACKGROUND

Network providers are reimbursed by the Local Mental Health Plan (LMHP) under the rules and guidelines established for Phase II Medi-Cal Consolidation which was effective June 1, 1998.

The LMHP amended its claiming system and the way in which Los Angeles County Medi-Cal beneficiary data is received and processed to comply with Federal mandates. The federal government enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve efficiency in healthcare delivery by standardizing electronic patient health, administrative and financial data and by developing security standards to protect the confidentiality and integrity of patient health information. Entities covered by HIPAA include mental health plans, clearinghouses, and billing agents/services, which are required to transmit mental health care data in a way that is compliant with, and regulated by, HIPAA.

On November 23, 2003, the LMHP implemented the Integrated System (IS), an electronic claiming system that receives and processes protected health information (PHI) and claims data in a format that complies with HIPAA. The IS is a comprehensive solution that is in compliance with federally mandated HIPAA guidelines regarding transactions and code sets, security, privacy, access, authorized use and content. The IS is also the LMHP's secure, HIPAA-compliant, internet-based claiming system which allows network providers to submit Medi-Cal claims using the Internet. The LMHP does not accept manual hardcopy claims from network providers.

When the LMHP receives HIPAA-compliant electronic claims from network providers, billing agents/services and clearinghouses, they are forwarded to the California Department of Health Care Services (DHCS) for adjudication as Short-Doyle/Medi-Cal (SD/MC) service claims. Payments made to network providers are based on IS approvals. The LMHP will recover from network providers denied claim amounts resulting from the DHCS adjudication of SD/MC services. The LMHP shall be held harmless from and against any loss to network providers resulting from any such State denials, unresolved explanation of benefit claims, and/or Federal and/or State audit disallowances.

### APPLYING FOR INTEGRATED SYSTEM ACCESS

A RSA SecurID card/token is required for each network provider, billing agent/service and clearinghouse to log on to the IS and to view or enter Medi-Cal beneficiary enrollment, eligibility and claiming information. The RSA SecurID card/token is a tool to ensure that Medi-Cal beneficiary information is secure as it is transmitted via the internet to the IS.

Network providers, billing agents/services and clearinghouses may apply for an RSA SecurID card/token via the "Outpatient Fee-For-Service" website at the following address: [http://lacdmh.lacounty.gov/hipaa/ffs\\_home.htm](http://lacdmh.lacounty.gov/hipaa/ffs_home.htm) . Select "IS Forms" and click on the "IS Access Application Checklist." The IS Access Application Checklist (Attachment I) itemizes the forms required for obtaining access, renewing access and terminating access to IS. After determining the forms required, revert back to the website listed above, download and complete the respective forms and mail them to the following address:

Department of Mental Health  
Provider Support Office  
Systems Access Unit  
695 S. Vermont Ave., 8th Floor  
Los Angeles, CA 90005

The normal processing time to obtain an RSA SecurID card/token is four to six weeks from the date applications are received by the Systems Access Unit. Complete the paperwork as soon as possible and allow adequate time for processing.

Note: The following roles should be entered on the Application Access Form to view and access IS reports: ADM01, ADM02, RPTPROV and GEN01.

Contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or FFS@dmh.lacounty.gov for DDE forms assistance.

Upon termination of user, the RSA SecurID card must be returned to the Systems Access Unit (SAU). It is the Provider's responsibility to notify SAU of user's termination by completing and submitting the Downey Data Center Registration form and the Applications Access form to SAU. Upon card expiration, the RSA SecurID card may be renewed by submitting the Downey Data Center SecurID Token Renewal Request form to SAU. The life of the card (expiration date) is visible on the back of the RSA SecurID card. If the RSA SecurID card is no longer needed by user upon the expiration date, please return the card to SAU.

## **CLAIMING OVERVIEW**

There are three options available for submitting HIPAA-compliant claims in the IS: 1.) Direct Data Entry (DDE), 2.) Electronic Data Interchange (EDI)/Secure File Transfer (SFT) and 3.) hiring a billing agent/service or clearinghouse to submit claims to the IS via DDE or EDI/SFT.

### **1. FIRST OPTION - DIRECT DATA ENTRY IN THE INTEGRATED SYSTEM**

The process of submitting Medi-Cal beneficiary HIPAA-compliant claims via DDE in the IS is initiated electronically by network providers after enrollment and eligibility transactions have been performed.

DDE involves logging onto the IS, and inputting data to submit electronic transactions such as client enrollment, Medi-Cal beneficiary eligibility and HIPAA-compliant claims processing.

A computer must have internet access, preferably with a "high speed connection" for this process. Internet service providers and cable companies usually provide this service and should be contacted for more details. To retrieve information about "Browser Settings" for the IS and "Making Your Browser Work" with the IS refer to the following website address: [http://lacdmh.lacounty.gov/hipaa/ffs\\_GettingStarte.htm](http://lacdmh.lacounty.gov/hipaa/ffs_GettingStarte.htm)

### **TRAINING-DIRECT DATA ENTRY PRODUCTION LAB AND ASSISTANCE**

A Production Lab is a computer-illustrated training session conducted by a Provider Support Office (PSO), Fee-for-Services Section staff member. The session provides an instructional step-by-step demonstration on how to electronically enroll, check eligibility and submit Medi-Cal

beneficiary claims in the IS. The sessions are held for 1 ½ hours. In an effort to provide one-on-one support, a maximum of one person is allowed per scheduled session.

Network providers, billing agents/services and clearinghouses are encouraged to contact the PSO, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) within the business hours of 8:00 a.m. to 5:00 p.m. to request DDE training after receipt of their RSA SecurID card/token.

Note: Production labs will only be scheduled if the user was previously issued an RSA SecurID card/token. The session will not be conducted in the event that a person schedules a Production Lab and arrives without a RSA SecurID card/token and claiming information.

Additional information regarding the DDE claim submission process can be found in the Fee-For-Service Getting Started Guide for Claiming at the following location: [http://lacdmh.lacounty.gov/hipaa/ffs\\_UIS\\_TrainingModules.htm](http://lacdmh.lacounty.gov/hipaa/ffs_UIS_TrainingModules.htm).

## **2. SECOND OPTION - ELECTRONIC DATA INTERCHANGE/SECURE FILE TRANSFER**

Electronic Data Interchange/Secure File Transfer (EDI/SFT) involves transferring electronic files that contain Medi-Cal beneficiary eligibility, enrollment and claims data over the internet to the LMHP HIPAA-compliant IS.

Technical requirements for HIPAA file structure, testing and transmission, will be explained by DMH EDI technical staff. This option is usually readily understood by billing agents/services and clearinghouses. The technical requirements include, but are not limited to, the following: (1) EDI/SFT submitter must provide verification of outside vendor HIPAA syntax testing to DMH; (2) use DMH approved HIPAA-compliant procedure and diagnosis codes (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates); and (3) participate in and successfully complete testing with the LMHP to obtain certification of HIPAA format and content.

## **3. THIRD OPTION - HIRING A BILLING AGENT/SERVICE OR CLEARINGHOUSE**

Network providers may choose to hire a billing agent/service or clearinghouse to submit claims to the IS on their behalf. The LMHP has compiled a list of certified billing agents/services, clearinghouses and software vendors who currently submit HIPAA-compliant claims to the LMHP and have agreed to be included on the published list, which is accessible via the following website address:

[http://lacdmh.lacounty.gov/hipaa/documents/Production\\_EDI\\_Vendor\\_List.pdf](http://lacdmh.lacounty.gov/hipaa/documents/Production_EDI_Vendor_List.pdf)

Note: It is strongly recommended that network providers hire a HIPAA-compliant billing agent/service or clearinghouse that currently submits electronic claims in production to the IS. Network providers must ensure that appropriate data content, including procedure and diagnosis codes, are used on claims or run the risk of receiving denied claims. Refer to Section IX for information on HIPAA-compliant procedure and diagnosis codes.

## **TRAINING-ELECTRONIC DATA INTERCHANGE/ SECURE FILE TRANSFER TESTING, TECHNICAL DETAILS AND ASSISTANCE**

The LMHP uses the ASC X12N standard of the HIPAA EDI 837P transaction set. The submitted transaction set can be used to submit health care billing information, encounter information or both, from providers of health care services to payers either directly or via intermediary billing agents/services and clearinghouses.

In preparing an 837P EDI claim, it is highly recommended that the creator of the program generating the transaction(s) have the requisite knowledge and expertise of the following: The HIPAA Structure Implementation Guide; the ASC X12 nomenclature, segments, data elements, looping structures and The LMHP Companion Guide. The LMHP Companion Guide can be downloaded from the following Outpatient Fee-For-Service website address: [http://lacdmh.lacounty.gov/hipaa/ffs\\_home.htm](http://lacdmh.lacounty.gov/hipaa/ffs_home.htm) . Select the "EDI/Secure File Transfer" link, and then select the "EDI Guides" link. Under the EDI Guides link, refer to the "DMH Companion Guides" and "EDI Guides." Or go direct at: [http://lacdmh.lacounty.gov/hipaa/ffs\\_EDI\\_Guides.htm](http://lacdmh.lacounty.gov/hipaa/ffs_EDI_Guides.htm)

The LMHP has adopted the ValiCert digital certificate as a validation tool to protect the privacy of the transactions. These digital certificates are issued to network providers, billing agents/services and clearinghouses that wish to electronically transact business data using EDI/SFT by way of the HIPAA EDI/SFT 837P standards. Submission of an EDI/SFT claim file containing the DMH issued ValiCert digital certificate is a secure way of authenticating the file's origin, the computer number, its user, and while in the process, applying data encryption and decryption to affirm PHI data, privacy and integrity. The certificates are installed on the computers being used to submit the claim transactions via an internet connection. Since the EDI transactions deal with voluminous claims, it is recommended that a high speed connection be employed in this process (e.g., ISDN, DSL, Cable Modem, Satellite or T1). A local Internet service provider can provide more information.

The two environments in this process are Test and Production. Each must have a respective digital certificate issued. While in the test environment, an EDI/SFT Testing and Certification Unit staff will be available to provide assistance throughout the testing processes. However, the tester or the programmer should be able to provide modifications to the programs to adapt to the requirements in the HIPAA-compliant LMHP 837P Companion Guide. The test environment is parallel to the production environment with respect to all data validations. Actual LMHP data is needed (i.e., Medi-Cal CIN number, DMH Client ID, actual procedure and diagnosis codes used, valid service dates, and, when applicable, delay reason codes) to validate the test claim transaction against the LMHP data repository. The claim however, is not processed for payment. It is in the production environment that these claims are processed upon submission. The testing process is tedious and sometimes lengthy. We encourage the tester to be diligent, as well as patient, with the testing process.

Network providers, billing agents/services or clearinghouses may experience denials when they first submit test and production files. The LMHP strongly recommends that network providers, billing agents/services and clearinghouses monitor denials and correct errors timely (Refer to IS Reports on the IS home page). Contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) for an explanation of the denial reasons and codes received on IS Reports. If the claiming information has not been received on an IS Report, please contact EDI Specialist at (213) 351-1335.

Network providers are strongly encouraged to obtain from their EDI/SFT software vendors, developers, programmers, clearinghouses and billing agents, on a weekly basis, a listing of EDI/SFT Phase I and Phase II test dates and files that were electronically submitted to the Chief Information Office Bureau (CIOB). It has been our experience that some EDI/SFT submitters, after submitting a Phase I or Phase II EDI/SFT test file that does not pass, do not regularly or timely submit another test file within the same week. This communication may not be provided to the provider. Our LMHP staff work diligently to provide timely statuses of EDI/SFT test files. We have no control over when submitters will correct their software/program (which may involve a cost to the said entity) and resubmit test files to meet requirements. As a result, it is the responsibility of the network provider to communicate with their billing agent or software vendor to obtain EDI/SFT test and re-test submission dates.

The EDI/SFT testing period takes at least ten weeks to complete. For this reason, the LMHP automatically grants DDE access to EDI/SFT applicants. Refer to the Training – DDE Production Lab and Assistance of this section. The LMHP highly recommends that network providers, billing agents/services or clearinghouses prepare to submit claims using the DDE method in the event that they are unable to obtain LMHP EDI/SFT certification for their software in a timely manner which runs the risk of having claims deny for un-timeliness. Network providers are encouraged to review the “Accuracy of Claims Data,” below, to ensure timely reimbursement and successful completion of EDI/SFT testing and production requirements. It includes information regarding IS issues, integrity of claims data, HIPAA-compliant procedure and diagnosis codes, EDI/SFT companion guides, revised IS codes and additional information.

You may contact the Help Desk at (213) 351-1335 within the business hours of 8:00 a.m. to 5:00 p.m., to speak with a network provider EDI/SFT specialist and receive EDI/SFT technical assistance.

## ACCURACY OF CLAIMS DATA

Network providers are requested to thoroughly review the accuracy of claims data before providing information to billing agents/services or clearinghouses to process. Whether claims are submitted via DDE or EDI, invalid claims data may prevent and prolong timely reimbursements or the ability to successfully pass EDI/SFT testing requirements. Due to the nature of most billing agents’/services’ and clearinghouses’ businesses, whether they use DDE or software for EDI/SFT, they simply format data files received from their network providers and are not responsible for data content. Therefore, network providers are required to ensure that all claims submitted to the LMHP on their behalf are as follows:

- 1) HIPAA-compliant;
- 2) Reimbursable by the LMHP, i.e.:
  - Procedure codes are HIPAA-compliant and appropriately submitted in the IS as reflected in *A Guide to Procedure Codes for Claiming Mental Health Services*. (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates.) Procedure codes are valid for the network provider’s taxonomy and contain the appropriate units of measurement (minutes) and service time; and,
  - Diagnosis codes are HIPAA-compliant and appropriately submitted as reflected in the DSM IV Crosswalk to ICD 9. (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates.)

- 3) Submitted with valid Medi-Cal CIN numbers (Social Security Numbers are no longer accepted in the “Medi-Cal CIN” field in the IS) and DMH Client IDs. There are two methods available to obtain the DMH Client ID. The first method is to use the IS DDE Medi-Cal beneficiary eligibility and enrollment transaction. The second method is to use the IS EDI/SFT eligibility capability offered by LMHP (270/271 Eligibility Inquiry/Response Transaction, 834 Benefit Enrollment and Maintenance Transaction). For those who prefer to use the EDI/SFT eligibility capability process, please have a technology provider contact the Help Desk at (213) 351-1335 and request to speak with a network provider EDI/SFT specialist. Network providers who are considering hiring a billing agent/service or clearinghouse may want to inquire whether they will perform this function on the network provider’s behalf;
- 4) Submitted subsequent to being enrolled in the MCF plan via the IS;
- 5) Contain valid HIPAA Delay Reason Codes (Late Codes) (Attachment II), as needed.
- 6) Entered using the correct IS IDs: (three separate numbers) Pay-to/Bill-to, service location, and rendering provider numbers. These numbers will be issued to the provider, billing agent/service or clearinghouse when their EDI/SFT applications are approved for testing; and
- 7) Submitted with a valid National Provider Identifier (NPI) number and according to the requirements listed in the EDI/SFT companion guide.

Claims submitted in the IS without the information listed above during testing and in production will be denied.

### **INVALID CHARACTERS MAY CAUSE DENIALS**

The following valid characters may assist DDE and EDI users in avoiding claim denials, negative eligibility and enrollment responses due to invalid character transmissions:

#### Approved Alphabet Format

“A” through “Z”  
“a” through “z”

#### Approved Numbers

“0” through “9”

#### Approved Symbols

Dash “ - “  
Number sign: “#”  
Period: “.”  
Ampersand: “&”

Beneficiary eligibility, enrollment and claims data received by DMH containing characters other than those identified and approved above will be denied and may delay successful EDI testing results.

### **SUPPLEMENTAL NETWORK PROVIDER CLAIMING INFORMATION**

The information listed below provides additional claiming requirements essential for network provider compliance:

- Network providers are required to supply the LMHP with their valid National Provider Identifier (NPI) numbers as follows:
  - 1.) Individual providers are required to furnish their type I NPI number;
  - 2.) Individual providers incorporated are required to furnish their incorporation’s type II NPI and their rendering providers’ type I NPI numbers; and

3.) Group providers are required to furnish their group's type II NPI number and their rendering providers' type I NPI numbers.

- Contact the National Plan and Providers Enumeration System at the following website address to apply for an NPI number:  
<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>
- Network providers submit claims using the American Medical Association's Physicians' Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes. Network providers are reimbursed after IS adjudication at the LMHP rates. (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates.)
- Network providers must list the starting time and ending time of the session in the client's chart and the number of minutes on the electronic claim to ensure full validation of time spent in the delivery of services to Medi-Cal beneficiaries. This rule is necessary to substantiate claims when the definition of the service involves time. In previous years, LMHP's data analysis using minimum times for service confirmed that some network providers were billing for over 20 hours daily. These claims are unacceptable and subject to recoupment. The LMHP will only reimburse for any appropriate and documented sessions.
- Proof of Medi-Cal beneficiary eligibility – Network providers must obtain and keep proof of Medi-Cal beneficiaries' eligibility for each month they receive services.
- The completed Uniform Method of Determining Ability to Pay (UMDAP) is required for all Medi-Cal beneficiaries. The UMDAP instructions are included in this section.
- Financial Folders - Each network provider must keep UMDAP and other financial information either in a separate financial folder or in the medical chart. Refer to Section XI: Financial Screening, the *Payor Financial Information* (PFI) form (Attachment I).
- All accounting records and supporting documents must be retained by network providers for seven years after the closing of the fiscal year or until such time as the audit has been settled for the fiscal year.
- All network providers must be credentialed and entered on the LMHP's Network Provider Master File by the Provider Credentialing Unit.
- Network providers are only paid for services rendered while under a contract with the LMHP, approved by the Board of Supervisors and contingent upon active license and credentials.

**Note: The LMHP does not have authority to retroactively pay for services provided outside of the credential/license/contract effective and expiration dates.**

- Network providers must contact the LMHP for prior authorization of all psychological testing and over-threshold services. When submitting a prior authorization request, the Medi-Cal beneficiary's CIN number, DMH Client ID number, network provider's Medi-Cal provider number, procedure code and diagnosis code must be identical on both the authorization request form and the electronic claim or the claim will be denied.
- Claims must be electronically submitted to the LMHP to be processed, approved, converted to a SD/MC claim format and then transmitted to the DHCS.
- Network providers is responsible to ensure claims are submitted in a timely manner and denied claims are promptly corrected and resubmitted in order to comply with all applicable statutes of limitations, or risk loss of reimbursement for their services. Claims that do not reach the LMHP in time to be processed, approved and transmitted to the DHCS within six months from the date of service will be considered late, and will be denied. Under special

circumstances, a valid HIPAA Delay Reason Code [Late Codes] (Attachment II) must be entered on DDE claims over the six month billing limitation but under the one year billing limit to be accepted for adjudication in the IS.

- The LMHP is not obligated to reimburse network providers for the services covered by any claim if provider submits the claim to County more than one hundred eighty (180) calendar days after the date provider renders the services, or more than ninety (90) calendar days after the contract terminates, whichever is earlier. Additionally, the LMHP is not obligated to reimburse Contractor where the claim does not meet applicable Short Doyle SD/MC requirements.
- Roughly 20% of all claims are denied. In most cases these denials are correctable if reviewed and resubmitted promptly. Network providers, billing agents/services and clearinghouses are to actively monitor the IS reports to reconcile and determine the status of claims that have been received and adjudicated in the IS.
- Contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov), Monday through Friday from 8:00 a.m. to 5:00 p.m., for electronic claim status inquiries.

## DENIAL REASON EDIT CODES

The “Denial Reason Edit Codes” is a chronological list of edits and reason descriptions found on IS reports used to assist network providers, billing agents/services and clearinghouses with the reconciliation of denied claims. The list can be downloaded at the following website address: <http://lacdmh.lacounty.gov/hipaa/documents/master%20denial%20code%20list.pdf> IS users are encouraged to monitor IS reports on a weekly basis and correct claims eligible for rectification in a timely manner.

Contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) for questions regarding denial edits and claim status.

## REIMBURSEMENT TIMELINE

Network providers are reimbursed based on IS approvals to comply with the DHCS certified public expenditure requirements. The LMHP will recover from network provider’s amounts denied by the State. Network providers shall hold County harmless from and against any loss resulting from any such State denials, unresolved explanation of benefit claims, and/or Federal and/or State audit disallowances. The reimbursement timeline is four to six weeks from the date of claim submission.

## CERTIFICATION OF MEDI-CAL CLAIMS

The California Code of Regulations, Title 9, Section 1840.112 requires that LMHPs provide certification of compliance with specific statutory, regulatory and contractual obligations that are required for Medi-Cal reimbursement of Short-Doyle/Medi-Cal claims. The Director of Mental Health certifies each monthly claim prior to submission to the State for reimbursement.

The LMHP is unable to certify claims submitted by network providers and Short-Doyle/Medi-Cal Providers and, therefore, requires that each network provider certify that Medi-Cal claims meet Federal and State regulations and statutes annually by completing the Certification on Medi-Cal Claim form MH 1982 (Attachment III A and B).

## ON-LINE VENDOR REGISTRATION REQUIREMENT

In order to receive payments, network providers who have contracted with the LMHP using a Federal Employment Identification Number (FEIN) are required to register as a vendor with the County of Los Angeles, Internal Services Department (ISD) at the following website address: <http://camisvr.co.la.ca.us/webven/>. Do not register as a vendor if the network provider contracted with the LMHP using a social security number only and did not provide a FEIN. It is recommended that network providers confirm in the system, via the "Vendor Search" link, whether a registration has already been completed before starting the registration process. Registrants should also be prepared to enter the network provider's FEIN.

Click on the "New Registration" link at the website listed above and select the scenario that best fits the network provider's current status.

Note: The network provider's name and address must be exactly the same as the billing address used on their credentialing application and contract to avoid reimbursement delays. In the event that a change of billing address becomes necessary, network providers must also update their ISD vendor registration by selecting "Change Registration" at the website listed above in a timely manner to avoid reimbursement delays.

Please contact ISD Vendor Relations at (323) 267-2725 for questions regarding vendor registration.

## ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS

The LMHP network provider legal agreement requires that each provider certify that he/she is not currently excluded from participation in any federally funded health care program or that a recent or current investigation would likely result in exclusion from any federally funded health care program.

Network providers must certify on the *Attestation Regarding Federally Funded Programs* form (Attachment IV A and B) that they will notify the LMHP within thirty days in writing of:

- Any event that would require exclusion or suspension under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or state government against the provider barring the provider from providing goods or services for which federally funded healthcare program payment may be made.

## INTEGRATED SYSTEM RESOURCE INFORMATION DOCUMENTS AND ONLINE SERVICES

### INTEGRATED SYSTEM CODES MANUAL

A complete and updated copy of the IS Codes Manual may be accessed at the following website address: <http://lacdmh.lacounty.gov/hipaa/index.html> Click on the "IS Codes Manual" link.

## INTEGRATED SYSTEM ALERT AND HOW TO SIGN UP

The LMHP has created a special news service for users of the IS called the “IS Alert.” IS Alert members receive emails from LMHP IS managers when there are system outages, policy and procedure changes or other issues that affect the IS. All network providers, billing agents/services and clearinghouses are encouraged to subscribe to the IS Alert at the following website: <http://lacdmh.lacounty.gov/hipaa/index.html>. Enter the user’s name and email address in the silver box on the left side of the screen. IS Alert has a special “double-opt in” security feature. An email confirming the subscription will be received. Click on the link in the email to confirm.

## “FIND CLIENT” FUNCTIONALITY

The “Find Client” function in the IS enables users to search for unknown Medi-Cal beneficiary DMH client identification numbers. EDI users may find the function particularly helpful to use when Medi-Cal beneficiaries have not been previously registered. Step-by-step instructions on the Find Client process can be found in the Fee For Service Getting Started Guide for Claiming located at: [http://lacdmh.lacounty.gov/hipaa/ffs\\_UIS\\_TrainingModules.htm](http://lacdmh.lacounty.gov/hipaa/ffs_UIS_TrainingModules.htm)

Contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) for issues regarding the “Find Client” functionality.

## INTEGRATED SYSTEM ISSUES WEBSITE

The Integrated System issues website is provided to allow immediate access to IS related issues. The issues tracked in the database are IS related, have a wide-spread impact on normal business for revenue processes and cannot be resolved within 24 hours through established processes. As a result, issues on the website require project management intervention. The issues are immediately viewable once entered or updated. Updates are made at least weekly or as progress occurs.

Note: The IS Alert in the LMHP HIPAA website remains the formal means for notification of IS related changes.

The official link to the IS Issues Website application is: <http://dmhapps.co.la.ca.us/ISIssues/>. Users will be prompted to enter their RSA SecurID card/token information and then they will be redirected to a page where they need to click “continue.” Once this is done, the log on screen will appear on the IS Issues application. The following user name and password are given to access the IS Issues application:

User Name: FFSSOutpatient  
Password: LMPH

**The following examples provide step-by-step instructions on how to access the Web based Issues Database, how to review issues, and how to sign out of the website.**

## ACCESSING ISSUES SITE

Instructions for accessing the IS Issues Website are listed below:

1. Copy and paste the application website address: <https://dmhapps.co.la.ca.us/ISIssues/> into the Browser and click “Go.”
2. The following screen will be displayed. Enter user’s logon ID and passcode. User will need the RSA secured card/token and the PIN provided with the card/token for the passcode.
3. Click “Log In.”

RSA SecurID : Log In - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address <https://dmhapps.co.la.ca.us/ISIssues/>

 **Los Angeles County**  
**Logon ID and Passcode Request**

(RSA ACE/Server 6.0)

Access to this protected resource requires RSA SecurID Token authentication.

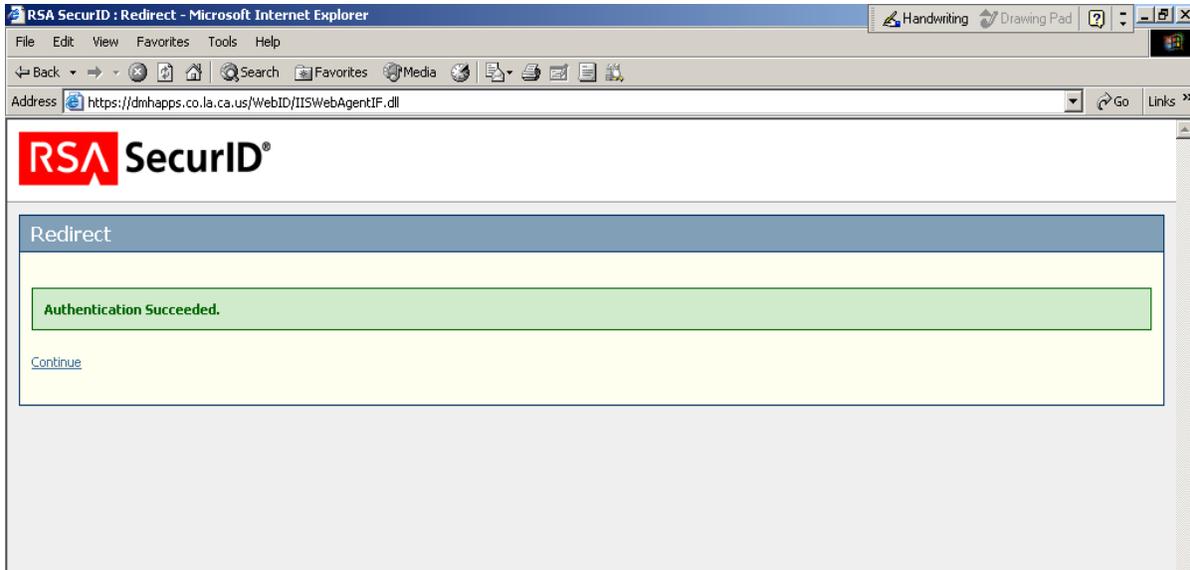
These computer systems including all related equipment, networks, and network devices are the property of the County of Los Angeles. These computer systems are provided for authorized use only and may be monitored for all lawful purposes. All information placed on or sent over these computer systems may be examined, recorded, copied, and used for other authorized purposes during monitoring. Use of these computer systems, authorized or unauthorized, constitutes consent to monitoring. Evidence of unauthorized use may be used for administrative, criminal, or other adverse actions. Unauthorized users may be subject to criminal prosecution. **By continuing, you agree to these terms.**

Logon ID:

Passcode:

Your Passcode is your PIN + the number displayed on your token (the Tokencode).

Done Internet



1. Enter User Name and Password. Then click “OK” to log in.



### Viewing Issues

1. The default view lists issues that impact network providers.

**Search for - Allows free text to Search by**

**Drop down boxes Filter list**

Issues ID	Date Opened	Problem Type	Impacted	Action	Assigned	Brief Description	Priority	CR #	Heat Ticket No.	Issue Status
159	7/22/2005	Adjudication	All Providers	(None)	(None)	Medi-Cal Billing in CalWORKS/ CalWORKS Denials.	High			Closed
158	6/21/2005	EDI	FFS OP	Escalate	Sierra Project Mgmt	IS010 and 835 questions	High			Open
157	6/14/2005	IS Admin	All Providers	(None)	(None)	Claims should be visible for at least 24 months of services	Medium			Closed

Clicking a hyperlink sorts the list (i.e. by priority, status, etc.)



**Comment**

Proj. Mgmt Mtg 8/2/05 - DonnaKay has approved closure of issue. Sierra 6/16/05 - the remaining claims were corrected 6/8. Assigning back to DMH CIOB to close issue out. John Ortega got a call yesterday from Didi Hirsch after they had worked through one of the new reports he's provided to them. They were seeing claims that were entered into Clinical and passed to Admin that they believed had been claimed and that didn't show up on an unclaimed units of service report. However, when they drilled down to the detail level, the claims had not been claimed. For Didi Hirsch, this category amounts to about 9,000 claims. John has run another report that shows 83,000 claims in the same status. At \$50 per claim, that's about \$4M. Some of the units of service may have been resubmitted by some clinics as a new claims, however, we think that will turn out to be a small number. Our hope is that there is some straightforward way to release the 83,000 claims. over 56,000 claims were corrected 6/5. There are still some remaining claims to be corrected after the 6/8 claims cutoff status. Will provide update by the next meeting 6/14.

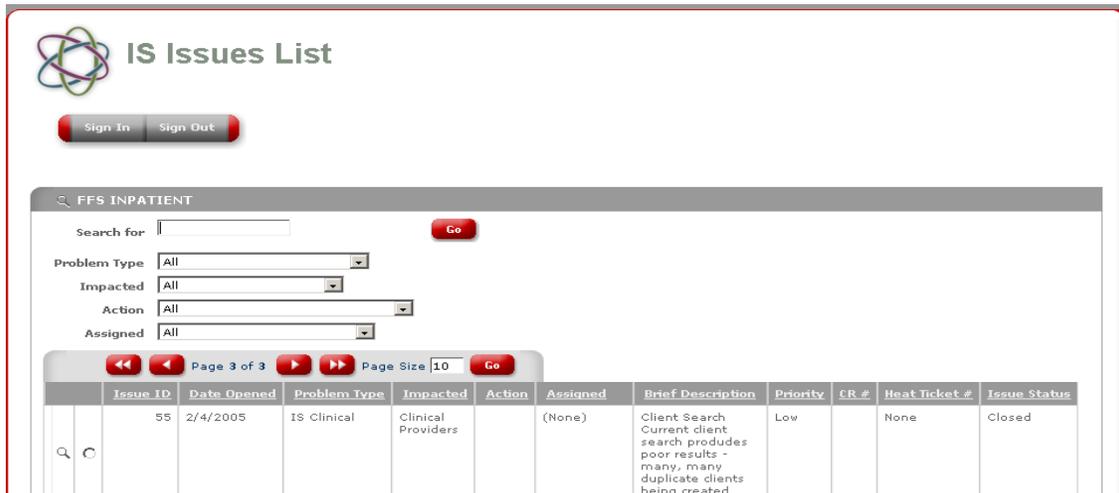
Click  to exit Issue

Please note:

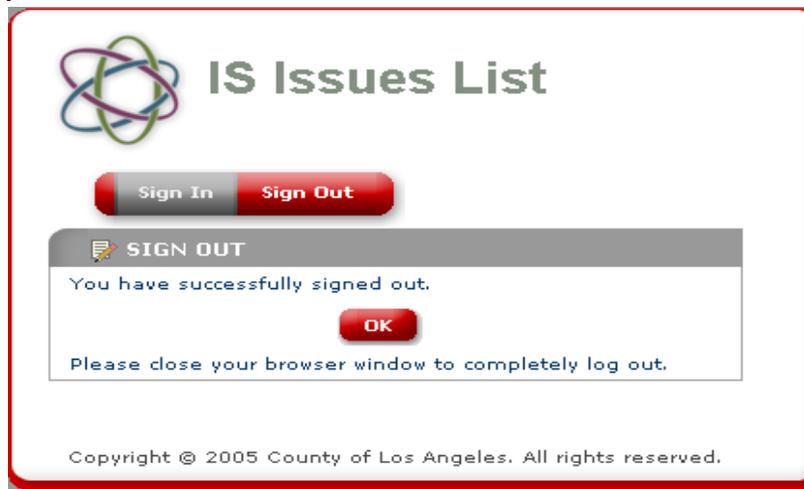
- ◆ While a HEAT ticket number may be listed, not every HEAT ticket number will be posted in the Issues Database.
- ◆ Issues are closed only with the CIOB Project Manager's Approval
- ◆ Recent comments are listed at the top of the Comment box

Signing out – 3 Important Clicks

- i. Click “Sign Out”



- ii. Click “OK”



- iii. Click “X” to close browser and completely sign out



Thanks for visiting the IS Issues website.

You may contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) if there are any questions regarding the IS Issues website. Contact the CIOB Help Desk at (213) 351-1335 if technical difficulties are experienced in accessing the IS Issues website application.

## INTEGRATED SYSTEM NEWS BULLETINS

Network providers, billing agents/services and clearinghouses should regularly review the IS News Bulletins for the latest updates regarding issues that may affect billing requirements. The IS News Bulletins may be accessed at the following website address: [http://lacdmh.lacounty.gov/hipaa/ffs\\_UIS\\_Special.htm](http://lacdmh.lacounty.gov/hipaa/ffs_UIS_Special.htm) in the “Outpatient Fee-For-Service” module of the IS. Click on the “Special Bulletins” link to access the bulletins.

## INTEGRATED SYSTEM REPORTS

Users of the IS may access various reports on the IS (home page) reports link to review claim and adjudication status.

**The following IS reports are available to IS users on the Clinical Operations link:**

1. Active Assigned Staff Register/Staff Roster with License Status Report (IS280)
  - Lists NPI number, license number, taxonomy description, expiration date and contract termination date.
2. Approved claims by Type Report (IS060)
  - Lists approved (paid) claims only.
3. Claim Rule Failure by Billing Provider Report (IS352)
  - Lists denied claims only.
4. Claim Status Detail Report (IS010)
  - Lists claim statuses and adjudication detail.
5. FFS Checkwrite Detail Report (IS706)
  - Lists approved (paid) claims only. Sequence number is required, which can be found in IS705 Report.
6. FFS Checkwrite Summary Report (IS705)
  - Lists check sequence numbers only.
7. FFS2 Claims Status Detail Report (IS704)
  - Lists claim statuses and adjudication detail.

The IS reports on the Clinical Operations link can be accessed by following these instructions:

1. Select the IS Home Module, click the “Reports” link and select the “Clinical Operations” link to access one of the desired reports identified above. The “Welcome, RPTDMH” screen will appear.
2. Select the desired report from the list. The next screen will be the “Report Parameter Form.” Various reports may request information entered in one or all of the data fields listed below.
3. The Billing Provider ID will be automatically populated or a dropdown menu will appear to select the network provider name. If the system does not auto-populate or provide a dropdown menu allowing the network provider’s name to be selected in the “Billing Provider ID” field, complete an Application Access Form and indicate the role of RPTPROV. Mail the form to the Systems Access Unit address listed in this section on page 2. You may also call

the CIOB Help Desk at (213) 351-1335, and request access to view IS reports. Proceed to instruction number 4 if access to the reports is already granted.

4. Enter the service date range, submit date range and select all claim statuses: Approved, Denied, Forwarded, Pending, Submitted, etc. Do not change any of the defaults. Select “Show Report.”
5. Select the “Print this Report” icon () on the top left side of the screen. Click “All” and select the Print button. When the open file prompt appears, click “Open file.”

Note: Some browsers may prompt the following message: “To help protect your security, etc. Click here for options.” Select “Download file” and repeat step 5.

### **The following IS reports are available to IS users on the Clinical Report Exports link:**

1. Claims Detail Export by Billing Provider (IS801)
  - Lists claim adjudication detail.
2. Claim Detail Export by Billing Provider Alt (IS701)
  - Lists claim adjudication detail.
3. FFS2 Claim Detail Export by Billing Provider (IS707)
  - Lists claim adjudication detail.

Note: IS reports found on the Clinical Report Exports link may be exported to a Microsoft Excel Spreadsheet. Excel – “data only” is the highly recommended format.

The IS reports on the Clinical Reports Exports link can be accessed by following these instructions:

1. Select the IS Home Module, click the “Reports” link and select the “Clinical Report Exports” link to access one of the desired reports (IS801, IS701, and IS702). The “Welcome, RPTDMH” screen will appear.
2. Repeat steps 2 through 4 under “Clinical Operations above.”
3. Select the “Export this Report” icon () on the top left side of the screen. In the dropdown menu, select “MS Excel 97-2000 (Data only)” format and click the “Export” button. Click “Open file” when the “open file” prompt appears. Some browsers may prompt the following message: “To help protect your security, etc. Click here for options.” Select “Download file” and repeat step 3.
4. Globally format all column widths to 10 to clearly view data content.

You may contact the Provider Support Office, Fee-for-Service Section at (213) 738-3311 or [FFS@dmh.lacounty.gov](mailto:FFS@dmh.lacounty.gov) if you have any questions or need additional assistance.

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR**

**MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION  
PROVIDER SUPPORT OFFICE  
FEE-FOR-SERVICE-SECTION**

Date:

TO: Department of Mental Health  
Provider Support Office  
Attn: Systems Access Unit  
695 S. Vermont Avenue, 8<sup>th</sup> Floor  
Los Angeles, CA 90005

FROM: \_\_\_\_\_  
Network Provider, Billing Agent/Service or Clearinghouse Name

SUBJECT: **INTEGRATED SYSTEM ACCESS APPLICATION CHECKLIST**  
[http://lacdmh.lacounty.gov/hipaa/ffs\\_ISForms.htm](http://lacdmh.lacounty.gov/hipaa/ffs_ISForms.htm)

Attached for processing are the forms required to submit claims electronically in the Integrated System via DDE.

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

**(A) Obtaining Access**

<b>1. Applications Access Form</b>
2. Application Access Form Attachment (For Application with additional assigned location)
3. Individuals Authorized to Sign CIOB Access
4. Confidentiality Oath
5. Downey Data Center Registration for Contractor/Vendor
6. Agreement for Acceptable Use
7. Rendering Provider Form
8. Rendering Provider Form Attachment (For Application with additional assigned location)

**(B) Renewing Access**

1. SecureID Token Renewal Request
2. Agreement for Acceptable Use

**(C) Termination Access**

1. Application Access Form
2. Downey Data Center Registration for Contractor/Vendor

If you have any questions or need additional information, you may contact CIOB Helpdesk at (213) 351-1335 or the Fee-for-Service Section at (213) 738-3311 or [Ffs2@dmh.lacounty.gov](mailto:Ffs2@dmh.lacounty.gov)

Attachments: \_\_\_\_\_  
4/17/2014

### HIPPA DELAY REASON CODES (LATE CODES)

These codes are required when a claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.

<u>Code</u>	<u>Description</u>
1	Proof of Eligibility Unknown or Unavailable
2	Litigation <b>(not accepted by the State)</b>
3	Authorization Delays <b>(not accepted by the State)</b>
4	Delay in Certifying Provider <b>(FFS 2 providers – Do not use)</b>
5	Delay in Supplying Billing Forms <b>(not accepted by the State)</b>
6	Delay in Delivery of Custom-made Appliances <b>(not accepted by the State)</b>
7	Third-party Processing Delay <b>(FFS 2 providers – Do not use)</b>
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules <b>(not accepted by the State)</b>
10	Administration Delay in the Prior Approval Process <b>(not accepted by the State)</b>
11	Other <b>(FFS 2 TAR delay use only)</b>

**(not accepted by the State)** – Do not use any of these codes.

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH  
 CERTIFICATION ON MEDI-CAL CLAIM  
 (MH1982) for Fiscal Years 2009-10, 2010-11, 2011-12, 2012-13, AND 2013-14**

FEE-FOR-SERVICE  
 INDIVIDUAL NETWORK  
 PROVIDER NAME:

PROVIDER NUMBER(S): 

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I HEREBY CERTIFY under penalty of perjury that I am responsible for the administration of Specialty Mental Health Services that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. I agree and shall certify under penalty of perjury that all claims for services provided to County Mental Health clients have been provided to the clients by me.

I also certify that the services were, to the best of my knowledge, provided in accordance with the client's written treatment plan and that all information entered into the Integrated System is accurate and complete. I understand that payment of these claims will be from Federal and /or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. I agree to keep for a minimum period of seven years from the date of service (except for children for whom records should be retained at least one year after 18 years of age, but never less than seven years) or until the audit is settled, a printed representation of all records that are necessary to disclose fully the extent of services furnished to the client. I agree to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Care Services; the Medi-Cal Fraud Unit; the California Department of Mental Health; the California Department of Justice; the Office of the State Controller; the U.S. Department of Health and Human Services, the Managed Risk Medical Insurance Board, or their duly authorized representatives. Amounts claimed herein for the Healthy Families program are only for children between the ages of one (1) year old to their nineteenth (19<sup>th</sup>) birthday who were assessed or treated for a serious emotional disturbance (SED). I also agree that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability. In addition, I meet the requirements of DMH Letters No. 95-01 and 95-06 the crossover billing for Medicare, Medi-Cal and private insurance.

Name of Network Provider

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Please print

Signature \_\_\_\_\_ Telephone # \_\_\_\_\_ Date \_\_\_\_\_  
Network Provider

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH  
 CERTIFICATION ON MEDI-CAL CLAIM  
 (MH1982) FOR FISCAL YEARS  
 2009-2010, 2010-2011, 2011-2012, 2012-2013 AND 2013-2014**

FEE-FOR-SERVICE  
 GROUP NETWORK  
 PROVIDER NAME:

--

PROVIDER NUMBER(S):

--	--	--	--	--	--	--	--	--	--

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I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Specialty Mental Health Services at:

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(Group Network Provider Name)

in and for said claimant; that this group network provider has not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. I agree and shall certify under penalty of perjury that all claims for services provided to County Mental Health clients have been provided to the clients by this group network provider.

I also certify that the services were, to the best of my knowledge, provided in accordance with the client's written treatment plan and that all information either entered into the Integrated System or submitted is accurate and complete. This group network provider understands that payment of these claims will be from Federal and /or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. This group network provider agrees to keep for a minimum period of seven years from the date of service (except for children for whom records should be retained at least one year after 18 years of age but never less than seven years) or until the audit is settled, a printed representation of all records that are necessary to disclose fully the extent of services furnished to the client. This group network provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Care Services; the Medi-Cal Fraud Unit; the California Department of Mental Health; the California Department of Justice; the Office of the State Controller; the U.S. Department of Health and Human Services, the Managed Risk Medical Insurance Board, or their duly authorized representatives. Amounts claimed herein for the Healthy Families program are only for children between the ages of one (1) year old to their nineteenth (19<sup>th</sup>) birthday who were assessed or treated for a serious emotional disturbance (SED). This group network provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability. In addition, this group network provider does meet the requirements of DMH Letters No. 95-01 and 95-06 the crossover billing for Medicare, Medi-Cal and private insurance.

Name of person authorized to sign Legal Agreement

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Please print

Signature \_\_\_\_\_ Telephone # \_\_\_\_\_ Date \_\_\_\_\_  
 Name of Person Authorized to Sign Legal Agreement

**ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS**

In accordance with the DMH Medi-Cal Professional Services Agreement’s Paragraph 41 (CONTRACTOR’S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM):

I, the undersigned certify that I am not presently excluded from participation in federally funded health care programs, nor is there an investigation presently pending or recently concluded of me which is likely to result in my exclusion from any federally funded health care program, nor am I otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I further certify as the network provider responsible for the administration of specialty mental health services, (hereafter “Contractor”) that I am not presently excluded from participation in any federally funded health care programs, nor is there an investigation presently pending or recently concluded of Contractor which is likely to result in an exclusion from any federally funded health care program, nor is Contractor likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I understand and certify that I will notify DMH within thirty (30) calendar days, in writing of:

- Any event that would require Contractor exclusion or suspension under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or state government against Contractor barring Contractor from providing goods or services for which federally funded healthcare program payment may be made.

Name of Network Provider \_\_\_\_\_  
Please print name

Signature of Network Provider \_\_\_\_\_ Date \_\_\_\_\_

**ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS**

In accordance with the DMH Medi-Cal Professional Services Agreement's Paragraph 41 (CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM):

I, the undersigned certify that I am not presently excluded from participation in federally funded health care programs, nor is there an investigation presently pending or recently concluded of me which is likely to result in my exclusion from any federally funded health care program, nor am I otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I further certify as the official responsible for the administration of specialty mental health services, (hereafter "Contractor") that all of its officers, employees, agents and/or sub-contractors are not presently excluded from participation in any federally funded health care programs, nor is there an investigation presently pending or recently concluded of any such officers, employees, agents and/or sub-contractors which is likely to result in an exclusion from any federally funded health care program, nor are any of its officers, employees, agents and/or sub-contractors otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I understand and certify that I will notify DMH within thirty (30) calendar days, in writing of:

- Any event that would require Contractor or any of its officers, employees, agents and/or sub-contractors exclusion or suspension under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or state government against Contractor, or one or more of its officers, employees, agents and/or sub-contractors, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federally funded healthcare program payment may be made.

Name of authorized official \_\_\_\_\_  
Please print name

Signature of authorized official \_\_\_\_\_ Date \_\_\_\_\_

## SECTION XIII – PROCESS FOR RESOLVING FISCAL AND AUTHORIZATION REQUEST APPEALS

### FISCAL APPEALS

The Board of Supervisors of the County of Los Angeles authorized the Local Mental Health Plan (LMHP) to establish a process for the resolution of fiscal appeals. The Alternate Dispute Resolution (ADR) process includes procedures for a First Level Appeal and/or a Second Level Appeal to resolve small claims presented to the LMHP by network providers. This appeal process offers network providers and billing agents who are dissatisfied with the processing or payment of an initial or resubmitted claim, a method for resolving disputed claims.

### PRINCIPLES OF THE ALTERNATE DISPUTE RESOLUTION PROCESS

1. Time is of the essence and network providers should take all the necessary steps to initially submit a claim to the Department as soon as possible after providing service. Delay in the submission of a claim may attribute to a State denial that would have otherwise been a valid claim.
2. While there will be no commitment to pay all claims, this process offers an expeditious administrative review of denied claims and where it is determined the LMHP or its agent(s) are fully or partially at fault, there is a commitment to a reasonable settlement resolution.
3. The burden of proof will be on the network provider to establish the LMHP or its agent(s) were fully or partially at fault for the denial.

### GENERAL STEPS IN THE ALTERNATE DISPUTE RESOLUTION PROCESS

1. Network providers and billing agents must ensure the timely submission of a claim. Refer to general claiming instructions for timelines:
  - Prepare and submit a claim for payment as soon as possible after providing the service.
  - Check the IS reports for claim disposition; network providers are strongly encouraged to submit and reconcile claims weekly and no later than one month after the date of service.
  - If the claim is denied, the claim denial reason code should immediately be accessed to determine whether a claim is eligible for correction. Refer to the Denial Reason Codes List at the following website address: [http://lacdmh.lacounty.gov/hipaa/ffs\\_HandlingDeniedClaims.htm](http://lacdmh.lacounty.gov/hipaa/ffs_HandlingDeniedClaims.htm)
  - Prepare and submit a new and corrected claim as soon as possible. The submission of a claim filed more than six months and up to twelve months from the service date will require an appropriate delay reason (late) code. Refer to the IS Codes Manual at the following website address to obtain a complete listing of Late Codes: [http://lacdmh.lacounty.gov/hipaa/ffs\\_UIS\\_Manuals.htm](http://lacdmh.lacounty.gov/hipaa/ffs_UIS_Manuals.htm)

- If steps above in timely submitting a claim do not result in a provider reimbursement, a network provider may submit a First Level Appeal and/or Second Level Appeal.
- 2. The First Level Appeal must be submitted to the LMHP within 90 calendar days of the denial. The LMHP has 60 calendar days from the receipt of the appeal to provide a written statement of the decision and any action to be taken by the network provider.
- 3. A Second Level Appeal may be submitted if the First Level Appeal decision is not to the provider's satisfaction. The Second Level Appeal must be submitted within 30 calendar days of the date on the written decision of the First Level Appeal. The LMHP has 60 calendar days from receipt of the Second Level Appeal to notify provider of the decision.
- 4. If an appeal leads to a settlement proposal, payment will be made upon the network provider's agreement with the proposal and execution of an appropriate release.

### **DOCUMENTATION REQUIREMENTS FOR THE FIRST LEVEL AND SECOND LEVEL APPEAL**

Network providers who wish to submit a First Level or Second Level Appeal must provide the following documentation:

- A detailed cover letter explaining the reason for the dispute, the circumstances concerning the denial and why the network provider or billing agent determined the fault was that of the LMHP;
- Any correspondence related to the processing of the disputed claim(s) from the LMHP;
- A completed Appeal Form indicating whether the appeal is a First Level or Second Level Appeal;
- A printout of an Integrated System (IS) report(s) that lists the history of the disputed claim(s) and error reason(s) or discussion of the original electronic claim(s);
- Proof of Medi-Cal beneficiary eligibility for the date of service;
- A copy of the claim(s); and
- Copy of an approved outpatient treatment authorization request (OTAR) or hospital treatment authorization request (TAR), if applicable.

Mail and fax all appeal documents to:

Department of Mental Health  
Provider Support Office– Appeals Section  
695 S. Vermont Ave., 11th Floor  
Los Angeles, CA 90020

### **INSTRUCTIONS FOR COMPLETION OF THE FIRST LEVEL AND SECOND LEVEL APPEAL FORM**

Each item below refers to an area on the *Appeal Form* (Attachment I).

ItemDescription

- A. **Appeal Number.** For LMHP use only.
- B. **Appeal Reference Number.** For LMHP use only.
- C. **Network Provider Name/Address.** Enter contracted individual or group network provider's name and mailing address, city, state, and zip code.
- D. **Network Provider Telephone/Fax numbers.** Enter network provider's telephone and fax numbers.
- E. **Rendering Provider Number.** Enter the nine-digit network provider number (ex. MF0000000, 00A000000, PSY000000, etc.) Without the correct network provider number, appeal acknowledgment and processing may be delayed.
- F. **Claim Type.** Enter an "X" in the appropriate box to indicate whether the claim type is in an inpatient or outpatient setting. Only one box may be checked.
- G. **Appeal Level.** Check the box to indicate First Level or Second Level Appeal.
- H. **Statement of Appeal.** Network provider's attestation statement.
- I. **Client's Name.** Last name, First name.
- J. **Client's Medi-Cal ID.** Enter the Medi-Cal beneficiary's CIN (client index number) obtained from the beneficiary identification card (BIC).
- K. **Number of Minutes.** Enter the number of minutes used by the provider for services.
- L. **IS Claim ID #.** Enter the Integrated System claim ID number, which can be obtained from one of the IS adjudication detail reports that displays the disputed claim(s).
- M. **POS (Place of Service).** Enter the appropriate service location/facility type code of the place where the service was rendered.
- N. **Date of Service.** Enter the date on which services were rendered to the Medi-Cal beneficiary.
- O. **Prior Authorization #.** If applicable, enter the hospital treatment authorization request number (TAR) or over-threshold authorization request number (OTAR).
- P. **Procedure Code.** Enter the procedure code.
- Q. **Diagnosis Code.** Enter the diagnosis code.

- R. Reason for the Appeal.** Indicate the reason for filing the appeal. Be as specific as possible. All supporting documentation must be included and attached to the appeal form in order for the examiners to consider all relevant issues concerning the dispute.
- S. Denial Code.** Enter the denial code (0201, 0708, Validate diagnosis code ,etc.) received on an IS report.
- T. Common Appeal Reasons.** Check one of these boxes, if applicable. Include a copy of the claim and supporting documentation.
- U. Signature and Date.** The network provider or an authorized representative (i.e., billing agent, group or organizational provider administrator) must sign and date the Appeal Form.

## OVERVIEW OF THE ALTERNATE DISPUTE RESOLUTION REVIEW PROCESS

1. All appeal packages are reviewed applying the same set of rules. The appeal review process is as follows:
  - Packages are logged in to ensure they are received timely;
  - A log is maintained to track each appeal;
  - A cover sheet is attached to each appeal package for status control;
  - Each appeal is sent to the review team, who manually reviews the package based on the review rules. Deductions are made per the rules;
  - The average deduction and approval percentages are calculated;
  - If the entire appeal is denied, there is no further action; and
  - If any portion of the appeal is approved, the claim line detail is forwarded for payment the LMHP Accounting Division - Provider Reimbursement Unit.
2. An electronic review is conducted to:
  - Calculate the correct rate for each minute of service on the date of service;
  - Ensure the claim(s) is not a duplication of an approved claim(s);
  - Ensure there are not duplicate claims in the appeal package;
  - Verify the network provider had a valid contract and credentials on the date of service;
  - Verify that the service occurred during the appeal period;
  - The procedure code billed is valid for the provider type and date of service; and
  - The network provider number is valid.
3. Deductions are made due to the following reasons:

Late submission of claims (denied claims that were not resolved and paid before the six-month billing limitation from the date of service. These claims are considered late and are measured as the amount of time that passed from the six-month billing limitation up to the one-year billing limitation).

  - 20% - 3+ months after the six (6) month billing limit;
  - 30% - 4+ months after the six (6) month billing limit; or
  - 40% - 5+ months after the six (6) month billing limit.

Insufficient or missing documentation (determined by the nature of the claim – documentation that directly supports the appeal is required by the review team).

- 100% - Is deducted if no documentation is submitted to support the appeal issue;
  - 10% - Is deducted per piece of information the appeals committee felt the network provider should have submitted (partial deductions); or
  - 20% - Is deducted if a reasonable explanation was not provided as to why the network provider was unable to provide documentation (partial deductions).
- Follow-up (this is measured by the level of follow-up claim activity performed by the network provider as demonstrated in the appeal and the documentation).

- 10% - Incorrect claim resubmitted;
- 20% - No corrected claim submitted;
- 40% - No follow-up demonstrated; or
- 100% - If the network provider failed to explain why the denials were the fault of the LMHP.

Once the electronic review is complete, deductions found for each claim will be taken per claim and the appeal total is calculated. This amount represents what the LMHP agrees to pay the network provider and the LMHP's amount of responsibility for the denial of appealed claims.

4. The burden of proof will be on the network provider to establish that the LMHP or its agent(s) were fully or partially at fault for the denial.

## **PAYMENT**

Upon completion of the ADR process, the LMHP will disburse the approved funds to the network provider. The payment is mailed to the network provider with the County Counsel approved Settlement and Release Form.

To receive the claim line detail of the claims paid on an appeal, send an email to [FFS2@dmh.lacounty.gov](mailto:FFS2@dmh.lacounty.gov) with the following information:

- Provider name and number;
- Sequence/Warrant/Check number and date; and
- Amount of the check

## **AUTHORIZATION REQUEST APPEALS**

### **OVER-THRESHOLD**

When over-threshold requests are denied or modified, the network provider will be sent a Notice of Action (NOA-B and NOA-Back) within three days of the Central Authorization Unit (CAU) decision (Refer to Section XVII: Notice of Action.).

Network providers who wish to appeal a denied or modified request may submit an informal appeal within 15 days of receipt of the NOA-B by contacting the CAU at (213) 738-2465 to request reconsideration of the decision.

If the informal appeal does not result in an amended decision, the network provider may submit a Level I Formal Provider Appeal within 90 calendar days of the receipt of the NOA or failure to act on the provider's request. The documentation to initiate a Level I Formal Provider Appeal may include, but is not limited to:

- Clinical records supporting medical necessity;
- A summary of reasons why the services should be approved; and
- Name, address, email, telephone and fax numbers of the contact person.
- A completed Formal Provider Appeal Form (Attachement II)

The CAU will forward the documentation to the Clinical Management Review Committee (CMRC) for a formal review within 24 hours of receipt. The CMRC is comprised of clinicians who had no involvement in the treatment or authorization of services for the client. The CMRC will review the Level I Provider Appeal and issue a written decision to the provider within 30 calendar days of receipt of the appeal. The approval start date will coincide with the CMRC decision date.

Note: An expedited appeal may be requested when the network provider certifies that taking the time for a standard appeal resolution would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. A written decision will be issued to the provider no later than 3 working days after receipt of the appeal.

If the Level I Formal Provider Appeal does not result in an amended decision from the CMRC, the provider may file a Level II Formal Provider Appeal within 30 calendar days of notification of the Level I denial. The Level II Formal Provider Appeal shall be submitted with the following:

- A cover letter requesting a Level II Formal Provider Appeal;
- A copy of the completed Level I Formal Provider Appeal form;
- The written Level I CMRC denial; and
- Any other supporting documentation.

The CAU will forward the Level II Formal Provider Appeal to the Office of the Medical Director within 24 hours of receipt of the documents. A written response will be sent from the Medical Director's office to the network provider within thirty 30 calendar days of receipt of the appeal.

Mail or fax all appeal documents to:

Department of Mental Health  
Central Authorization Unit – Appeals Section  
550 S. Vermont Ave., 7th Floor, Room 703B  
Los Angeles, CA 90020  
Fax: (213) 351-2023

## **PSYCHOLOGICAL TESTING**

The referring party or provider may appeal a denied or modified request for psychological testing authorization and/or payment approval by initiating an informal appeal, a Level I Formal Provider Appeal or a Level II Formal Provider Appeal.

The referring party/provider may initiate an informal Appeal for denial or modification of psychological testing by contacting the CAU at (213) 738-2465 to request reconsideration of the decision. The CAU will reconsider the informal appeal and attempt to facilitate a resolution within five working days.

If the informal appeal does not result in an amended decision, the referring party/provider may submit a Level I Formal Provider Appeal must be submitted within 90 calendar days of the initial notification of modification or denial of psychological testing. To initiate a Level 1 Formal Provider Appeal the following documentation must be submitted:

- A Formal Provider Appeal Form (Attachment II)
- Clinical records supporting medical necessity; and
- A summary of reasons why the request for psychological testing should have been approved.

The documentation will be forwarded to the Clinical Management Review Committee (CMRC); a multidisciplinary clinical committee established by the LMHP and authorized to review provider clinical appeals. The CMRC will issue a written decision to the referring party/provider within 30 calendar days of receipt of the Level I Formal Provider Appeal.

If approval is based upon the same documentation submitted prior to the decision of the CAU, it will be retroactive to the date of the original request. If the approval is based upon additional documentation presented to CMRC, but not previously submitted to the CAU, the approval date will coincide with the CMRC decision date.

Note: An expedited appeal may be requested when the network provider certifies that taking the time for a standard appeal resolution would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. A written decision will be issued to the provider no later than 3 working days after receipt of the appeal.

If the Level I Formal Provider Appeal does not result in an amended decision from the CMRC, the referring party/provider may file a Level II Provider Appeal to the LMHP Medical Director within 30 calendar days of notification of the Level I Appeal denial. The Level II Appeal is to include:

- A cover letter requesting a Level II Appeal;
- Copies of the Level I Formal Provider Appeal form;
- The written Level I denial from the CMRC; and
- Other relevant supporting documentation

The written decision from the Medical Director will be sent to the referring party/provider within thirty 30 calendar days of receipt of the appeal.

Mail or fax all appeal documents to

Department of Mental Health  
Central Authorization Unit – Appeals Section  
550 S. Vermont Ave., 7th Floor, Room 703B  
Los Angeles, CA 90020  
Fax: (213) 351-2023

A. Appeal Number

B. Appeal Reference Information: Reserved for DMH Use:

**APPEAL FORM – CoLA DMH LMHP – Specialty Mental Health Services**

**READ INSTRUCTIONS PRIOR TO COMPLETING AND SIGNING THIS FORM.**

C. Provider Name:  
 Provider Address:  
 D. Provider Telephone:  
 Provider Fax Number:

E. Rendering Provider No:  
 F. Claim Type  
 Check Only One  
 Inpatient Setting   
 Outpatient

G. First Level Appeal   
 Second Level Appeal

H. As provided by the California Administrative Code Title 22, Section 51015, and by Section 1850.305 of Title 9, Chapter 11 of the Cal. Code of Regulations, I am submitting an appeal of my claim as defined below. I have enclosed all documentation required for this appeal.

**PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW**

I. Patient's Name

J. Patient's Medi-Cal I.D.

R. Reason for Appeal (Enclose all supporting documentation, including copy of claim)	S. Denial Code	K. # of Min.	L. IS Claim ID #	M.	N.	O. Prior Auth # (if applicable)	P. Proc. Code	Q. Diag. Code
				POS	Date of Service			
		01						
		02						
		03						
		04						
		05						
		06						
		07						
		08						
		09						
		10						
		11						
		12						
		13						

T. Common Appeal Reasons  
 CHECK ONLY ONE (IF APPLICABLE)

Eligibility  (POS Attached)  
 TAR/PA/HPA Denial  (TAR/PA/HPA Attached)  
 Crossover  (3<sup>rd</sup> Party Denial Attached)  
 Adjustments Request  (Paid Warrant Attached)  
 Past 6 Months SD/MC  (Billing History Attached)

This is to certify that the information contained above is true, accurate and complete and that the Provider has read, understands, and agrees to be bound by and comply with the conditions required by the County of Los Angeles DMH Local Mental Health Plan.

U. Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR  
Medi-Cal Professional Services and Authorization Division  
**FORMAL PROVIDER APPEAL**

**Provider Information**

Print Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone No.: \_\_\_\_\_ Provider Fax No.: \_\_\_\_\_ Provider email: \_\_\_\_\_

Contact Person Name (if applicable): \_\_\_\_\_ Contact Person Phone No.: \_\_\_\_\_

**Statement of Appeal** (Please attach copies of all relevant documentation to support the appeal)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DMH USE ONLY BELOW THIS LINE**

Date Appeal Received: \_\_\_\_\_ Date Appeal Logged: \_\_\_\_\_

Provider Relations Specialist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable Federal or State Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you have received this message in error, please telephone the originator of this message immediately

## **SECTION XIV – CARE COORDINATION BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH PROVIDERS**

Communication between primary health care physicians (PCP's) and the Local Mental Health Plan (LMHP) specialty mental health providers is essential to ensure care coordination and access to services. Periodically, a care coordination packet is disseminated to the PCPs affiliated with Health Net and L.A. CARE health plans. The packet includes Health Insurance Portability and Accountability Act (HIPAA) regulations regarding federally mandated guidelines for Protected Health Information (PHI). Under HIPAA, health plans, health care clearinghouses, and health care providers that maintain or transmit PHI must maintain reasonable and appropriate administrative, technical, and physical safeguards. This is to ensure the integrity and confidentiality of the information, protect against unauthorized use or disclosure of the information, and ensure compliance by their officers and employees.

The care coordination packet also informs PCP's how to make referrals to the LMHP. The *Physical and Mental Health Care Coordination – Exchange of Information Forms* (Attachment I - A & I-B) are for use by PCPs and the LMHP mental health providers. The Exchange of Information Forms allows information exchange between PCPs and network providers. Information requested on the form includes essential medical information such as current medication, significant medical conditions and mental health conditions. By completing the information requested on the form, PCPs and network providers will have crucial information in order to facilitate care coordination.

Providers must obtain from the Medi-Cal beneficiary, a signed consent to release information form (Attachment II). This form must contain all of the required elements and conform to all other requirements according to the current federal and state regulations. Network providers are to retain a copy of the medical information received from the PCP in the client record. When faxing PHI, a HIPAA-compliant cover sheet is required. For convenience, a HIPAA fax sheet is included in this section (Attachment III). For more information on HIPAA refer to the following website address: [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) and click on the "References" link then scroll down to "HIPAA Update."

Medi-Cal beneficiaries often self-refer to mental health network providers without the knowledge of their PCP. It is important for care coordination and the welfare of the beneficiary for the network provider to obtain a signed consent and forward pertinent information to the PCP. Medi-Cal beneficiaries may not be enrolled in a Medi-Cal managed care physical health plan without having a PCP. In such cases, network providers may obtain a referral for physical health care for these Medi-Cal beneficiaries by contacting the ACCESS Center at (800) 854-7771

### **SPECIALTY MENTAL HEALTH SERVICES TO ASSIST PRIMARY CARE PHYSICIANS IN THE TREATMENT OF MEDI-CAL LMHP BENEFICIARIES**

#### **CLINICAL EVALUATION AND CONSULTATION PROCEDURES\***

1. Outpatient Evaluation and Consultation Services  
Routine and Urgent Outpatient Evaluation and Consultation

- PCP's may obtain routine and urgent outpatient evaluations and consultations to assist in the mental health diagnosis and clinical management (psychotherapeutic and psychopharmacological) of health plan beneficiaries. In contrast to routine services, an urgent evaluation and consultation is required when the beneficiary has non-life threatening symptomatology, that left untreated within 24 hours, may lead to a life threatening emergency or further decompensation. Recommendations may be obtained from a network provider for continued clinical management through the PCP or through initiation of specialty mental health services. Routine and urgent outpatient evaluations and consultations should be sought through:
  - The ACCESS Center at: (800) 854-7771; or
  - Contact with the Medi-Cal beneficiary's mental health provider, if currently in treatment.

#### Emergency Outpatient Evaluation and Consultation

- An emergency mental health condition is defined as behavioral symptomatology that may result in imminent harm to self or others. Emergency life-threatening mental health situations should be treated expeditiously. Emergency services may be sought through:
  - Calling 911; or
  - The ACCESS Center at: (800) 854-7771; or
  - Contact with the Medi-Cal beneficiary's mental health provider, if currently in treatment; or
  - The Psychiatric Mobile Response Team (PMRT) at (800) 854-7771; or
  - The Local Police Department.
- Requests for Emergency Outpatient Evaluations should be followed with contact with the current specialty mental health provider to facilitate disposition planning.

## 2. Inpatient Evaluation and Consultation Services

#### Routine and Urgent Inpatient Evaluations

- Routine and urgent inpatient evaluations are rendered through psychiatrists with clinical staff privileges at the facility in which the Medi-Cal beneficiary is being treated. Information and access to hospital staff psychiatrists are available through the specialty mental health facility.

#### Emergency Inpatient Evaluations

- Psychiatrists affiliated with the facility treating the Medi-Cal beneficiary render emergency inpatient and emergency room evaluations. Freestanding medical facilities that may not have access to psychiatric evaluations in emergency situations should contact any of the following resources:
  - The ACCESS Center at (800) 854-7771;
  - The PMRT at (800) 854-7771; or
  - The Local Police Department or 911

\*Please be aware that all consultations require a face-to-face clinical evaluation.

Listed below are the telephone numbers of the two health care plans, L.A. Care and Health Net, and their Plan Partners. Most Los Angeles County Medi-Cal beneficiaries are enrolled in L.A. Care or Health Net.

#### L.A. CARE AND L.A. CARE PLAN PARTNERS

<ul style="list-style-type: none"> <li>L.A. Care</li> </ul>	Medi-Cal Referral Information: (877) 431-2273 Fax: (213) 438-5777 Pharmacy Prior Authorization: (800) 788-2949
<ul style="list-style-type: none"> <li>Anthem Blue Cross</li> </ul>	Member Services: (888) 285-7801
<ul style="list-style-type: none"> <li>Community Health Plan</li> </ul>	Member Services: (800) 440-1561 Pharmacy Prior Authorization: (888) 256-6132
<ul style="list-style-type: none"> <li>Kaiser Permanente</li> </ul>	Member Services: (800) 464-4000
<ul style="list-style-type: none"> <li>Care 1<sup>st</sup></li> </ul>	Member Services: (800) 605-2556 Pharmacy Prior Authorization: (866) 712-2731 Questions Re: Prior Authorization: (877) 792-2731

#### HEALTH AND HEALTH NET PLAN PARTNERS

<ul style="list-style-type: none"> <li>Health Net</li> </ul>	Member Services: (800) 675-6100 Pharmacy Prior Authorization: (800) 867-6564 Prior Authorization Fax: (800) 977-8226 Caremark Pharmacy: (800) 600-0180
<ul style="list-style-type: none"> <li>Molina Medical</li> </ul>	Main number: (800) 526-8196 Ext. 127854 Fax: (866) 508-6445 Prior Authorization: (800) 526-8196 Ext. 126400 Fax: (800) 811-4804

**County of Los Angeles – Local Mental Health Plan  
MEDI-CAL MANAGED CARE PROGRAMS  
Physical and Mental Health Care Coordination – Exchange of Information Form**

**For Mental Health Referral Information Contact (800) 854-7771**

This form is to be utilized by physical health care providers when referring Los Angeles County Medi-Cal beneficiaries to Local Mental Health Plan (LMHP) providers or when requesting information on beneficiaries who are currently receiving services from a LMHP provider.

**BENEFICIARY INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Health Plan: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Medi-Cal #: \_\_\_\_\_ SSN: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** – Please check as appropriate:  INITIATING REFERRAL  REQUESTING CONSULTATION

If you are referring a beneficiary to a County of Los Angeles LMHP provider or would like mental health information on a beneficiary already being seen by an LMHP provider, please complete this portion of the form and the Consent for Release of Information.

- 1) Submit the form directly to the LMHP provider if you know the name of the provider; or
- 2) Give the form to the beneficiary to take to their LMHP provider, who will complete the bottom portion of the form and return the information to you; or
- 3) Contact the ACCESS Center at 1-800-854-7771 to assist you in obtaining a referral. Once an appointment has been established, you may mail or fax the form to the LMHP provider.

Primary Care Physician Name: \_\_\_\_\_ Medical Group: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Diagnosis(es): \_\_\_\_\_

Current Medication: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

**LOCAL MENTAL HEALTH PLAN PROVIDER – RESPONSE TO REQUEST FOR REFERRAL/CONSULTATION**

The Primary Care Physician (PCP) initiating this form is requesting a mental health evaluation and/or a consultation for the above named beneficiary. In an effort to ensure well-coordinated care between providers, please confirm your evaluation by completing this form and mailing or faxing to the PCP listed above. Please file this document in the clinical record for future reference. You must have a Consent for Release of Information form, signed by the beneficiary prior to submitting this information to the PCP.

Date of evaluation: \_\_\_\_\_ LMHP Provider Name (print): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

FAX: \_\_\_\_\_ Telephone: \_\_\_\_\_ Organizational Affiliation: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Psychotherapeutic Interventions: \_\_\_\_\_

Diagnosis(es): \_\_\_\_\_ Disposition: \_\_\_\_\_

Physician/Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Consultations require physician signature.)

County of Los Angeles – Local Mental Health Plan  
MEDI-CAL MANAGED CARE PROGRAMS

Attachment I-B

Physical and Mental Health Care Coordination – Exchange of Information Form

FOR LA CARE HEALTH PLAN MEDI-CAL REFERRAL INFORMATION contact (888) 452-2273  
FOR LA CARE HEALTH PLAN HEALTHY FAMILIES REFERRAL INFORMATION contact (888) 839-9909  
FOR HEALTH NET HEALTH PLAN REFERRAL INFORMATION contact (800) 675-6110

This form is to be utilized by Local Mental Health Plan (LMHP) providers when referring Los Angeles County Medi-Cal beneficiaries to physical health care providers or when requesting information on beneficiaries who are currently receiving services through L.A. Care or Health Net.

**BENEFICIARY INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Health Plan: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Medi-Cal #: \_\_\_\_\_ SSN: \_\_\_\_\_

**LMHP PROVIDER** – Please check as appropriate:  INITIATING REFERRAL  REQUESTING CONSULTATION

If you are referring a beneficiary to a County of Los Angeles Medi-Cal Managed Care Plan, either L.A. Care or Health Net, or would like physical health information on a beneficiary already being seen by a County of Los Angeles Medi-Cal Managed Care Health Plan provider, please complete this portion of this form and the Consent for Release of Information form.

- 1) Submit the form directly to the Medi-Cal Managed Care Health Plan PCP, if you know the name of the provider; or
- 2) Give the form to the beneficiary to take to their Primary Care Physician (PCP), who will complete the bottom portion and return the information to you; or
- 3) Determine which Medi-Cal Physical Health Care Plan the beneficiary is assigned to, contact the appropriate number listed at the top of this page to assist you in obtaining a referral. Once an appointment has been established, you may FAX the form to the PCP.

After the beneficiary has been evaluated, the PCP will submit confirmation of the evaluation by completing the lower half of this form and returning it to you. Please file in the clinical record for future reference.

LMHP Provider Name: \_\_\_\_\_ Organization Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Diagnosis(es): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Psychotherapeutic Interventions: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN (PCP) – RESPONSE TO REQUEST FOR REFERRAL/CONSULTATION**

The LMHP provider initiating this form is requesting a physical health evaluation and/or a consultation for the above named beneficiary. In an effort to ensure well-coordinated care between providers, please confirm your evaluation by completing this form and mailing or faxing to the LMHP provider listed above. Please file this document in the clinical record for future reference. **You must have a Consent for Release of Information form signed by the beneficiary prior to submitting this information to the LMHP provider.**

Date of evaluation: \_\_\_\_\_ PCP Name (print): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

FAX: \_\_\_\_\_ Telephone: \_\_\_\_\_ Organizational Affiliation: \_\_\_\_\_

Medication: \_\_\_\_\_

Diagnosis(es): \_\_\_\_\_ Disposition: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COUNTY OF LOS ANGELES  
LOCAL MENTAL HEALTH PLAN**

**CONSENT FOR PHYSICAL AND MENTAL HEALTH CARE COORDINATION  
FOR MEDI-CAL MANAGED CARE PROGRAM BENEFICIARIES**

\_\_\_\_\_  
Name of Beneficiary

\_\_\_\_\_  
Date of Birth

I consent to the sharing of information between the physical health and mental health care providers, named on the bottom of this consent, as is necessary for the purpose of coordination of my overall health care. I understand that all mental health records and information have special protection from release under California Welfare & Institutions Code 5328 and, once the stated purpose of the original release is fulfilled, the information may not be released further without my consent. Information specifically released between my physical health and mental health provider may cover:

- The information supplied at the bottom of this form by either party
- Other information regarding my physical health or mental health deemed relevant in the course of my care by either professional and discussed with me prior to the release.

This consent is effective the date of my signature below and remains in effect for one year. A new consent must be obtained each year by my physical and mental health providers who wish to exchange information. I have the option of revoking this consent at any time to the extent that action has not already been taken. I also understand that I have the right to receive a copy of this consent if requested.

The following is a summary record of information shared between my health and mental health care professionals.

Date Discussed With Beneficiary	Information Released	Date Released
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Copy of Consent received

_____ Signature of Beneficiary	_____ Date
_____ Signature of Responsible Adult*	_____ Date
_____ Signature of Witness	_____ Date

Consent Revoked

_____ Signature of Beneficiary or Responsible Adult*	_____ Date
---	---------------

\* Responsible Adult = Legal guardian or court appointed custodian, P.P.S. Conservator, or Parent of Minor unless DMH Form 521, CONSENT OF MINOR, has been completed.

# FAX COVER FOR TRANSMITTING PHI

## FAX DETAILS

Date Transmitted: \_\_\_\_\_ Time Transmitted: \_\_\_\_\_

Number of Pages (including cover sheet): \_\_\_\_\_

Intended Recipient: \_\_\_\_\_

### TO

### FROM

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Facility: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Documents being faxed:

Clinical Records

Other: \_\_\_\_\_

## CONFIDENTIALITY STATEMENT

This facsimile transmission may contain information that is privileged and confidential and is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use, or distribution of this information is strictly prohibited. In addition, there are federal, civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received this transmission in error, please notify the contact person listed below immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.

## VERIFICATION OF TRANSMISSION OF PHI

Please contact \_\_\_\_\_ at \_\_\_\_\_ to verify receipt of this Fax or to report problems with the transmission.



I verify the receiver of this Fax has confirmed its transmission:

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

## **SECTION XV – OVER-THRESHOLD AND INPATIENT PROFESSIONAL SERVICES**

### **UNDER-THRESHOLD SERVICES**

Under-threshold services are defined as eight services rendered by a psychiatrist and eight services rendered by a psychologist to clients in a four month trimester period. For clients under the age of 21, under-threshold services are eight services rendered by a psychiatrist and eight services rendered by any other network provider in a four month trimester period. A client meeting medical necessity criteria, as defined in this section, is authorized to receive these services without pre-authorization.

The Local Mental Health Plan (LMHP) defines the four month trimester period within which the eight services may be rendered as follows: January 1 – April 30, May 1 – August 31, and September 1 – December 31. At the beginning of each trimester period network providers may again provide eight under-threshold sessions without prior authorization.

Client visits to multiple providers will accumulate toward the total of eight threshold services. Network providers should determine if the client is currently receiving specialty mental health services from other network providers. If clients are currently receiving services, providers assume the financial risk that the client may have already received the maximum eight sessions. Network providers may contact the Provider Support Office at (213) 738-3311 for assistance in verifying whether a client has seen other network providers within a trimester period.

### **OVER-THRESHOLD SERVICES**

All services provided which exceed eight sessions per trimester period, as defined above, are considered over-threshold and require prior authorization from the Central Authorization Unit (CAU).

Over-threshold services may be authorized in increments of one to eight additional sessions of service within a trimester period in which the service falls above threshold limits. Services may be authorized for more than eight sessions, up to 12 sessions, if at least one individual session and at least one family therapy session is included in the treatment plan.

Note: Family therapy must be clearly documented and include family therapeutic interventions. Each member of the family in attendance must be documented in the record. Only one claim for the family session is to be submitted, regardless of the number of clients in attendance.

Services that are excluded from the threshold limit, and therefore do not require prior authorization, are:

- Professional services rendered in an acute psychiatric inpatient unit;
- Professional services rendered in a medical/surgical hospital unit;
- Emergency services;
- Medication support (procedure codes 90862 and M0064 only); and
- Psychological testing services.

## OBTAINING PRIOR AUTHORIZATION FOR OVER-THRESHOLD SERVICES

To obtain prior authorization for over-threshold services, the following criteria must be met:

- Over-threshold services will be authorized based upon continued medical necessity. To support medical necessity, the network provider must establish that the proposed treatment approach, additional visits requested, proposed time frame, and expected outcome are appropriate to the client's diagnosis and functional impairment.
- The client's condition, as stated in the documentation, must demonstrate the need for over-threshold specialty mental health services. The following list contains examples of conditions that might contribute to increased impairment without additional intervention:
  - ◆ Suicidality
  - ◆ Homicidality
  - ◆ Significant decompensation in functioning
  - ◆ Loss of placement
  - ◆ Significant change in living or social situation
  - ◆ Recent use of more costly/restrictive setting
  - ◆ Any other life change that leads to significant impairment in life functioning
- All supporting documentation should be complete, legible and include the *Client Plan/Over-Threshold Authorization Request* (OTAR) form (Attachment I), the progress notes from the current trimester period, and the initial assessment. The assessment need only be submitted with the first OTAR request, unless an updated assessment or addendum is necessary.
- If an OTAR form is returned to a provider for correction and/or additional information/documentation is required, the requested documents must be returned to the CAU within fourteen working days. If the documents are not returned within the time allotted, the over-threshold request will be administratively denied and a *Notice of Action* (NOA) form will be issued. (Refer to Section XVII: Notice of Action.)
- The "Service Request Begin Date" must be the anticipated ninth session, not the first date of the trimester period. The "Service Request End Date" must be the last day of the trimester period.
- In order to complete the request for over-threshold services, the network provider must enter the request for services on the County's claim processing information system. Providers will need their own unique logon ID and password to access this system.
- The CAU will review the documentation, and approve, deny or modify the request via The County's claim processing information system. The network provider will also be able to view the results of their request via the same system. Contact the CAU at (213) 738-2466 for assistance in using the system.
- If further sessions are required, an additional OTAR form must be submitted. The CAU will consider approval of a second OTAR in a trimester period only when the need for continued services is clearly documented.
- Over-threshold services authorized but not utilized by the network provider will not carry over to the next trimester period.
- When submitting an OTAR, the County's claim processing information system will generate an authorization number. Keep track of this number because you will need it to complete subsequent steps in the authorization process

## APPEAL PROCESS

When over-threshold requests are denied or modified, the network provider will be sent a Notice of Action (NOA-B and NOA-Back) within three days of the CAU decision. (Refer to Section XVII: Notice of Action.) The network provider may request an informal appeal of a denied or modified request within 15 days of receipt of the NOA-B by notifying the CAU by mail, telephone or fax. CAU will respond to the network provider and attempt to facilitate a resolution of the informal appeal within ten business days from the date the request was received.

If the informal appeal does not result in an amended decision, the network provider may submit a Level I *Formal Provider Appeal* form (Attachment II) to the CAU within 90 calendar days of the receipt of the NOA. The network provider is to submit the form along with documentation that supports the request for reconsideration. The documentation may include, but is not limited to:

- Clinical records supporting medical necessity;
- A summary of reasons why the services should be approved; and
- Name, address, email, telephone and fax numbers of the contact person.

The CAU will forward the documentation to the Clinical Management Review Committee (CMRC) for formal review within 24 hours of receipt. The CMRC is comprised of clinicians who had no involvement in the treatment or authorization of services for the client.

The CMRC will review the Level I Formal Provider Appeal and issue a written decision to the network provider within 30 calendar days of receipt of the appeal. The approval start date will coincide with the CMRC decision date.

Note: An expedited appeal may be requested when the network provider certifies that taking the time for a standard appeal resolution would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. A written decision will be issued to the provider no later than 3 working days after receipt of the appeal.

If the Level I Formal Provider Appeal does not result in an amended decision from the CMRC, the provider may file a Level II *Formal Provider Appeal* within 30 calendar days of notification of the Level I denial. The Level II Formal Provider Appeal shall be submitted with the following:

- A cover letter requesting a Level II appeal;
- A copy of the completed Level I *Formal Provider Appeal* form;
- The written Level I CMRC denial; and
- Any other supporting documentation.

The CAU will forward the Level II Formal Provider Appeal to the Office of the Medical Director within 24 hours of receipt of the documents. The decision made by the Medical Director is final. A written response will be sent from the Medical Director's office to the network provider within 30 calendar days of receipt of the appeal.

Mail or fax all appeal documents to:

Department of Mental Health  
Central Authorization Unit – Appeals Section  
550 S. Vermont Ave., Room 704B  
Los Angeles, CA 90020  
Fax: (213) 351-2024

## INPATIENT PROFESSIONAL SERVICES

Clients receiving acute psychiatric inpatient services must also be electronically enrolled in the IS. (Refer to Section V: Confirmation of Medi-Cal Eligibility and Electronic Medi-Cal Beneficiary Enrollment).

Reimbursement for inpatient professional services delivered in acute inpatient hospital settings (a psychiatric hospital or a mental health unit of a general acute care fee-for-service hospital) is linked to approved inpatient hospital days determined by State medical necessity criteria and Treatment Authorization Request (TAR) approval guidelines. Therefore, the claim submitted for inpatient professional services must include the TAR number and the name of the inpatient facility. The TAR number will be used to determine the number of approved hospital days eligible for reimbursement of inpatient professional services.

It is, therefore, imperative that the network provider be notified by the inpatient acute facility of DMH action on all TARs. The specific manner of communication between facility and network provider is to be established by each inpatient facility.

Inpatient professional services provided in a psychiatric hospital, a mental health unit of a general acute care hospital facility or a general medical/surgical hospital facility are excluded from the threshold limit, and therefore do not require prior authorization for services that exceed the threshold. A TAR is not required for inpatient professional services delivered in a general medical/surgical hospital unit.

In adult and child/adolescent residential care settings, including board and care and skilled nursing facilities, specialty mental health services are authorized in the same manner and under the same guidelines as when delivered in other outpatient settings.

Note: Inpatient professional services rendered in a Short-Doyle mental health unit of a psychiatric or general acute care hospital facility will **not** be reimbursed by the LMHP.

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH**  
**OFFICE OF THE MEDICAL DIRECTOR**  
**Medi-Cal Professional Services and Authorization Division**  
**CLIENT PLAN/**  
**OVER-THRESHOLD AUTHORIZATION REQUEST (OTAR)**

Desired outcome(s) as stated by:  Client and/or  Parent/Responsible Adult Initial Date of Service \_\_\_\_\_

Major Barriers/Impairments to attaining outcome(s): \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ Nomenclature: \_\_\_\_\_

Need for additional services and risk factors (Attach progress notes from current trimester period, most recent assessment if this is a first OTAR, and any other relevant documentation): \_\_\_\_\_

Check one or more of the following boxes and describe:

Severe life crisis: \_\_\_\_\_

Decompensation/marked decline in functioning: \_\_\_\_\_

Use of more costly/restrictive setting: \_\_\_\_\_

Other: \_\_\_\_\_

Goal(s) (must be specific, observable and quantifiable): \_\_\_\_\_ Date: \_\_\_\_\_

Intervention Plan for requested services (must be consistent with diagnosis and client goals):

Provider's Intervention Plan: \_\_\_\_\_

Client's Role: \_\_\_\_\_

Participation of Significant Other: \_\_\_\_\_

Not desired by client Medication Evaluation:  Yes  No Date: \_\_\_\_\_

Intervention Partner(s) (Note any other professionals currently providing services and their role(s)): \_\_\_\_\_

Progress toward goals since date of last client plan (OTAR): \_\_\_\_\_ Date: \_\_\_\_\_

**Service Request**

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Procedure Code: \_\_\_\_\_ No.: \_\_\_\_\_

Procedure Code: \_\_\_\_\_ No.: \_\_\_\_\_ Procedure Code: \_\_\_\_\_ No.: \_\_\_\_\_

**Signatures**

Client and/or Parent/Guardian/Responsible Adult Date \_\_\_\_\_ Significant Other or Minor \_\_\_\_\_

If client is unwilling/unable to sign, give reason \_\_\_\_\_

Provider's Signature and Discipline \_\_\_\_\_ Date \_\_\_\_\_

<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of client/authorized representative to whom it pertains unless otherwise permitted by law.</p>	<p><b>Client Name:</b> _____ <b>Birth date:</b> _____</p> <p><b>Medi-Cal #:</b> _____ <b>DMH Client ID #</b> _____</p> <p><b>Facility/Provider:</b> _____</p> <p><b>MC Provider #:</b> _____</p> <p><b>Los Angeles County – Department of Mental Health</b></p>
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**CLIENT PLAN / OVER-THRESHOLD AUTHORIZATION REQUEST (OTAR)**



## SECTION XVI – PSYCHOLOGICAL TESTING AUTHORIZATION

All psychological testing administered by network providers requires the completion of a *Psychological Testing Authorization Request* (PTAR) form (Attachment I) and prior authorization by the Central Authorization Unit (CAU). The Local Mental Health Plan (LMHP) will reimburse network providers only after psychological testing has been authorized and the psychological testing reports have been reviewed and approved for payment.

### GOALS OF THE PSYCHOLOGICAL TESTING AUTHORIZATION PROCESS

- Ensure the timely delivery of psychological testing to clients;
- Ensure the quality of psychological test reports by using standardized quality control procedures;
- Increase interdisciplinary access to psychological testing;
- Improve the process of determining the need for psychological evaluations;
- Facilitate access by clients to appropriate mental health services;
- Facilitate the coordinated delivery of mental health services between service providers; and
- Promote case consultation to improve mental health outcomes for clients.

### RESPONSIBILITIES OF THE CENTRAL AUTHORIZATION UNIT

- Authorize individual network providers to perform psychological testing for clients;
- Refer and facilitate service coordination between network providers, local community mental health centers, and protective services for clients requiring psychological testing;
- Consult, train and support network providers, community mental health centers and referral sources to establish and maintain practices relevant to psychological testing, assessment and service planning for clients; and
- Promote community wide practice guidelines and standards for psychological testing consistent with the California Board of Psychology.

### CRITERIA FOR APPROVAL OF PSYCHOLOGICAL TESTING

One of more of the following criteria must be met for approval of psychological testing:

1. There is a need to clarify the client's diagnosis in order to further the treatment process;
2. An intervention or multiple interventions have failed;
3. A non-verbal client must be assessed in the absence of historical data;
4. To evaluate the client's capacity for informed consent, to emancipate successfully, and/or to ascertain benefits for Supplemental Security Income (SSI);
5. There is an unaccountable decline in the client's functioning;
6. The client presents with an unusual or high-risk behavior;
7. The client presents with a risk of non-emergency harm to self or others that is denied by the client; or
8. Other special circumstances. The CAU does not authorize psychological testing for:
  - General assessments unrelated to psychological treatment;

- Learning disabilities;
- Mental retardation;
- Pre-adoption studies;
- General intelligence testing;
- Diagnosing Attention-Deficit/Hyperactivity Disorder (ADHD);
- Court ordered testing;
- Ruling out dementias or other neurologically-based disorders prior to a evaluation by an appropriate medical specialist; and
- Determining if medication is warranted.

## **GUIDELINES FOR REVIEW OF PSYCHOLOGICAL TESTING**

The CAU psychologists utilize the following guidelines in approving requests for psychological testing:

1. The PTAR form must include information that provides a compelling rationale for psychological testing;
2. The client must meet medical necessity criteria in order to be considered for psychological testing;
3. Psychological testing must be an adjunct to ongoing mental health treatment;
4. Children and adolescents seven years and older, have not been tested within the last two years;
5. Children six years and younger have not been tested within the last year;
6. Neuropsychological testing requires a referral from a physician;
7. Psychological testing is not to be performed during a crisis;
8. Psychological testing shall not be performed to make decisions as to whether the client is to be on medication;
9. Referral questions are specific, relevant and individualized to the client and the treatment plan;
10. The request for psychological testing must clearly demonstrate that testing is necessary at this time; and
11. All requests to test minors under the supervision of the Department of Children and Family Services (DCFS) should be initiated by the Children's Social Worker (CSW) using DCFS form 5005. The form is completed by the CSW and then faxed directly to the CAU. The 5005 form must also be signed by the CSW's Supervising Children's Social Worker (SCSW).

## OBTAINING AUTHORIZATION FOR PSYCHOLOGICAL TESTING

In order to submit a request for Psychological Testing, the provider must submit the PTAR via County's claims processing information system. The provider will need to use his/her unique login ID and password to access this system.

The CAU will review the PTAR, and approve or deny the request via the County's claims processing information system. The provider will be able to view the CAU response to their request via the same system.

The CAU will approve, conditionally approve, pend or deny PTARs. Only the CAU psychologists are authorized to select and assign testing to a network provider. However, the referring party may suggest a network provider.

The CAU psychologists consult with the referring source or the network provider within five working days of the request. Requests are pended, i.e. deferred, when further information is needed.

When testing is approved by the CAU, a *Psychological Testing Authorization Request – Response* (PTAR-R) form (Attachment II) is sent to the network provider. The PTAR-R is formal notification of the network provider accepting the case and agreeing to do the testing. The PTAR-R also gives the network provider the number of hours authorized for testing and the time frame for testing to be completed.

When psychological testing services are denied or modified the provider will be sent a *Notice of Action* form (NOA-B and NOA-Back) within three days of the decision. (Refer to Section XVII: Notice of Action.)

## APPEALS PROCESS

The referring party or provider may ask for reconsideration of a denied or modified request for psychological testing authorization and/or payment approval within 90 calendar days of the date of the notification. The request for reconsideration may be initiated through an informal appeal, Level I Formal Provider Appeal, or Level II Formal Provider Appeal.

The referring party/provider may initiate an informal appeal for denial or modification of psychological testing by contacting the CAU at (213) 738-2465 to request reconsideration of the decision. The CAU will reconsider the informal appeal and attempt to facilitate a resolution within five working days.

If the informal appeal does not result in an amended decision, the referring party/provider may submit a Level I *Formal Provider Appeal* within 90 calendar days of the initial notification of modification or denial of psychological testing. In addition to the completed *Formal Provider Appeal* form (Attachment III), the referring party/provider is to include clinical records supporting medical necessity and a summary of reasons why the request for psychological testing should have been approved.

A Level I Formal Provider Appeal may be initiated by submitting the completed *Formal Provider Appeal* form and supporting documentation to:

Department of Mental Health  
Central Authorization Unit – Appeals Section  
550 S. Vermont Ave., Room 703B  
Los Angeles CA 90020  
Fax: (213) 351-2023

The documentation will be forwarded to the Clinical Management Review Committee (CMRC), a multidisciplinary clinical committee established by the LMHP and authorized to review provider clinical appeals.

The CMRC issues a written decision to the referring party/provider within 30 calendar days of receipt of the Level I Formal Provider Appeal. If approval is based upon the same documentation submitted prior to the decision of the CAU, it will be retroactive to the date of the original request. If the approval is based upon additional documentation presented to CMRC, but not previously submitted to the CAU, the approval date will coincide with the CMRC decision date.

Note: An expedited appeal may be requested when the network provider certifies that taking the time for a standard appeal resolution would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. A written decision will be issued to the provider no later than 3 working days after receipt of the appeal.

If the Level I Formal Provider Appeal does not result in an amended decision from the CMRC, the referring party/provider may file a Level II Formal Provider Appeal to the LMHP Medical Director within 30 calendar days of notification of the Level I Appeal denial. The documentation is to be forwarded to the CAU. The Level II Appeal is to include a cover letter requesting a Level II Formal Provider Appeal, copies of the Level I *Formal Provider Appeal* form, the written Level I denial from the CMRC, and other relevant supporting documentation.

The written decision from the Medical Director will be sent to the referring party/provider within 30 calendar days of receipt of the appeal.

## **PSYCHOLOGICAL TESTING REPORT**

The network provider must send all completed psychological test reports to the CAU at:

Department of Mental Health  
Central Authorization Unit  
550 S. Vermont Ave., Room 703A  
Los Angeles, CA 90020  
Fax: (213) 351-2023

Reports must be completed in a timely manner as specified in the PTAR-R. This will generally be within six weeks of authorization unless otherwise approved. The CAU psychologists will perform a standardized review of the test reports to promote and ensure report quality acceptability. Within five working days, the CAU will notify the network provider whether reports have been approved for reimbursement. Only reports meeting quality standards will be approved for reimbursement.

The CAU psychologists may obtain consultation and/or peer review of selected reports from members of the psychological community. *The Quality Assurance: The Clinical Evaluation* form (Attachment IV) may be used to evaluate psychological test reports.

Note: Psychological testing reports submitted without prior authorization, completed in an untimely manner, or of substandard quality will not be approved for payment. Psychological test reports must be sent to the CAU as well as to the referring party.

All testing must be:

1. Per American Psychological Association (APA) guidelines;
2. Clinically adequate; and
3. Placed in the Medi-Cal beneficiary's clinical record.

### **QUALITY ASSURANCE PROCESS FOR PSYCHOLOGICAL TESTING REPORTS**

The CAU expects that network providers will comply with the Ethical Principles and Code of Conduct (June 2003) of the *American Psychological Association* (APA). Network providers who conduct psychological testing and prepare psychological test reports should be familiar with the *Standards for Educational and Psychological Testing* (1999) adopted by the APA, in particular, Chapter 12 *Psychological Testing and Assessment* [American Educational Research Association (1999) *Standard for Educational and Psychological Testing* Washington, DC: APA].

The CAU also expects that network providers who conduct psychological testing and prepare psychological test reports for minors who are dependents (WIC300) of the Juvenile Court, will be familiar with the *Guidelines For Psychological Evaluations In Child Protection Matters* (1998) approved by the Council of Representatives of the APA [American Psychological Association Committee on Professional Practice and Standards (1998). *Guidelines for Psychological Evaluations in Child Protection Matters* Washington, DC: APA].

For these reasons, the CAU expects that network providers will answer referral questions that are within the scope of practice for a licensed psychologist. Furthermore, the CAU expects network providers not to answer referral questions that are outside the particular field or fields of competence as established by his or her education, training and experience.

The CAU will not accept or recommend payment for psychological test reports that:

1. Do not answer or address the reason(s) for referral;
2. Do not make clear whether the client's test-taking behavior did or did not allow the psychologist to arrive at a valid assessment of the client's functioning;
3. Do not offer a coherent psychological explanation for the behavior(s) of the client and how best to treat the behavior(s);
4. Do not employ a norm-referenced measure of adaptive behavior to assess the role of a still active developmental delay in the client's Axis I diagnosis;
5. Do not use age-related norms to describe test behavior when such norms are available;
6. Do not include a norm-referenced measure of cognitive functioning without an explanation as to why the use of such a measure would not be in the best interests of the client;

7. Do not include appropriate measures of academic achievement when school-related placement decisions are part of the referral process;
8. Do not offer diagnoses consistent with ICD-9 CM Codes criteria, or, offer diagnoses that do not meet the definition of mental disorders found in the ICD-9 CM manual. This is especially relevant to the severe and incapacitating developmental/behavioral deficits typically associated with the criteria that define the diagnosis of “Other Specified Early Childhood Psychoses” in the manual;
9. Do not consider diagnoses other than Oppositional Defiant Disorder for minors under the age of three years, or reports that offer a diagnosis of Oppositional Defiant Disorder to minors between the ages of three and five years without using carefully documented, behaviorally-based, norm-referenced criteria;
10. Do not consider diagnoses other than Attention-Deficit /Hyperactivity Disorder for children under the age of three years, or reports that offer a diagnosis of Attention-Deficit/Hyperactivity Disorder to minors between the ages of three and five years without using carefully documented, behaviorally-based, norm-referenced criteria;
11. Do not offer new understandings about the functioning of the client beyond what could be achieved without the use of psychological tests;
12. Do not use the most recent edition of a specific test;
13. Do not offer a diagnosis of Mental Retardation using norm-referenced instruments that address ICD-9 CM Code criteria. (Significant sub average intellectual functioning, i.e., an IQ of 70 or below on an individually administered IQ test, and concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety); and
14. Does not report test results consistent with the administration of a full test battery, whether a development inventory, a measure of cognitive functioning, or other psychological measure.

## **COMMUNICATION TO NETWORK PROVIDERS CONCERNING QUALITY OF REPORTS**

The CAU will review all psychological test reports conducted by network providers on behalf of clients, including those that are not submitted to the LHMP for payment.

### **Informal Correction Phase**

On receiving a report considered unacceptable according to the *Quality Assurance: The Clinical Evaluation* form, the network provider will receive informal feedback from the professional staff of the CAU prior to any formal notice. This informal consultation, usually performed by telephone, is designed to explore those areas within the test report that need improvement and how best to accomplish the correction. A face-to-face conference with the network provider to review problem areas in more detail may also be suggested.

### **Formal Correction Phase**

This phase begins when the CAU receives another test report from a previously counseled network provider that is again below the standard of care. Step one of this three step process is a letter to the network provider that details the deficiencies in the test report and informs the network provider that, in the future, payment will not be authorized for reports that contain these problems.

Upon receipt of a second unacceptable report, the network provider again receives written notice of the report's deficiencies and that he/she will have 14 calendar days from receipt of the letter to

correct the report and return it to the CAU. Until a corrected report is received, the network provider may not be authorized to provide psychological testing service to clients.

The network provider will be sent written notice specifying the deficiencies, when the CAU does not receive a corrected report within 14 calendar days, receives a corrected report that remains unacceptable, or receives a third unacceptable report thereafter. At that time, the network provider will be referred to the LMHP's Credentialing Review Committee to evaluate his/her work with respect to quality of care. During this period, the network provider will not be authorized to provide psychological testing services to clients.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR  
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Client Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone No(s): \_\_\_\_\_

Social Worker's Name: \_\_\_\_\_ Contact No: \_\_\_\_\_

(Form 5005 is **required** if under DCFS supervision. Please fax directly to the Psychological Testing Authorization Unit)

Psychological Testing Referral by: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Primary Therapist/Physician: \_\_\_\_\_ Agency: \_\_\_\_\_

Prior Psychological Testing  No  Yes Date tested: \_\_\_\_\_ By Whom: \_\_\_\_\_

Specific referral questions:

Test referral questions must relate to psychological treatment. Attach additional pages if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

Select One  Assign to psychologist selected by Psychological Testing Authorization Unit  
 Name of psychologist suggested for testing: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- Please note:**
- The Psychological Testing Authorization Unit reserves the right to assign specific psychologists
  - Fax this request to 213-487-9658 or 213-351-2023. Please use HIPPA compliant faxing procedures.
  - This client should be tested only after written authorization from the Psychological Testing Authorization Unit

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**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)**

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
 OFFICE OF THE MEDICAL DIRECTOR  
 MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST RESPONSE (PTAR-RESPONSE)**

Date: \_\_\_\_\_

Medi-Cal status must be verified prior to performing psychological testing.

Request for Testing of:

Client Name: \_\_\_\_\_ DMH Client ID: \_\_\_\_\_ MEDS ID number: \_\_\_\_\_

Client Address: \_\_\_\_\_

Assigned Psychologist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

I agree to:

- 6) Test this beneficiary only after receiving written authorization;
- 7) Consult with beneficiary's therapist/DMH Case Manager prior to testing, and to provide documentation of the consultation in the psychological report;
- 8) Conduct a comprehensive psychological evaluation that includes: history, test behavior, mental status examination, along with individually administered measures of intelligence, achievement, neuropsychological screening, diagnosis, and personality;
- 9) Provide a report to the referring source that integrates current test results and prior test results, as well as directly answering the referral questions which are specific and unique to this beneficiary; and
- 10) Forward a copy of the test report to the Psychological Testing Authorization before a copy is given to the referring party.

Signature of Testing Psychologist: \_\_\_\_\_ Date: \_\_\_\_\_

**DMH USE ONLY BELOW THIS LINE**

**Psychological Testing Authorization**

- Testing request approved for \_\_\_\_\_ hours of psychological testing between \_\_\_\_ - \_\_\_\_ - \_\_\_\_ and \_\_\_\_ - \_\_\_\_ - \_\_\_\_
- (1 additional hour for scoring via computer service)

**Request Pending**

- Testing request pending (testing authorization withheld till the following conditions are met):
  - Receipt of Form 5005 *directly* from CSW with SCSW signature.
  - Receipt of permission to test from conservator.
  - Client must be examined by a medical specialist prior to psychological testing. Please inform this office when the exam has occurred.
  - Other \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

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**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST RESPONSE (PTAR-RESPONSE)**



**COUNTY LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
Psychological Testing Authorization Unit**

**Quality Assurance: The Clinical Evaluation**

Evaluator's Name: \_\_\_\_\_ Date of Eval: \_\_\_\_\_ Test Report? Y N

Reviewing Psychologist Name: \_\_\_\_\_ Date of Review: \_\_\_\_\_ Total Score \_\_\_\_\_

Beneficiary's Name: \_\_\_\_\_ Beneficiary's Age: \_\_\_\_\_

DIRECTIONS FOR THE REVIEWER: Circle the number that best describes the psychological report where "4" is high and "1" is low.

<b>REFERRAL QUESTIONS ARE SPECIFIC AND UNIQUE</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
---	----------	----------	----------	----------

- Specific referral questions are listed
- Referral questions are unique to this beneficiary

<b>REFERRAL QUESTIONS ARE SPECIFIC AND UNIQUE</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
---	----------	----------	----------	----------

- Methods are appropriate and sufficient to address the referral questions
- Conditions effecting the reliability and validity of the data are considered
- Quantitative procedures are appropriately scored and data presented in tabular form
- Diagnoses are documented, behaviorally-based, and consistent with DSM-IV-TR criteria

<b>DATA ARE APPROPRIATELY INTERPRETED</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
---	----------	----------	----------	----------

- Data address the referral questions
- Interpretations of data are empirically and logically sound
- Inconsistencies in the data are noted and discussed
- Alternative interpretations of the data are considered

<b>CONCLUSIONS INTEGRATE DATA FROM MULTIPLE SOURCES</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
---	----------	----------	----------	----------

- Arise from consistent patterns of data found throughout the evaluation
- Integrate data from all sources, e.g., history, significant others, observed behavior, self-report and quantitative measures
- Integrate beneficiary's cognitive, perceptual-motor, emotional and social-adaptive behavior
- Incorporate current behavioral science to generate a coherent psychological explanation of the beneficiary's behavior

**REPORT IS UNIQUE TO THIS BENEFICIARY**

**4 3 2 1**

- Is organized around the beneficiary, not around the tests
- Provides reader with a sense of the beneficiary as a whole person, a good “word-picture”
- Interprets data consistent with the beneficiary’s developmental level, ethnic and cultural background, and, unique needs and abilities
- Describes beneficiary’s unique inner world, motivation, needs, and, coping skills

**REPORT IS RESPECTFUL OF THE BENEFICIARY**

**4 3 2 1**

- Addresses beneficiary’s strengths as well as weaknesses; does not “pathologize” beneficiary
- Compares beneficiary’s behavior with that of others in a constructive way
- Is written in language that is easy to understand
- Protects privacy of beneficiary’s family

**RECOMMENDATIONS ARE CONSISTENT WITH THE FINDINGS**

**4 3 2 1**

- Address the referral questions
- Follow logically from conclusions
- Are consistent with behavioral science
- Are appropriately comprehensive

**RECOMMENDATIONS ARE USEFUL TO THE BENEFICIARY**

**4 3 2 1**

- Address the beneficiary’s unique needs
- Are practical and can be implemented given the beneficiary’s situation
- Are prioritized in terms of urgency
- Specify treatment/intervention resources

**A D D I T I O N A L C O M M E N T S**

## SECTION XVII– NOTICE OF ACTION

### WHAT IS A NOTICE OF ACTION

A Notice of Action (NOA) is a required written notice to a Medi-Cal beneficiary when the Local Mental Health Plan (LMHP) or a network provider takes an action which results in the modification, reduction, denial or termination of specialty mental health services. An NOA is also required if a covered specialty mental health service is not provided within the timeframe for delivery of the service. The NOA also informs the beneficiary of the right to appeal the action by requesting a State Hearing within 90 days after receipt of the NOA. There are five (5) types of NOA's described below. Providers are typically responsible for issuing the NOA-A and NOA-E. Copies of the various NOA's are included as attachments to this section. Translated versions of the NOA's for threshold languages are available through the DMH Patient's Rights Office at (213) 738-4949.

#### ***NOA-A (Attachment I)***

- An NOA-A is to be completed when a Medi-Cal beneficiary is denied specialty mental health services because the results of the assessment indicate the client does not meet medical necessity criteria.
- The network provider is to complete the NOA-A form within three working days of the decision, and send the original to the client along with the NOA-Back and the LMHP *Complaint and Grievance Procedures* pamphlet
- The network provider is to retain a copy of the NOA form in the beneficiary's record and send a copy to the LMHP at:

Department of Mental Health  
Patient's Rights Office  
550 S. Vermont Ave., 6th Floor  
Los Angeles, CA 90020

#### ***NOA-Back (Attachment II)***

- *The NOA Back informs the beneficiary of the right to appeal the action by requesting a State Hearing and includes information about requesting the hearing.*
- *All NOA's must include the NOA-Back.*

#### ***NOA-B (Attachment III)***

- An NOA-B is completed when:
  - Over-threshold services requested by a network provider are denied, modified, or reduced by the LMHP Central Authorization Unit (CAU);
  - Psychological testing services requested by a network provider are denied, modified, or reduced by the CAU; or when

- Specialty mental health services requested by an out-of-county provider, for a Los Angeles County Medi-Cal beneficiary residing outside of Los Angeles County, are denied, modified, or reduced by the CAU.
- The CAU completes the NOA-B form, sends the original with the NOA-Back to the beneficiary and sends a copy to the network provider. A copy is retained in the CAU record.

### ***NOA-C (Attachment IV)***

- An NOA-C is completed when a psychiatric inpatient provider is denied payment for a specialty mental health service that has already been provided because:
  - The Medi-Cal beneficiary did not meet medical necessity criteria for psychiatric inpatient hospital services;
  - The Medi-Cal beneficiary did not meet medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services;
    - The service provided is not covered by the LMHP; or
    - Additional information was requested from the psychiatric inpatient provider that was not submitted to the LMHP.
- The NOA-C is sent by the LMHP to the requesting psychiatric inpatient provider. A copy is sent to the Medi-Cal beneficiary and a copy is retained for the LMHP record.
- The Medi-Cal beneficiary will not have to pay for the service or services.

### ***NOA-D (Attachment V)***

- An NOA-D is completed when the LMHP does not process a beneficiary's grievance or appeal within the required time frame.
- The completed NOA-D form is sent to the beneficiary. A copy is retained for the LMHP record.

### ***NOA-E (Attachment VI)***

- An NOA-E is issued to the Medi-Cal beneficiary when the network provider or LMHP has not provided services timely, from the date of the initial service request.
- The completed NOA-E form is sent to the beneficiary. The network provider is to retain a copy of the NOA form in the beneficiary's record and send a copy to the LMHP at:

Department of Mental Health  
Patient's Rights Office  
550 S. Vermont Ave., 6th Floor  
Los Angeles, CA 90020

## THE BENEFICIARY GRIEVANCE AND APPEAL PROCESS

A beneficiary may file a grievance in writing or verbally when they are dissatisfied or unhappy about the services they are receiving or have any other concerns about the network provider or the LMHP. A grievance may not be filed for a problem covered by the appeal and State Fair Hearing processes.

An appeal is a request for review of a problem the beneficiary has with the LMHP or the network provider that involves a denial or changes to their mental health services. An appeal may be filed over the phone but must be followed-up with a signed written appeal.

Beneficiaries may contact the LMHP Patients' Rights Office at (213) 738-4949 for assistance in filing a grievance or appeal. Refer to Section VI for information on obtaining additional information on Grievance and Appeals Procedures and Beneficiary Grievance forms.

### **STATE FAIR HEARING**

A State Fair Hearing is an independent review conducted by the California Department of Social Services to resolve a beneficiary's dispute with the network provider or the LMHP. A State Fair Hearing may be filed only after the LMHP Grievance and/or Appeals process is completed by either contacting the Patients' Rights Office at (213) 738-4949 or the State at (800) 952-5253, or submitting the request in writing to:

State Hearings Division  
California Department of Social Services  
P.O. Box 944243, Mail Station 19-37  
Sacramento, CA 94244-2433  
Phone: (800) 952-5253

A Medi-Cal beneficiary may file an appeal or State Fair Hearing whether or not an NOA has been issued.

### **AID PAID PENDING**

Aid Paid Pending (APP) is the suspension of an agency's proposed action until a hearing and/or a decision is rendered. The network provider and the LMHP are required to provide APP to Medi-Cal beneficiaries who want to continue to receive mental health services while in the process of resolving their dispute through an Appeal or State Fair Hearing when the following criteria are met:

- The request for APP was filed 10 days from the date the NOA was mailed, 10 days from the date the NOA was personally given to the beneficiary, or before the effective date of the change, whichever is later;
- The beneficiary is receiving mental health services which do not require prior authorization; and
- The beneficiary is receiving mental health services under an existing service authorization which is being terminated, reduced or denied for renewal by the LMHP.

When the network provider or the LMHP receives a notice that the Medi-Cal beneficiary has requested an Appeal or State Fair Hearing, the network provider or the LMHP is responsible for determining if the hearing request involved APP. If the criteria specified above for APP are met, the network provider and the LMHP are required to provide the APP.

**Medi-Cal Specialty Mental Health Program  
NOTICE OF ACTION  
(Assessment)**

Date: \_\_\_\_\_

To: \_\_\_\_\_, Medi-Cal Number: \_\_\_\_\_

The mental health plan for Los Angeles County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

- Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section I 830.205(b)(1)).
- Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).
- The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section I 830.205(b)(3)(A) and (B)).
- Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at (800) 854-7771 or write to:

Patients' Rights Office, 550 S. Vermont Ave., Los Angeles CA 90020  
Attn: Beneficiary Services Program

**If you don't agree with the plan's decision, you may do one or more of the following:**

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at: (213) 738-4949 or write to:

Patients' Rights Office, 550 S. Vermont Ave., Los Angeles CA 90020  
Attn: Beneficiary Services Program

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (213) 738-4949 or write to:

Patients' Rights Office, 550 S. Vermont Ave., Los Angeles CA 90020  
Attn: Beneficiary Services Program

or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at  
or write to:

Patients' Rights Office, 550 S. Vermont Ave., Los Angeles CA 90020  
Attn: Beneficiary Services Program

**If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing.**

I certify that the Medi-Cal Beneficiary has received the Original Copy of this NOA-A, a copy of the NOA Back, and a copy of the Grievance and Appeal Procedures – A Consumer Guide. (LACDMH Medi-Cal Speciality Mental Health Service Provider Manual, 5<sup>th</sup> edition, February 2014, Section XVI)

Staff Signature \_\_\_\_\_

Print Staff Name \_\_\_\_\_

Date: \_\_\_\_\_

**YOUR HEARING RIGHTS**

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan’s appeal decision notice, OR
2. The day after the postmark date of this mental health plan’s appeal decision notice.

**Expedited State Hearings**

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the 1<sup>st</sup> box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearing Division.

**To Keep Your Same Services While You Wait for A Hearing**

- You must ask for a hearing within 10 days from the date the mental health plan’s appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will state the same until a final hearing decision is made which is adverse to you, you withdraw your request or a hearing, or the time period or service limits for your current services expire, whichever happens first.

**State Regulations Available**

State regulations, including those covering state hearings, are available at your local county welfare office.

**To Get Help**

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253  
If you are deaf and use TDD, call: 1-800-952-8349

**Authorized Representative**

You can represent yourself t the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

**Information Practices Act Notice (California Civil Code Section 1798, et. seq.)** The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Department of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

**HOW TO ASK FOR A STATE HEARING**

**The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:**

State Hearings Division  
California Department of Social Services  
P.O. Box 944243, Mail Station 19-37  
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

**HEARING REQUEST**

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of \_\_\_\_\_ County.

Check here if you want an expedited state hearing and include the reason below.

**Here’s why:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check here and add a page if you need more space.

**My name: (print)** \_\_\_\_\_

**My Social Security Number:** \_\_\_\_\_

**My Address: (print)** \_\_\_\_\_

**My phone number:** ( ) \_\_\_\_\_

**My signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I need an interpreter at no cost to me. My language or dialect is: \_\_\_\_\_

I want the person name below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number: \_\_\_\_\_

Medi-Cal Specialty Mental Health Service Program  
NOTICE OF ACTION

Date \_\_\_\_\_

To: \_\_\_\_\_ Medi-Cal Number \_\_\_\_\_

The mental health plan for \_\_\_\_\_ County has  denied  changed your provider's request for payment of the following service(s):

\_\_\_\_\_

The request was made by: (provider name) \_\_\_\_\_

The original request from your provider was dated \_\_\_\_\_

The mental health plan took this action based on information from your provider for the reason checked below:

- Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1830.205).
- Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): \_\_\_\_\_  
\_\_\_\_\_
- The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.
- The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: \_\_\_\_\_  
\_\_\_\_\_
- Other \_\_\_\_\_  
\_\_\_\_\_

**If you don't agree with the plan's decision, you may:**

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at \_\_\_\_\_ or write to: \_\_\_\_\_  
\_\_\_\_\_, or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period \_\_\_\_\_. The effective date for the change in these services is \_\_\_\_\_.
2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a state hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period \_\_\_\_\_. The effective date for the change in these services is \_\_\_\_\_. The services may continue while you wait for a resolution of your hearing.
3. You may ask the plan to arrange for a second opinion about mental health condition. To do this, you may call and talk to a representative of our mental health plan at \_\_\_\_\_ or write to: \_\_\_\_\_

**Medi-Cal Specialty Mental Health Services Program  
NOTICE OF ACTION  
(Post-Service Denial of Payment)**

Date: \_\_\_\_\_

To: \_\_\_\_\_, Medi-Cal Number \_\_\_\_\_

The mental health plan for \_\_\_\_\_ County has  denied  changed your provider's request for payment of the following service(s):

\_\_\_\_\_

The request was made by: (provider name) \_\_\_\_\_

The original request from your provider was dated \_\_\_\_\_ and your provider says that you received the service on the following date or dates: \_\_\_\_\_

**THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.**

The mental health plan took this action based on information from your provider for the reason checked below:

- Your mental health condition as described to us by your provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).
- Your mental health condition as described to us by your provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital service for the following reason (Title 9, CCR, Section 1830.205): \_\_\_\_\_
- \_\_\_\_\_
- The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- The mental health plan requested additional information from your provider that the plan needs to approve payment of the service you received. To date, the information has not been received.
- Other \_\_\_\_\_
- \_\_\_\_\_

**If you don't agree with the plan's decision, you may:**

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at \_\_\_\_\_ or write to: \_\_\_\_\_

\_\_\_\_\_ or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice

**If you are unhappy with the outcome of your appeal, you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.**

**Medi-Cal Specialty Mental Health Services Program  
NOTICE OF ACTION  
(Delays in Grievance/Appeal Processing)**

Date: \_\_\_\_\_

To: \_\_\_\_\_, Medi-Cal Number: \_\_\_\_\_

The mental health plan for \_\_\_\_\_ County has not processed your:

grievance       appeal       expedited appeal on time.

Our records show you made your request on:

\_\_\_\_\_

You requested that \_\_\_\_\_

\_\_\_\_\_

We are sorry for the delay in answering your request. We will continue to work on your request and hope to provide you with a decision soon.

**If your request was about the denial of or a change in the mental health services you receive from the mental health plan and you do not want to wait for our decision, you may request a state hearing to consider the denial or change. You may also ask that the state hearing consider the reason for the delay.**

If your request was about another issue, you may request a state hearing to consider the reason for the delay. The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulation, Part 438, Subpart F.

**Medi-Cal Specialty Mental Health Services Program  
NOTICE OF ACTION  
(Lack of Timely Service)**

Date: \_\_\_\_\_

To: \_\_\_\_\_, Medi-Cal Number \_\_\_\_\_

**The mental health plan for \_\_\_\_\_ County has not provided services within \_\_\_\_\_ working days of the date of the initial service request.**

Our records show that you requested services, or services were requested on your behalf on \_\_\_\_\_

The following services were requested by you or on your behalf:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We are sorry for the delay in providing timely services. We are working on your request and hope to provide you with the requested service(s) soon.

**You may request a state hearing to consider the reason for the delay.**

The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

- I certify that the Medi-Cal Beneficiary has received the Original Copy of this NOA-E, a copy of the NOA Back, and a copy of the Grievance and Appeal Procedures – A Consumer Guide. (LACDMH Medi-Cal Specialty Mental Health Services Provider Manual, 5<sup>th</sup> edition, February 2014, Section XVI).
- I certify that a copy of this NOA-E was sent/faxed to the LACDMH Patients’ Office (213) 365-2481.

Staff Signature: \_\_\_\_\_

Print Staff Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SECTION XVIII – MEDICATION, PHARMACY, LABORATORY AND MEDICARE PART D

### DRUG FORMULARIES

Many Medi-Cal beneficiaries have their physical health care needs met by one of the participating plan partners of L.A. Care or Health Net while other Medi-Cal beneficiaries receive their physical care directly through other physical health care providers.

If a Medi-Cal beneficiary is enrolled in a plan partner of L.A. Care or Health Net, medications are handled in one of two ways. Carved out medications, specifically psychotropic medications and mainly anti-psychotic and anti-manic medications are paid by the California Department of Health Care Services. All medications not specifically carved out, including psychotropic medications, are the responsibility of the plan partners of L.A. Care and Health Net.

The California Department of Health Care Services (DHCS) is responsible for all medications for Medi-Cal beneficiaries who are not enrolled in a participating plan partner of L.A. Care or Health Net.

The DHCS Drug Formulary and the drug formularies of the participating plan partners of L.A. Care and Health Net are available online.

The DHCS Drug Formulary is located at the following website:

1. <http://www.dhs.ca.gov>
2. Select "Department of Health Care Services."
3. On the left column under "Quick Links" select "A-Z Index."
4. Scroll down to "Formulary/List of Contract Drugs, Medi-Cal."

The formularies of the plan partners of L.A. Care and Health Net are located at the following website:

1. [http://dmh.lacounty.gov/Exec\\_Team.asp](http://dmh.lacounty.gov/Exec_Team.asp)
2. Under "Medical Director", select "OMD Website."
3. Scroll down to the section titled "Pharmacy."
4. Select "A Link to Health Plan Formularies." This replaces the former DMH Multi-Plan Formulary List

The "A Link to Health Plan Formularies" website contains information on drug formularies for the State of California only and will allow network providers to:

1. Search formularies based on the drug name. Upon entering the drug name, this website will provide a listing and classification of the drug coverage for each formulary in the State of California.
2. Determine carve out drugs. These are the responsibility of the California Department of Health Care Services Fee-for-Service Medi-Cal program. Carve out drugs will be reimbursed by any pharmacy which accepts Medi-Cal as payment for medications.

3. Determine non-carve out drugs. For Medi-Cal beneficiaries enrolled in a Medi-Cal physical health care plan, select medications on the formularies of the various plan partners of L.A. Care or Health Net. The procedures will show the medication selected and which plan partner will reimburse for those drugs. You may use only those medications indicated for the plan partner to which the Medi-Cal beneficiary belongs. Remember, for non-carve out drugs, clients must use the pharmacies designated by the plan partner.

Attachment I is a quick reference guide to obtain the authorization phone numbers of the participating plan partners of L.A. Care and Health Net

## **LINK TO MEDICATION INFORMATION**

Information on medications is located at the following website:

1. [http://dmh.lacounty.gov/Exec\\_Team.asp](http://dmh.lacounty.gov/Exec_Team.asp)
2. Under "Medical Director", select "OMD Website."
3. Scroll down to the section titled "Pharmacy."
4. Enter a medication next to "Drug Lookup."
5. The information will be displayed on the screen.

## **LOCAL MENTAL HEALTH PLAN CONTRACTED PHARMACIES**

Pharmacies contracted with the Local Mental Health Plan that accept Medi-Cal are located at the following website:

1. <http://dmh.lacounty.gov>
2. Select "Provider Tools."
3. Select "Pharmacy."
4. Click on link under "Pharmacy List."
5. The information will be displayed alphabetically.

Note: Prescriptions will be filled by any pharmacy that accepts Medi-Cal payment.

## **LABORATORY**

All laboratory services are included as part of the pre-paid health plan benefit and therefore, Medi-Cal beneficiaries should be directed to a laboratory contracted with their Medi-Cal health plan. Network providers can continue to direct Medi-Cal beneficiaries to laboratory services that accept Medi-Cal.

## **MEDICARE PART D**

The Medicare Part D drug benefit, which was effective January 1, 2006, offers voluntary coverage of outpatient Prescription Drug Plans (PDPs) and Medicare Advantage (MA) drug plans. Individuals dually eligible for both Medicare and Medi-Cal are required to enroll in

Medicare Part D. Dually eligible beneficiaries formally called Medi-Medi, who did not enroll on their own prior to December 31, 2005, were “auto-enrolled” in a drug plan.

Dually eligible beneficiaries were also “auto-enrolled” into the “Extra Help” Low Income Subsidy (LIS) to help offset the costs of the new prescription drug plans. Applications can be obtained at any Social Security Office, completed online at the following website address: [www.ssa.gov](http://www.ssa.gov) or mailed upon request by calling the Social Security Administration at (800) 772-1213. The applications are also available at any County of Los Angeles Department of Public Social Services office, or by calling (877) 481-1044.

The most important change for dually eligible beneficiaries is that they began receiving their prescription drug coverage through Medicare, not Medi-Cal. To obtain access to drug coverage they must be enrolled in a PDP or MA-PD. As a network provider, it is beneficial to know what plan your client is enrolled in to determine which prescribed medications are covered by their health plan. Dually eligible beneficiaries or the network provider should also contact the pharmacy of choice to determine if the pharmacy is enrolled in the client’s health plan.

For more information:

1. Visit [www.medicare.gov](http://www.medicare.gov) or call (800) MEDICARE (633-4227) for:
  - Medicare prescription drug coverage information;
  - Plan choices under Medicare, including Medicare Advantage Plans;
  - Plan formularies, requirements including required drugs and excluded drugs; and
  - To order Medicare publications
2. Contact the following advocacy resources:
  - [www.healthconsumer.org](http://www.healthconsumer.org)
  - [www.cahealthadvocates.org](http://www.cahealthadvocates.org)
  - [www.calmedicare.org](http://www.calmedicare.org)
  - [www.wclp.org](http://www.wclp.org)
  - [www.healthlaw.org](http://www.healthlaw.org)
  - [www.nscic.org](http://www.nscic.org)
3. Contact the State Health Insurance Assistance Program for California at (800) 434-0222.

You may contact Pharmacy Services at (213) 738-4725 for questions or assistance with any information provided in this section.

Listed below are the telephone numbers of the two health care plans: L.A. Care and Health Net and their Plan Partners. Most Los Angeles County Medi-Cal beneficiaries are enrolled in L.A. Care or Health Net.

#### L.A. CARE AND L.A. CARE PLAN PARTNERS

<ul style="list-style-type: none"> <li>L.A. Care</li> </ul>	Medi-Cal Referral Information: (877) 431-2273 Fax: (213) 438-5777 Pharmacy Prior Authorization: (800) 788-2949
<ul style="list-style-type: none"> <li>Anthem Blue Cross</li> </ul>	Member Services: (888) 285-7801
<ul style="list-style-type: none"> <li>Community Health Plan</li> </ul>	Member Services: (800) 440-1561 TTY: (866) 816-2479 Pharmacy Prior Authorization: (888) 256-6132
<ul style="list-style-type: none"> <li>Kaiser Permanente</li> </ul>	Member Services: (800) 464-4000
<ul style="list-style-type: none"> <li>Care 1<sup>st</sup></li> </ul>	Member Services: (800) 605-2556 Pharmacy Prior Authorization: (866) 712-2731 Questions Re: Prior Authorization: (877) 792-2731

#### HEALTH AND HEALTH NET PLAN PARTNERS

<ul style="list-style-type: none"> <li>Health Net</li> </ul>	Member Services: (800) 675-6100 Pharmacy Prior Authorization: (800) 867-6564 Prior Authorization Fax: (800) 977-8226 Caremark Pharmacy: (800) 600-0180
<ul style="list-style-type: none"> <li>Molina Medical</li> </ul>	Main number: (800) 526-8196 Ext. 127854 Fax: (866) 508-6445 Prior Authorization: (800) 526-8196 Ext. 126400 Fax: (800) 811-4804

## SECTION XIX: MEDICAL TRANSPORTATION SERVICES

All requests for client transportation services, such as ambulances or medical vans, are processed through the ACCESS Center at (800) 854-7771. No payment for transportation services will be reimbursed without authorization from the Access Center.

In a psychiatric emergency, transportation services can only be requested by appropriate LMHP administrative, clinical or contractor staff who have been certified by the LMHP to evaluate clients in psychiatric emergencies and prepare involuntary holds pursuant to Welfare and Institutions Code Sections 5150 and 5585. The ACCESS Center will authorize and activate evaluation services for hospitalization in the event of an emergency.

The LMHP is not responsible for providing, arranging or payment for transportation services, except when the purpose of the medical transportation service is to transport a Medi-Cal beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of twenty-four hour care facility because the services in the facility to which the Medi-Cal beneficiary is being transported will result in lower costs to the LMHP.

### TRANSPORTATION AUTHORIZATION FOR MEDI-CAL BENEFICIARIES ENROLLED IN PRE-PAID HEALTH PLANS

Transportation authorization or reimbursement services for Medi-Cal beneficiaries who are members of a Plan Partner of LA Care or Health Net are the responsibility of the Plan Partner. A client must be Medi-Cal eligible on the date of service in order to receive reimbursement.

For information concerning transportation for LA Care and Health Net enrollees please contact the following Plan Partners:

#### LA Care Plan Partners

Anthem Blue Cross	(888) 285-7801
Community Health Plan (CHP)	(800) 440-1561
Care 1 <sup>st</sup>	(800) 605-2556
Kaiser Permanente	(800) 464-4000

#### Health Net Plan Partners

Molina Medical	(800) 526-8196
----------------	----------------

### TRANSPORTATION AUTHORIZATION FOR MEDI-CAL BENEFICIARIES NOT ENROLLED IN PRE-PAID HEALTH PLANS

Transportation reimbursement for Medi-Cal beneficiaries, who are not enrolled in an LA Care or Health Net Plan Partner, is provided by the California Department of Health Care Services (DHCS). Medi-Cal covers ambulance and other medical transportation only when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private transportation is medically contraindicated and medical transportation is required for obtaining needed medical care. A client must be Medi-Cal eligible on the date of service in order to receive reimbursement.

To obtain information about the regulations governing DHCS Fee-for-Service Medi-Cal transportation services for Medi-Cal beneficiaries not enrolled in an LA Care or Health Net Plan

Partner, go to the Medi-Cal website address at: [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov). Select “Provider Manuals” in the right column. Under “Allied Health” Select “Medical Transportation”. Scroll down to the “Medical Transportation” link of interest.

For information concerning transportation claims contact the Medi-Cal Telephone Service Center at (800) 541-5555.

### **CLIENTS WITHOUT MEDI-CAL/INDIGENT CLIENTS**

The ACCESS Center is responsible for all transportation services provided to indigent clients. No client will be transported unless evaluated by authorized staff of the LMHP.

### **CLIENTS WHO MUST BE RETURNED TO COUNTY OF RESIDENCE**

The ACCESS Center will arrange transportation for psychiatric clients from surrounding jurisdictions who must be returned to their county of residence for treatment or other reasons deemed appropriate by the ACCESS Center. Call the ACCESS Center at (800) 854-7771 for consultation and authorization for ambulance services in these situations.

## SECTION XX – OUT-OF-COUNTY SERVICES

Out-of-county services are services provided to a Los Angeles County Medi-Cal beneficiary outside the geographic boundaries of Los Angeles County by a provider who is not contracted with the Local Mental Health Plan (LMHP).

It is the policy of the LMHP to ensure timely and effective clinical treatment regardless of a Medi-Cal beneficiary's county of residence. Only licensed specialty mental health providers who have met the requirements established by the LMHP will be reimbursed for specialty mental health services provided to Los Angeles County Medi-Cal beneficiaries outside the geographical boundaries of Los Angeles County.

Emergency, crisis and urgent care specialty mental health services may be provided to a Los Angeles County Medi-Cal beneficiary outside the geographic boundaries of Los Angeles County by an out-of-county Medi-Cal provider without prior authorization from the LMHP.

### AUTHORIZATION OF ROUTINE SERVICES

#### CHILDREN AND ADOLESCENTS

Out-of-county providers, not contracted with the LMHP, who wish to provide routine specialty mental health services to Los Angeles County Medi-Cal beneficiaries, under 20 years of age, who are placed in a foster home, kinship care, or group home care in another county, are required to enroll in Value Options, a managed care organization contracted with the LMHP and many other California counties. Contact Value Options at (800) 236-0756 to obtain information regarding provider enrollment, registration of Medi-Cal beneficiaries, authorization, claiming, and reimbursement.

For any other out-of-county services to children less than 18 years of age, contact the LMHP Children's System of Care at (213) 739-2339.

#### ADULTS

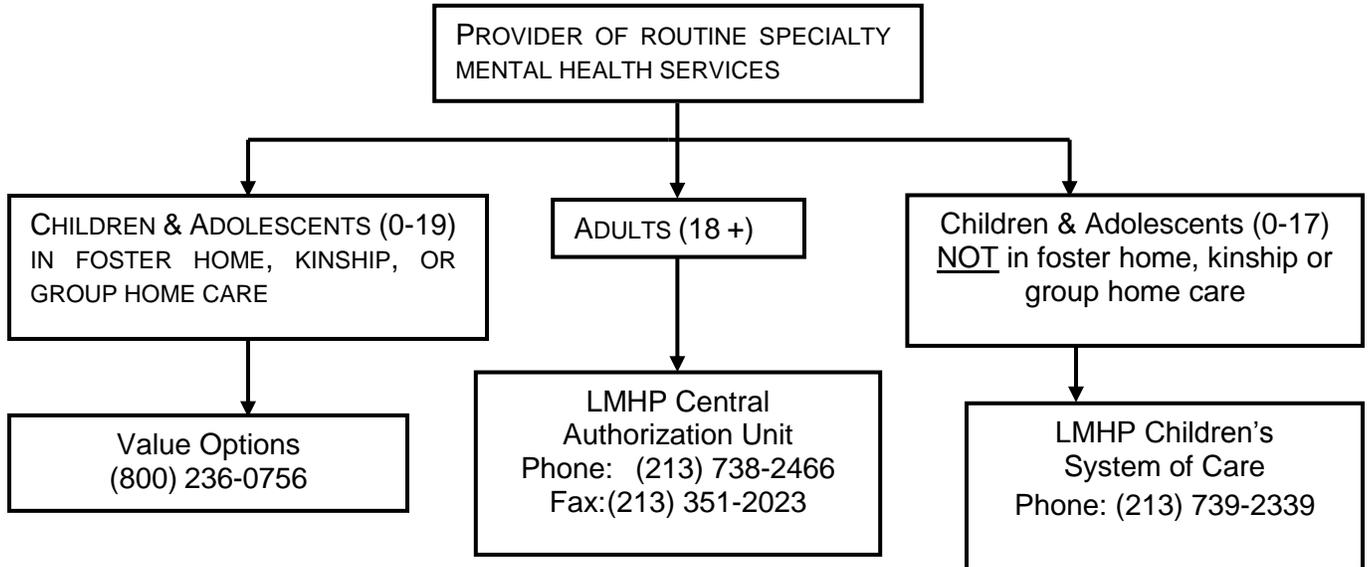
Out-of-county routine services to Los Angeles County Medi-Cal beneficiaries, 18 years of age and older, are subject to the authorization requirements of the LMHP Central Authorization Unit (CAU). Pre-authorization is required **before** the service is delivered in order for a provider to receive reimbursement. The CAU can be reached by calling (213) 738-2466 or by faxing to (213) 351-2023.

### SERVICES PROVIDED TO OUT OF COUNTY MEDI-CAL BENEFICIARIES WITHIN LOS ANGELES COUNTY

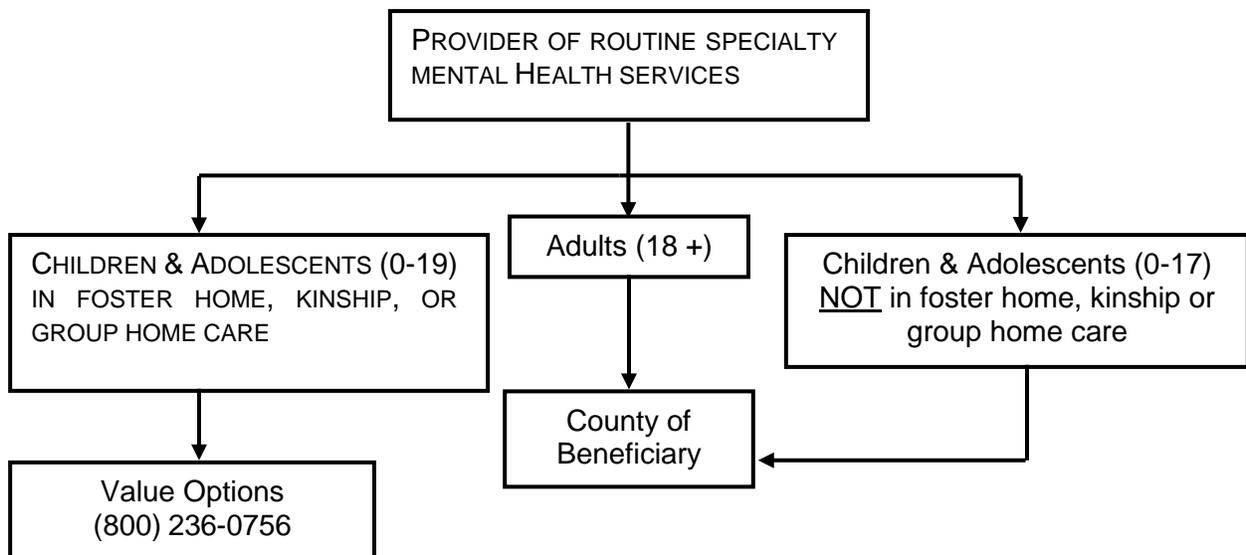
All Medi-Cal beneficiaries will receive emergency, crisis and urgent specialty mental health services regardless of their county of residence. LMHP network providers are to contact either Value Options at (800) 236-0756 or the respective county of the Medi-Cal beneficiary to receive authorization for routine mental health services for children and adolescents who are not Los Angeles County beneficiaries. LMHP network providers are to contact the respective county of the Medi-Cal beneficiary for authorization to provide routine mental health service to adult Medi-Cal beneficiaries.

**FIGURE C: OUT-OF-COUNTY FLOW CHART**

**LOS ANGELES COUNTY MEDI-CAL BENEFICIARY  
/OUT-OF-COUNTY PROVIDER**



**OUT-OF-COUNTY BENEFICIARY/LMHP  
NETWORK PROVIDER**



## **GLOSSARY OF TERMS**

Appeal	A request by a beneficiary or a beneficiary's representative for review of any action.
Access Center	Operates 24 hours/day, 7 days/week as the entry point for mental health services in Los Angeles County. Services include deployment of crisis evaluations teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services and patient transport.
Advance Directive	Legal documents or statements, including a living will, which are witnessed and allow an individual to convey in expressed instructions or desires concerning any aspect of an individual's health care, such as the designation of a health care surrogate, the making of an anatomical gift, or decisions about end-of-life care ahead of time. An Advance Directive provides a way for an individual to communicate wishes to family, friends and health care professionals, and to avoid confusion about end-of-life care ahead of time.
Annual Liability	Also known as UMDAP liability, is based on a sliding scale fee and applies to services extended to the client and dependent family members.
Assessment	A service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status, determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
Assessment	A professional review and evaluation of an individual's mental health needs and conditions, in order to determine the most appropriate course of treatment, if indicated, and may ascertain eligibility for specific entitlement or mandated programs
Beneficiary	Any person certified as eligible under the Medi-Cal program.
Board of Supervisors (BOS)	Los Angeles County Board of Supervisors that oversee all county departments, including LACDMH. This Board is an elected body.
Border Community	A community located outside of the State of California that is not considered to be out of state for the purpose of excluding coverage by the MHP's because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.
California Institute for Mental Health (CIMH)	The mission of CIMH is to promote excellence in mental health services through training, technical assistance, research, and policy development
California Mental Health Director's	CMHDA provides assistance, information, training, and

Association (CMHDA)	advocacy to the public mental health agencies that are its members. The mission of the Association is to provide leadership, advocacy, expertise and support to California's county and city mental health programs (and their system partners) that will assist them in serving persons with serious mental illness and serious emotional disturbance.
Centers for Medicare and Medicaid Services (CMS)	US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.
Central Authorization Unit	A unit of the Managed Care Division in the DMH office of the Medical Director that conducts monitoring and authorization of services. Specific service authorizations include Over Threshold Authorization, psychological testing, day treatment and requests for authorization of out-of-county services.
Collateral	A service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.
Co-Occurring Disorders (COD)	Two disorders occurring to one individual simultaneously. Clients said to have COD have more than one mental, developmental, or substance-related disorder, or a combination of such disorders. COD exists when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.
Co-occurring/Comorbidity	The existence of two or more illnesses – whether physical or mental – at the same time in a single individual
Coordination of Benefits	A process for determining the respective responsibilities and priority order of two or more insuring entities that have some financial responsibility for a medical claim.
Crisis Intervention	A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements.
Crisis Stabilization	A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely

	<p>response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site and staffing requirements.</p>
Cultural Competence	<p>A set of congruent practice skills, behaviors, attitudes and policies in a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross cultural situations.</p>
Cultural Competency	<p>The practice of continuous self-assessment and community awareness by service providers to ensure a focus on the specific needs regarding linguistic, socioeconomic, educational, spiritual and ethnic experiences of consumers and their families/support systems relative to their care.</p>
Day Rehabilitation	<p>A structure program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.</p>
Day Treatment Intensive	<p>A structure, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.</p>
Day Treatment Rehabilitation	<p>A structured program of therapeutic services and activities, in the context of a therapeutic milieu, designed to improve, maintain and restore personal independence and functioning consistent with age-appropriate learning and development. It provides services to a distinct group of clients. Day Rehabilitation is a packaged program with services available at least three (3) hours and less than twenty-four (24) hours each day the program is open. In Los Angeles County these services must be authorized by the Central Authorization Unit.</p>
Department of Health Care Services	<p>State Department of Health Care services that includes Mental Health component</p>
Dual Diagnosis	<p>Occurs when an individual has two separate but interrelated diagnoses of a mental illness and a chemical dependency.</p>

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Mental Health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age, that have been determined by the State Department of Health Services.
Early Intervention	Diagnosing and treating mental illnesses early in their development.
Electronic Data Interchange (EDI)	A set of standards for structuring information to be electronically exchanged between and within businesses, organizations, government entities and other groups.
Evidence-based Practices (EBP)	Practices that have quantitative and qualitative data showing positive outcomes. These practices have been subject to expert/peer review that has determined that a particular approach or program has a significant level of evidence of effectiveness in public health research literature.
Expedited Appeal	An appeal to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.
Expedited Fair Hearing	
Fair Hearing	The State hearing provided to beneficiaries
Federal Financial Participation (FFP)	Federal matching funds available to services provided to Medi-Cal beneficiaries under the Medi-Cal program
Fee-For-Service/Medi-Cal Hospital	A hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the fiscal intermediary
Full-time equivalent (FTE)	A way to measure a worker's completed weekly hours. An FTE of 1.0 means that the person is equivalent to a full-time worker (40 hours/ week), while an FTE of 0.5 signals that the worker is only half-time (20 hours/week)
Grievance	An expression of dissatisfaction by a beneficiary/client.
Group Provider	An organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics
Health Insurance Portability and Accountability Act (HIPAA)	HIPAA defines numerous offenses relating to health care and sets civil and criminal penalties for them. It also creates several programs to control fraud and abuse within the health care system.
HIPAA Final Security Rules	Rules dealing specifically with electronic protected health information, which lay out three types of security safeguards required for compliance: administrative, physical, and technical.

Hospital	An institution that has been certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services. Hospital includes general acute care hospitals of the Health and Safety Code, and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.
Individual Provider	Licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.
Intake Period	Initial clinical evaluations must be completed within 60 days of intake for a new admission (no open episodes), or within 30 days when the client is being opened to a new service but has other open episodes.
Intervention	The act of intervening, interfering or interceding with the intent of modifying the outcome. In health and mental health, an intervention is usually undertaken to help treat or cure a condition.
Licensed Mental Health Professional	Licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.
Managed Care	The organized system for delivering comprehensive mental health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment.
Medi-Cal Managed Care Plan	An entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries.
Medicare Fiscal Intermediary	Private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the administration of claims payment.
Medication Support Services	Services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and

	collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
Megan's law	California's Megan's Law provides the public with certain information on the whereabouts of sex offenders so that members of local communities may protect themselves and their children.
Memorandum of Understanding (MOU)	A written agreement between mental health plans and Medi-Cal managed care plans describing their responsibilities in the delivery of specialty mental health services to beneficiaries who are served by both parties.
Mental Health Plan (MHP)	An entity that enters into a contract with the Department to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.
Mental Health Services	Individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
MHP of Beneficiary	The MHP responsible for providing or arranging and paying for specialty mental health services for a beneficiary. The responsible MHP is the MHP serving the county that corresponds to the beneficiary's county of responsibility code as listed in the Medi-Cal Eligibility Data System (MEDS), unless another MHP is determined responsible.
MHP Payment Authorization	The written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary.
National Provider Identifier (NPI)	A unique, ten-digit numeric identifier assigned to covered health care providers by the National Plan and Provider Enumeration System. This identifying number does not carry any information about health care providers, such as the state in which they practice or their provider type or specialization. The intent of the NPI is to improve the efficiency and effectiveness of electronic transmission by allowing providers and business entities to submit the same identification number(s) to all payers, such as insurance plans, clearinghouses, systems vendors, and billing services.
Notice of Action (NOA)	A written notice from the MHP to a beneficiary when an MHP takes an action or when an MHP or its providers

	take an action.
Office of the Medical Director (OMD)	A division of DMH that has Department wide professional responsibility for the design, implementation, and quality management of clinical services.
Onset	The beginning of a serious psychiatric illness that can be diagnosed by the DSM IV. In this respect, onset can include the onset of depression in an older adult or a new mother experiencing the onset of post-partum depression. Onset can apply to any psychiatric illness. Individuals may experience onset of a serious psychiatric illness a number of times.
Outreach & Engagement (O&E)	A component within the Mental Health Services Act (MHSA), which aims to inform the public about MHSA, gather community input, and integrate feedback into the planning process. O&E activities focus on organizing the wide diversity of backgrounds and perspectives represented within the county, with a special emphasis on underserved and unserved populations. It seeks to facilitate the creation of an infrastructure that supports partnerships with historically
Patient's Rights Office	The Patients' Rights Office of the Los Angeles County Department of Mental Health was created in response to legislation requiring each county mental health director to appoint a patients' rights advocate(s) to protect and further the Constitutional and statutory rights of mental health care recipients. Some of the duties of this office include; investigation of complaints, representation of patients at certification review and medication capacity hearings, beneficiary services program, residential care advocacy, minors' rights program, jail advocacy program, LPS designation functions, training and consultation, monitoring Electroconvulsive treatment (ECT), data collection, legislative interaction, missing person locator and peer advocacy program.
Peer	Any individual who uses their personal or family lived experience related to mental health, mental illness services and treatment, to advance the well-being of others in a mental health supportive program setting
Prevention	The Prevention element of the MHSA PEI component includes programs and services defined by the Institute of Medicine (IOM) as Universal and Selective, both occurring prior to a diagnosis for a mental illness.
Primary Care	The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.
Primary Contact	The individual at a Billing Provider who discusses specific client service needs with the client and/or Rendering Providers and is identified in the LAC-DMH electronic database at the episode level.

Prior Authorization	The issuance of an MHP payment authorization to be provided before the requested service has been provided.
Protected Health Information (PHI)	Any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.
Provider	Person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program.
Provider	A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program.
Psychiatric Inpatient Hospital Professional Services	Specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services
Psychiatrist Services	Services provided by licensed physicians, within their scope of practice, who have contracted with MHP to provide specialty mental health services and or medication support, who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program, to diagnose or treat a mental illness or condition.
Psychologist Services	Services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition.
Public Guardian Office (PGO)	This office receives referrals from mental health professionals who wish to evaluate clients for both "grave disability" and mental disorder. The Director of the Los Angeles County Public Guardian Office acts as the conservator for individuals and their estate when the court has determined—based on the results of the evaluation—that the individual cannot provide for their basic needs of food, clothing, and shelter.
Quality Assurance Activities	Indirect activities defined by the Federal government that assist a Local Mental Health Plan in insuring and improving the quality of care delivered by its organization

	that are not provided as a service to or in relation to a specific client of the Department. Claiming for these services is currently paperbased. Only licensed professionals may claim for QA activity.
Quality Improvement Program	DMH program involving DMH leadership management, staff, consumers and family members intended to create and sustain a culture of system wide involvement and continuous improvement to the delivery of care.
Receipt or Date of Receipt	Receipt of a Treatment Authorization Request or other document. Date of receipt means the date the document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver.
Rehabilitation	A service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.
Service Activities	Activities conducted to provide specialty mental health services when the definition of the service includes these activities. Service activities include, but are not limited to, assessment, collateral, therapy, rehabilitation, and plan development.
Service Planning Areas (SPA)	Los Angeles County is administratively divided into eight (8) geographically-based Service Planning Areas, also referred to as "Service Areas". This organizational structure facilitates closer coordination among agencies providing services in that geographic area.
Specialized Intensive Foster Care	is a community-based alternative placement for children who require out-of-home care along with therapy and specialized services including those children who are emotionally and behaviorally disturbed, developmentally disabled, and medically disabled. Specialized Intensive Foster Care programs involve the application of specific evidence-based practices designed to treat this population.
Specialty Mental Health Services	Rehabilitative mental health services, including: Mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, psychiatric health facility services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist service, EPSDT supplemental specialty mental health services and psychiatric nursing facility services.
Spirituality	A person's deepest sense of belonging and connection to a higher power or transcendent life philosophy which may

	not necessarily be related to an organized religious institution (Adapted from California Mental Health & Spirituality Initiative). Spirituality is a process of pursuing meaning and purpose in life
Stakeholder	A person or group of people who impacts or is directly impacted by mental health services or, a person who represents others' interests relative to mental health services.
Submit or Date of Submission	To transfer a document by mail, fax, or hand delivery. The "date of submission" means the date the document was submitted as indicated by the postmark date, the fax date, or the date of hand delivery as shown by the date stamp made by the receiver. For documents submitted by mail, the postmark date shall be used as the date submission.
Therapy	A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.
Third Party Liability	An amount owed for specialty mental health services on behalf of a beneficiary by any payer other than the MHP, the Medi-Cal program or the beneficiary
Threshold Language	The California Department of Mental Health tracks how many people are served in each county in mental health. If a county has 3,000 Medi-Cal consumers that speak a certain language then that language becomes a "threshold language" and the county is required to provide services and written materials in that language. Los Angeles County has 13 threshold languages. These languages are Armenian, Cambodian/Khmer, Cantonese, Farsi, Korean, Mandarin, other- Chinese, Russian, Spanish, Tagalog, Arabic and Vietnamese.
Transition Age Youth (TAY)	Youth and young adults between the age 16 and 25.
Unit of Service	The increment unit of time used to capture the quantity of services provided (e.g. 1 minute = 1 Unit of Service) during mental health service procedure. Claims are generated based upon service provided and multiplied by the rate for that procedure.
Urgent Care Centers (UCCs)	Provide intensive crisis services to individuals who otherwise would be brought to emergency rooms for up to 23 hours of immediate care and linkage to community-based solutions. UCCs provide crisis intervention services, including integrated services for co-occurring substance abuse disorders and are geographically located throughout the County. UCCs focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment.

Usual and Customary Charges

Uniform charges that are listed in a provider's established charge schedule which are in effect and applied consistently to post patients.

## **ACRONYMS & ABBREVIATIONS**

AB	Assembly Bill
AC	Auditor Controller
ADA	Americans with Disabilities Act
AEVS	Automated Eligibility Verification System
ASCX12N	Electronic Data Interchange Standards
ATCMS	Adult Targeted Case Management Service
BES	Beneficiary Eligibility System
BIC	Benefits Identification Card
CAU	Central Authorization Unit
CCCP	Client Care/Coordination Plan
CCR	California Code of Regulations
CDAD	Contracts Development and Administration Division
CFA	Cognitive and Functional Ability
CIF	Claim Inquiry Form
DHCS	Department of Health Care Services
CGF	County General Funds
CIMH	California Institute on Mental Health
CIN	Client Index Number
CIOB	Chief Information Office Bureau
CL	Client
CMHDA	California Mental Health Directors Association
CMS	Centers for Medicare & Medicaid Services
CMS 1500	Centers for Medicare & Medicaid Services- 1500
COD	Co-Occurring Disorder
CPT Code	Current Procedural Terminology
DCFS	Department of Children and Family Services
DDE	Direct Data Entry
DMH	Los Angeles County Department of Mental Health
DOS	Date of Service
DPSS	Los Angeles County Department of Public Social Services
DR	Day Rehabilitation
DSM	Diagnostic & Statistical Manual of Mental Disorders
DT, DTx	Day Treatment
DTI	Day Treatment Intensive
DX	Diagnosis
E & M	Evaluation & Management
EBT	Electronic Benefit Transfer
ECR	Error Correction Report
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
EFT	Electronic Fund Transfer

EHR	Electronic Health Record
EM	Evaluation and Management
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ERA	Electronic Remittance Advice
EVC	Eligibility Verification Confirmation
FFCC	Former Foster Care Children Program
FFP	Federal Financial Participation
FFS	Fee For Service
FH	Fair Hearing
FICA	Federal Insurance Contribution Act
FMLA	Federal Family and Medical Leave Act
FSB	Financial Services Bureau
FSP	Full Service Partnership
FY	Fiscal Year
HCFA	Health Care Financing Administration
HF	Healthy Families
HIPAA	Health Insurance Portability and Accountability Act of 1996
IBHIS	Integrated Behavioral Health Information System
ICD-9-CM	International Classification of Diseases, Clinical Modification
IMD	Institution for Mental Disease
IS	Integrated System
LA	Los Angeles
LAC	Los Angeles County
LACLMHP	Los Angeles County Local Mental Health Plan
LACO	Los Angeles County
LCSW	Licensed Clinical Social Worker
LMHP	Local Mental Health Plan
LOC	Level of Care
LPS	Lanterman-Petris-Short Act
MC	Managed Care
Medi-Medi	Medicare – Medi-Cal
MEDS	Medi-Cal Eligibility Data System
MFCC	Licensed Marriage, Family & Child Counselor
MFT	Marriage and Family Therapist
MHFFS	Mental Health Fee-for-Service
MHP	Mental Health Plan
MHS	Mental Health Services
MHSA	Mental Health Services Act
MNC	Medical Necessity Criteria
MOU	Memorandum of Understanding
NOA	Medi-Cal Notice of Action
NP	Nurse Practitioner

NPI	National Provider Identifier
OHC	Other Health Coverage
OMD	Office of the Medical Director
OOC	Out of County
OTAR	Over Threshold Authorization Request
P&P	Policy & Procedure
PFAR	Provider File Adjustment Request
PHI	Protected Health Information
POS	Place of Service/ Point of Service device
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RA	Remittance Advice
SDHCS	State Department of Health Care Services
SED	Serious Emotional Disturbance
SFC	Specialized Foster Care
SFPR	Single Fixed Point of Responsibility
SGF	State General Fund
SIFT	Secure Internet File Transfer
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOC	Share of Cost
SOC	System of Care
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
STAR	System for Treatment Authorization Request
TAR	Treatment Authorization Request
TAY	Transitional Age Youth
TCM	Targeted Case Management
TFA	Therapeutic Fee Adjustment
TIN	Taxpayer Identification Number
UCC	Urgent Care Center
UMDAP	Uniform Method of Determining Ability to Pay
UR	Utilization Review
VET/ADM	Veterans Administration
W&I	Welfare & Institutions Code

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