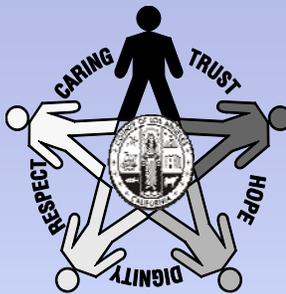




County of Los Angeles
Department of Mental Health
Local Mental Health Plan



Medi-Cal Specialty
Mental Health Services

Provider Manual
Fourth Edition

July 2009

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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, Fourth Edition, July 2009 replaces, in its entirety, the Provider Manual, Third Edition, May 2006. 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, Fourth Edition, July 2009.

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 Medi-Cal Professional Services and Authorization Division Provider Relations Unit 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) 738-2466
Patients' Rights/Beneficiary Services Program	(213) 738-4949
Provider Credentialing	(213) 738-2466
Provider Reimbursement Unit	(213) 738-2309
Provider Relations Unit	(213) 738-3311
Psychological Testing	(213) 738-6151
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 individual 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 providers who are licensed or certified (registered nurses only) to practice 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. A clinical nurse specialist may also have a master's degree in a related field.

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.

Mental health providers who wish to work within an organizational network provider should apply to the organizational provider directly. The LMHP does not credential mental health providers working for an organizational network provider.

APPLICATION

Mental health providers may request a credentialing application by contacting the Provider Credentialing Unit at (213) 738-2814 or at (213) 738-2466. A request may also be faxed to (213) 351-2495. When requesting credentialing applications, mental health providers should provide the following information: 1) full name, discipline and address; 2) telephone and fax number; 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 I).

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

- Psychiatrists 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 III) 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 III) 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, a completed *Rendering Provider Form* (Attachment III) 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 in a related field.
- Nurse practitioners are also to submit proof of graduation from a master's degree program in psychiatric/mental health nursing as a nurse practitioner and a DEA certificate.

All affirmative answers to any professional liability or attestation questions on pages four and five 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.

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 II) by contacting the Provider Credentialing Unit at (213) 738-2814 or at (213) 738-2466. A request may also be faxed to (213) 351-2495. 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 703A
Los Angeles, CA 90020
Fax: (213) 351-2495

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.

Network providers are required to re-credential every two years in order to continue to participate in the LMHP Provider Network. Providers will be sent a reminder 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.

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 IV to VII).

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.

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 vendor 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 information must be correct and current in order to continue to receive payments. Contact the Provider Relations Unit at (213) 738-3311 if assistance is needed to modify the information in the system.

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 VIII) 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., 5th 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 the provider's 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 LMHP ACCESS Center or the Beneficiary Services Program to receive referrals to other LMHP network providers, directly operated providers or contract providers if they so choose. Network providers may elect to utilize the sample notification letter (Attachment IX). 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 the provider's clients that were sent the notification letter to:

Department of Mental Health
Beneficiary Services Program
550 S. Vermont Ave., 6th Floor
Los Angeles, CA 90020

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 two 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.
- All questions must be completed.
- 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 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.
- Psychiatrists 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 *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 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 *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*, 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 or a master’s degree in a related field. 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 \$2,000,000 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 Medi-Cal 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 703A
Los Angeles, CA 90020
Fax: (213) 351-2495

Credentialing Unit Telephone Numbers: (213) 738-2466 or (213) 738-2814

**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:
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Social Security Number: _____ Federal Tax Identification Number: _____

Name Affiliated with Federal Tax Identification Number: _____

National Provider Identifier (NPI): _____

Is /are there any other name(s) under which you have been known?

Name(s):

Gender:	Birth date:	Ethnicity:	Degree:
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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:
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City:	State:	Zip Code:
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E-Mail Address (if applicable): _____

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

LOCATION #1 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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LOCATION #2 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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LOCATION #3 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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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

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:
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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 five years have you been a party to any malpractice actions? Yes No

Within the past five 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.

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

2. 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 Yes No

3. 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? Yes No
 - a. Have you ever surrendered your clinical privileges upon threat of censure, restriction suspension or revocation of such privileges? Yes No

4. Has your membership in any professional society or association ever been canceled revoked or censured? Yes No

5. 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

6. Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? Yes No

7. Have you ever been convicted of a misdemeanor, other than a traffic violation? Yes No

8. 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

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 with the state licensing board(s), 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 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. I agree to give written notice by registered mail to the Local Mental Health Plan at least thirty days in advance of any modification or termination of insurance.

Signature of Applicant

Date

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"/> American Sign Language | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Native American Dialects |
| <input type="checkbox"/> Amharic | <input type="checkbox"/> Hindi | <input type="checkbox"/> Other Chinese |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hmong | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Korean | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Lao | <input type="checkbox"/> Temne |
| <input type="checkbox"/> French | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Vietnamese |
| | | <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"/> Family Therapy | <input type="checkbox"/> Psychotic Disorders |
| <input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder | <input type="checkbox"/> Gang Members | <input type="checkbox"/> Sex Offenders |
| <input type="checkbox"/> Disorders of Adolescence | <input type="checkbox"/> Gender Identity Disorders | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Disorders of Childhood | <input type="checkbox"/> Grief/Bereavement | <input type="checkbox"/> The Use of American Psychological Association Guidelines in Child Protection Matters |
| <input type="checkbox"/> Disorders of Infancy | <input type="checkbox"/> Group Therapy | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Other, specify _____ |

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

- | | | | |
|------------------------------------|-------|-------------|----|
| <input type="checkbox"/> Monday | _____ | AM to _____ | PM |
| <input type="checkbox"/> Tuesday | _____ | AM to _____ | PM |
| <input type="checkbox"/> Wednesday | _____ | AM to _____ | PM |
| <input type="checkbox"/> Thursday | _____ | AM to _____ | PM |
| <input type="checkbox"/> Friday | _____ | AM to _____ | PM |
| <input type="checkbox"/> Saturday | _____ | AM to _____ | PM |
| <input type="checkbox"/> Sunday | _____ | AM to _____ | PM |

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
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) 738-2814
Fax: (213) 351-2495

June 26, 2009

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: _____

City/State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Official Group Name: _____

Group Medi-Cal Provider Number: _____ Tax ID: _____

NPI Number: _____

Please fax or mail the requested information to:

Department of Mental Health
Provider Credentialing Unit
550 S. Vermont Ave., Room 703A
Los Angeles, CA 90020
Fax: (213) 351-2495

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.

Sincerely,

Muriel Janes, M.N., R.N.
Supervisor, Provider Credentialing Unit
Medi-Cal Professional Services and Authorization Division

DWK:MJ:mj

**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) 351-2495

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.

Individual Provider Name	9 Digit Provider Number	NPI Number

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 License Reporting Unit Effective Date Terminate Name Change

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. PPIN Medicare No. Expiration Date
(DMH directly-operated only)

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

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

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

SUBJECT: CREDENTIALING OF PROVIDERS	POLICY NO. CR 1	EFFECTIVE DATE 1/1/09	PAGE Page 2 of 6
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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.



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

SUBJECT: CREDENTIALING OF PROVIDERS	POLICY NO. CR 1	EFFECTIVE DATE 1/1/09	PAGE Page 3 of 6
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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.



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

SUBJECT: CREDENTIALING OF PROVIDERS	POLICY NO. CR 1	EFFECTIVE DATE 1/1/09	PAGE Page 4 of 6
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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.



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

SUBJECT: CREDENTIALING OF PROVIDERS	POLICY NO. CR 1	EFFECTIVE DATE 1/1/09	PAGE Page 5 of 6
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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.



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

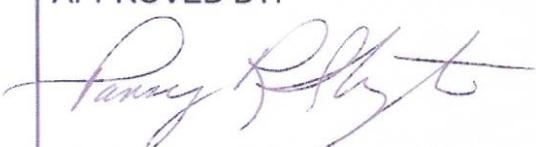
SUBJECT: CREDENTIALING OF PROVIDERS	POLICY NO. CR 1	EFFECTIVE DATE 1/1/09	PAGE Page 6 of 6
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Evidence must exist that any such history does not adversely affect the applicant's ability to perform his/her professional duties.

- 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.



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

SUBJECT: CREDENTIALING REVIEW COMMITTEE	POLICY NO. CR2	EFFECTIVE DATE 1/1/09	PAGE 1 of 6
APPROVED BY: 	SUPERSEDES 6/3/03	ORIGINAL ISSUE DATE 2/1/99	

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.



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

SUBJECT:	POLICY NO.	EFFECTIVE DATE	PAGE
CREDENTIALING REVIEW COMMITTEE	CR2	1/1/09	2 of 6

- 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.



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

SUBJECT:	POLICY NO.	EFFECTIVE DATE	PAGE
CREDENTIALING REVIEW COMMITTEE	CR2	1/1/09	3 of 6

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.



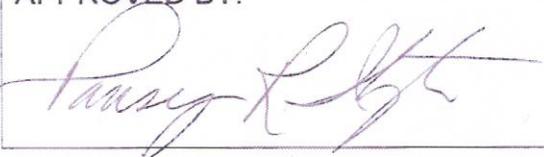
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- 9.1.6 Excessive or significant beneficiary or provider complaints as verified by primary source and/or internal quality management information.
 - 9.1.7 Excessive or egregious administrative non-compliance as determined by internal quality management 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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APPROVED BY: 	SUPERSEDES 12/1/04	ORIGINAL ISSUE DATE 10/19/99	

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:



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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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APPROVED BY: 	SUPERSEDES 12/4/04	ORIGINAL ISSUE DATE 12/1/04	

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.



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

SUBJECT: INDEPENDENT REVIEW OF CREDENTIALING AND RECREDENTIALING DECISIONS; HEARING PROCEDURES; FINAL DECISIONS	POLICY NO. CR4	EFFECTIVE DATE 1/1/09	PAGE 7 of 7
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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, 5th 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.

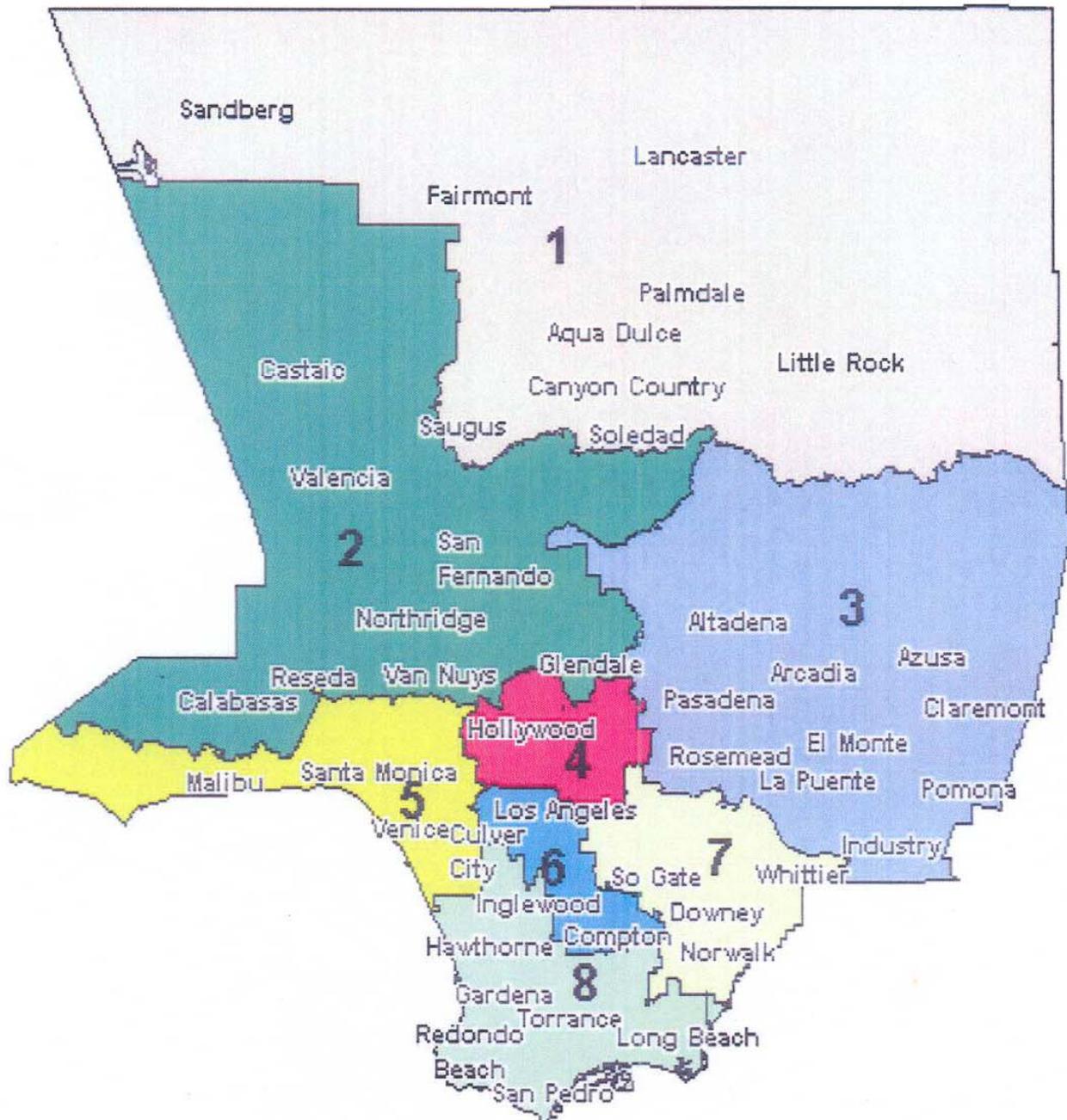
If you need additional assistance you may also contact the Beneficiary Services Program at (213) 738-4949.

Sincerely,

Provider Name

FIGURE A:

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



SECTION III – ACCESS TO SERVICES

Medi-Cal beneficiaries can access specialty mental health services through the Local Mental Health Plan (LMHP) ACCESS (Access to Community Care and Effective Services and Support) 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 Relations Unit.

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

Confirmation of Medi-Cal eligibility is initiated electronically in the Integrated System (IS) by network providers, billing agents/services and clearinghouses. Network providers are strongly encouraged to verify client Medi-Cal eligibility every month prior to providing services.

Medi-Cal eligibility and share of cost information may also be verified by entering the Medi-Cal beneficiary's Client ID 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: 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 may be accessed by calling (800) 456-2387. Refer to pages 100-54-1 through 100-54-19 of the State Medi-Cal Manual for additional 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 Relations Unit 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 www.medi-cal.ca.gov/Eligibility/Login.asp, or AEVS at (800) 456-2387.

It is recommended that network providers print and maintain a copy of the Medi-Cal eligibility confirmation obtained from the IS and also print and maintain a copy of Medi-Cal eligibility obtained from one of the State eligibility systems listed above.

Electronic Medi-Cal beneficiary enrollment is a process that requires network providers, billing agents/services and clearinghouses to enroll Medi-Cal eligible beneficiaries in the Local Mental Health Plan HIPAA-compliant IS. The first two digits of a beneficiary identification card designate the assigned county where the client is Medi-Cal eligible. The code for Los Angeles County is 19. Network providers may only enroll Medi-Cal beneficiaries in the IS with county code 19.

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 IS.

Contact the Provider Relations Unit at (213) 738-3311 for questions regarding Medi-Cal beneficiary enrollment and Medi-Cal eligibility transactions.

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

MEDI-CAL BENEFICIARY MATERIALS

Under California Code of Regulations, Title 9, Chapter 11, the Local Mental Health Plan (LMHP) and its network providers are required to provide verbal and written information to Medi-Cal beneficiaries upon admission on how to:

- Access specialty mental health services;
- File a complaint and/or grievance with the LMHP about services; and
- Request a State Fair Hearing about services at any time for any reason.

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:** brochure informs Medi-Cal beneficiaries on how to access and obtain routine and emergency specialty mental health services;
- **Complaint & Grievance Procedures:** pamphlet describes the informal and formal processes for filing a complaint and/or 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 in compliance with California Code of Regulations, Title 9, Chapter 11. The network provider should post the Beneficiary Poster in prominent locations and/or waiting areas where Medi-Cal beneficiaries obtain outpatient specialty mental health services.

You may contact the Patients' Rights Office at (213) 738-4949 to obtain any of the above Medi-Cal beneficiary materials. The materials, other than the Beneficiary Poster, are also available on the Patients' Rights Office website at http://dmh.lacounty.gov/patient_rights.asp. Additional ordering instructions are also located on the Patients' Rights website.

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) 738-4949. 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; and
 - ◆ Request a State Fair Hearing at any time for any reason.
- 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) and investigate and resolve DMH HIPAA complaints.

BENEFICIARY ASSISTANCE

- Assist in the problem resolution process for complaints and grievances filed with the LMHP about access to service and service delivery issues.
- Record, investigate, and coordinate resolution of complaints and 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 complaint or 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 California Code of Regulations, Title 9, Chapter 11.
- Educate network providers on landlord/tenant law.

SECTION VI – 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. If a client is discharged, either by the clinician or in the LMHP Integrated System (IS), a new *Consent for Services* form must be signed for the new 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 clinical information contained in the 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.

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.	Name: _____ DMH Client ID#: _____
	Individual/Group/Organizational Provider Name: _____

CONSENT FOR SERVICES

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.

SELF SUFFICIENT: (To be completed by the client) This minor is self sufficient as exhibited by being able to declare all of the following (Cal Fam Code 6922).

I am 15 years of age or older, having been born on the _____ day of _____ in the year _____ .

I am living at the address given on admission for services which is apart from the home/residence of my parents or legal guardian.

I am managing my own financial affairs indicated by the financial information provided by me on admission for services.

I understand that I am financially responsible for the charges for my mental health services and I may not disaffirm this consent because I am a minor.

Signature of Client Date

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. the client meets on of the following:

- 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)/guardians(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

<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 the client/authorized representative to who it pertains unless otherwise permitted by law.</p>	<p>Name: _____ DMH Client ID #: _____</p> <p>Individual/Group/Organizational Provider Name:</p> <p>_____</p>
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CONSENT OF MINOR

**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 dia _____ del mes de _____ del ano _____.

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 porque 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

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	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.

MH 603N
11/17/2005

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 VII – 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, group or organizational network provider and a confidentiality/disclosure statement similar to the statement on the LMHP forms.

INITIAL ASSESSMENTS

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. The assessment must clearly establish that mental health services are medically necessary. The assessment is to include, but is not limited to, the following:

- Presenting problem(s) and relevant conditions affecting the client's physical and mental health status, i.e., living situation, daily activities, social support;
- Impact of functional impairments on life functioning;
- Clear indication as to why the client is seeking treatment at this time and a behavioral history that includes:
 - ◆ Previous treatment dates;
 - ◆ Previous and present mental health providers;
 - ◆ Previous therapeutic interventions and responses;
 - ◆ Relevant family information;
 - ◆ Relevant lab reports, consultations, and sources of clinical data, and
 - ◆ Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and/or over-the-counter drugs;

- For children and adolescents, pre-natal and peri-natal events and a complete developmental history;
- A brief psychosocial history;
- A relevant mental health status examination with a narrative describing symptoms;
- A medical summary that contains a brief relevant medical history;
- History of psychiatric medications that have been prescribed, including dosages of each medication;
- Client's self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities;
- Client's strengths in achieving service plan goals;
- Special status situations that present a risk to the client and updated changes;
- Adequate information to assess the client's needs in order to formulate a treatment plan;
- A five axis diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 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 California Code of Regulations (CCR), Title 9, Chapter 11, Section 1830.205(b)(1)(A-R). (Refer to Section VIII: Procedure Codes, Diagnosis Codes and Rates.); and
- Housing, employment, and benefit status.

The primary assessment forms are:

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

The California Department of Mental Health 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 LMHP 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. Clinicians who have assessment formats that 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, assessment updates, or to confirm information on the original assessment.

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 client's treatment plan and reflect client care, clinical decisions, interventions, progress and referrals.

The progress note must include:

- Date of service;
- 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;
- All services provided, including relevant clinical decisions and specific interventions;
- Procedure code;
- Location of service;
- Total time of service delivery;
- For family therapy, the names of the family members and other clients present in the family session;
- A description of changes in medical necessity criteria, when they occur;
- What was attempted and/or accomplished during the contact toward the attainment of the Medi-Cal beneficiary's goals;
- The treatment plan, if not recorded on a separate form;
- The discharge summary (when applicable), if not recorded on a separate form; and
- The signature and discipline of the provider.

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 is 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.

CLIENT TREATMENT PLAN

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. The treatment plan must be consistent with the diagnosis and must include:

- Specific, observable and quantifiable goals;
- The proposed types of interventions;
- The proposed duration of the interventions; and
- The signature of the provider.

Documentation must indicate the Medi-Cal beneficiary's participation and agreement with the treatment plan and that the beneficiary was offered a copy of the plan. In many cases, a client

signature is utilized as evidence of the Medi-Cal beneficiary's participation and agreement with the treatment plan.

A new or revised client treatment plan must be formulated annually.

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 XIV: Over-Threshold and Inpatient Professional Services.)

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 the 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 VI: Consents and Release of Information Forms.)

When medications are prescribed, the service may be documented on either the *Network Provider Complex Medication Support Service (90862)* form (Attachment VIII) or the *Network Provider Brief Follow-Up Medication Support Service (M0064)* form (Attachment IX) 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 client'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 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria, as defined in the CCR, Title 9, Chapter 11, Section 1830.205, must be met for reimbursement by the LMHP for all outpatient services rendered by network providers. Treatment rendered to Medi-Cal beneficiaries who do not meet the medical necessity criteria below may be claimed directly to the State provided the client has an ICD-9 diagnosis code.

The Medi-Cal beneficiary must have one of the included diagnoses in the DSM and listed in CCR, Title 9, Chapter 11, Section 1830.205. Network providers must use the color-coded DSM crosswalk to ICD-9 diagnosis codes. (Refer to Section VIII: Procedure Codes, Diagnosis Codes and Rates for a list of included diagnoses.) The list of diagnosis codes is also available on the LMHP website at http://dmh.lacounty.info/hipaa/ffs_UIS_Manuals.htm.

- A. The beneficiary must have at least one of the following criteria as a result of the mental disorder:
1. A significant impairment in an important area of life functioning;
 2. A reasonable probability of significant deterioration in an important area of life functioning;
 3. A reasonable probability a beneficiary, under the age of 21 years, will not progress developmentally as individually appropriate.
- B. The intervention must meet each of the following intervention criteria:
1. The focus of the proposed intervention is to address the condition identified in “B” above;
 2. The expectation is that the proposed intervention will significantly diminish the impairment, or prevent significant deterioration in an important area of life functioning;
 3. Allow a beneficiary under the age of 21 years, to progress developmentally as individually appropriate; and
 4. The condition would not be responsive to physical health care based treatment.

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder

Outpatient Treatment Standards

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

A. Signs and Symptoms

- Must be sufficiently documented to support the diagnosis; and
- Must be followed with sufficient diligence to monitor changes in clinical condition and impairments in life functioning.

B. Diagnostic Assessment

- Must be undertaken in a timely manner;
- Must be directed toward the establishment of treatment decisions that are specific to the diagnosis; and
- Must consist of testing, consultation, and procedures, which are generally acknowledged to have the greatest clinical value specific to the diagnosis.

C. Treatment Goals

- Must be generally acknowledged as appropriate for the diagnosis and severity of symptomatology; and
- Must be realistic goals that may be accomplished in a time frame consistent with the acceptable length of stay in the treatment setting.

D. 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.

E. 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.

F. Treatment Course

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

CLINICAL RECORD CONTENT

Clinical Minimum Record Content	Attachment	Comments
Referral Information from LMHP	N/A	Referral Information from LMHP
Network Provider Child/Adolescent Assessment or Network Provider Adult Assessment	Attachment I Attachment II	An assessment must be completed for all new Medi-Cal beneficiaries unless a recent assessment equivalent accompanies the referral.
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.
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 <ul style="list-style-type: none"> • 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	The summary of the course of treatment with a final diagnosis may be documented in the progress notes as an alternative to the use of the Discharge Summary.

III. History	
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	

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

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease/symp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>		Weight/appetite chg
	<input type="checkbox"/>	<input type="checkbox"/>	Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease/symp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal disease/symp	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea
	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision/glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Sexual dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (If Yes, specify):									<input type="checkbox"/>	<input type="checkbox"/>		Sexually trans disease
	<input type="checkbox"/>	<input type="checkbox"/>	Pap smear If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>		Mammogram If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>		HIV Test If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>		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/Means 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>Grooming & Hygiene: <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>Mood: <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><input type="checkbox"/> None Apparent</p> <p>Delusions: <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>Eye Contact: <input type="checkbox"/> Normal for culture <input type="checkbox"/> Little <input type="checkbox"/> Avoids <input type="checkbox"/> Erratic Comments:</p>	<p>Affect: <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>Ideations: <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>Motor Activity: <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>Perceptual Disturbance <input type="checkbox"/> None Apparent</p> <p>Hallucinations: <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>Behavioral Disturbances: <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>Speech: <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>Self-Perceptions: <input type="checkbox"/> Depersonalizations <input type="checkbox"/> Ideas of Reference Comments:</p>	<p>Suicidal/Homicidal: <input type="checkbox"/> Denies Ideation Only <input type="checkbox"/> Threatening <input type="checkbox"/> Plan <input type="checkbox"/> Past Attempts Comments:</p>
<p>Interactional Style: <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>Thought Process Disturbances <input type="checkbox"/> None Apparent</p> <p>Associations: <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>Passive: <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>Orientation: <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>Concentration: <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>Other: <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>
<p>Intellectual Functioning: <input type="checkbox"/> Unimpaired <input type="checkbox"/> Impaired Comments:</p>	<p>Abstractions: <input type="checkbox"/> Intact <input type="checkbox"/> Concrete Comments:</p>	
<p>Memory: <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>Judgments: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Comments:</p>	
<p>Fund of Knowledge: <input type="checkbox"/> Average <input type="checkbox"/> Below Average <input type="checkbox"/> Above Average Comments:</p>	<p>Insight: <input type="checkbox"/> Adequate <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Comments:</p>	
	<p>Serial 7's: <input type="checkbox"/> Intact <input type="checkbox"/> Poor Comments:</p>	

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

NETWORK PROVIDER ADULT ASSESSMENT

IX. Summary and Diagnosis

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. 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 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 9th 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 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: _____

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential 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.

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	<input type="checkbox"/> Prin	<input type="checkbox"/> Sec Code _____	Nomenclature _____
		<input type="checkbox"/> Sec Code _____	Nomenclature _____
		Code _____	Nomenclature _____
		Code _____	Nomenclature _____
Axis II	<input type="checkbox"/> Prin	<input type="checkbox"/> Sec Code _____	Nomenclature _____
		<input type="checkbox"/> 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 VIII – PROCEDURE CODES, DIAGNOSIS CODES AND RATES

PROCEDURE CODES

One of the objectives of the Health Insurance Portability and Accountability Act (HIPAA) is to enable health care providers throughout the country to be 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 Common Procedure Coding System (HCPCS). The CPT codes are five digit numeric codes, such as 90804. The HCPCS are a letter followed by four digits, such as H2012.

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

Network providers must ensure that procedure codes documented in the client record and submitted to the Integrated System on electronic claims accurately reflect the specialty mental health services provided to the client. The procedure codes available for individual, group and organizational network providers are listed in this Section on Attachments II-A and II-B.

A Guide to Procedure Codes for Claiming Specialty Mental Health Services is also available at http://dmh.lacounty.info/hipaa/ffs_home.htm. Select “Outpatient Fee-for-Service Providers.” On the left column select “Using the IS.” Select “Codes Manuals.” Then select “*A Guide to Procedure Codes for Claiming Specialty Mental Health Services.*”

DIAGNOSIS CODES

The initial assessment is 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 diagnosis codes reimbursed by the Local Mental Health Plan (LMHP) are those listed without yellow highlight in the right column of the DSM IV Crosswalk to ICD 9 (Attachment I). The LMHP will deny claims submitted with the diagnosis codes highlighted in yellow.

The DSM IV Crosswalk to ICD 9 is also located at http://dmh.lacounty.info/hipaa/ffs_home.htm, Select “Outpatient Fee-for-Service Providers.” On the left column select “Using the IS.” Select “Manuals and Guides” link. Then select “DSM Crosswalk to ICD 9.”

PROCEDURE CODE RATES

The individual, group and organizational network provider rates associated with the procedure codes are included in the procedure code lists on Attachment II-A and II-B.

CLARIFICATION OF FAMILY THERAPY AND TEAM CONFERENCE/CASE CONSULTATION PROCEDURE 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, you 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.

Multi-family 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.

TEAM CONFERENCE/CASE CONSULTATION

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 and include a summary of the client treatment planning process. The names of all attendees are to be included in the progress note.

DSM IV Crosswalk ICD 9

(Yellow background indicates codes not reimbursable through the LMHP OP services and blue type indicates codes with ICD 9 fifth digit detail)

DSM IV CODE	DMH DSM DESCRIPTION	ICD9 CODE	ICD9 DESCRIPTION
Axis I			
290.0	Dementia of Alzheimer's Uncomplicated late onset	294.1	Dementia in conditions classified elsewhere
290.10	Dementia due to Creutzfeldt-Jakob Disease/Pick's Disease/Alzheimer's Type with early onset, uncomplicated	294.1	Dementia in conditions classified elsewhere
290.11	Dementia of Alzheimer's with delirium, early onset	293.0	Acute Delirium
290.12	Dementia of Alzheimers with delusions, early onset	293.81	Organic Delusional Syndrome
290.13	Dementia of Alzheimers Depressed Mood, early onset	293.83	Organic Affective Syndrome
290.20	Dementia of Alzheimers with delusions, late onset	293.81	Organic Delusional Syndrome
290.21	Dementia of Alzheimers Depressed Mood, late onset	293.83	Organic Affective Syndrome
290.3	Dementia of Alzheimer's with delirium, late onset	293.0	Acute Delirium
290.40	Vascular Dementia, Uncomplicated	290.40	Arteriosclerotic Dementia, uncomplicated
290.41	Vascular Dementia, with Delirium	290.41	Arteriosclerotic Dementia, with delirium
290.42	Vascular Dementia, with Delusions	290.42	Arteriosclerotic Dementia, with delusions
290.43	Vascular Dementia, with Depressed Mood	290.43	Arteriosclerotic Dementia, with depressive features
291.0	Alcohol Intoxication/Withdrawal Delirium	291.0	Alcohol Withdrawal Delirium
291.1	Alcohol-Induced Persisting Amnestic Disorder	291.1	Alcohol Amnestic Syndrome
291.2	Alcohol-Induced Persisting Dementia	291.2	Other Alcoholic Dementia
291.3	Alcohol-Induced Psychotic Disorder, with Hallucinations	291.3	Alcohol Withdrawal Hallucinosis
291.5	Alcohol-Induced Psychotic Disorder, with Delusions	291.5	Alcoholic Jealousy
291.81	Alcohol Withdrawal	291.81	Alcohol Withdrawal
291.89	Alcohol-Induced Anxiety/Mood/Sleep Disorders/Sexual Dysfunction	291.89	Other Specific Alcoholic Psychosis
291.9	Alcohol Related Disorder NOS	291.9	Unspecified Alcoholic Psychosis
292.0	Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium	292.0	Drug Withdrawal Syndrome
292.11	Drug Induced Psychotic Disorder, with Delusions	292.11	Drug-induced Organic Delusional Syndrome
292.12	Drug Induced Psychotic Disorder, with Hallucinations	292.12	Drug-induced Hallucinosis
292.81	Drug Induced Delirium	292.81	Drug Induced Delirium
292.82	Drug Induced Persisting Dementia	292.82	Drug Induced Dementia
292.83	Drug Induced Persisting Amnestic Disorder	292.83	Drug Induced Amnestic Syndrome

292.84	Drug Induced Mood Disorder	292.84	Drug Induced Organic Affective Syndrome
292.89	Drug Induced Disorder NEC	292.89	Other Specified Drug-Induced Mental Disorders; Other
292.9	Drug Related Disorder NOS	292.9	Unspecified Drug-induced Mental Disorder
293.0	Delirium Due to...(Indicate Medical Condition)	293.0	Acute Delirium
293.81	Psychotic Disorder Due to...(Indicate Medical Condition) with Delusions	293.81	Organic Delusional Syndrome
293.82	Psychotic Disorder Due to...(Indicate Medical Condition) with Hallucinations	293.82	Organic HallucinosiS Syndrome
293.83	Mood Disorder Due to...(Indicate Medical Condition)	293.83	Organic Affective Syndrome
293.84	Anxiety Disorder Due to...(Indicate Medical Condition)	293.84	Organic Anxiety Syndrome
293.89	Catatonic Disorder Due to...(Indicate Medical Condition)	293.89	Other Specified Transcient Organic Mental Disorders; Other
293.9	Mental Disorder NOS Due to...(Indicate Medical Condition)	293.9	Unspecified Transient Organic Mental Disorder
294.0	Amnestic Disorder Due to...(Indicate Medical Condition)	294.0	Amnestic Syndrome
294.1	Dementia Due to...(Indicate the General Medical Condition, including HIV) (Also code on Axis III)	294.1	Dementia in conditions classified elsewhere
294.8	Amnestic Disorder NOS/Dementia NOS	294.8	Other Specifed Organic Brain Syndromes (chronic)
294.9	Cognitive Disorder NOS	294.9	Unspecified Organic Brain Syndrome (chronic)
295.10	Schizophrenia, Disorganized Type	295.10	Schizophrenic Disorder; Disorganized Type, unspecified
		295.11	Schizophrenic Disorder; Disorganized Type, subchronic
		295.12	Schizophrenic Disorder; Disorganized Type, chronic
		295.13	Schizophrenic Disorder; Disorganized Type, subchronic with acute exacerbation
		295.14	Schizophrenic Disorder; Disorganized Type, chronic with acute exacerbation
		295.15	Schizophrenic Disorder; Disorganized Type, in remission
295.20	Schizophrenia, Catatonic Type	295.20	Schizophrenic Disorder; Catatonic Type, unspecified
		295.21	Schizophrenic Disorder; Catatonic Type, subchronic
		295.22	Schizophrenic Disorder; Catatonic Type, chronic
		295.23	Schizophrenic Disorder; Catatonic Type, subchronic with acute exacerbation
		295.24	Schizophrenic Disorder; Catatonic Type, chronic with acute exacerbation
		295.25	Schizophrenic Disorder; Catatonic Type, in remission
295.30	Schizophrenia, Paranoid Type	295.30	Schizophrenic Disorder; Paranoid Type, unspecified
		295.31	Schizophrenic Disorder; Paranoid Type, subchronic

		295.32	Schizophrenic Disorder; Paranoid Type, chronic
		295.33	Schizophrenic Disorder; Paranoid Type, subchronic with acute exacerbation
		295.34	Schizophrenic Disorder; Paranoid Type, chronic with acute exacerbation
		295.35	Schizophrenic Disorder; Paranoid Type, in remission
295.40	Schizophreniform Disorder	295.40	Acute Schizophrenic Episode, unspecified
		295.41	Acute Schizophrenic Episode, subchronic
		295.42	Acute Schizophrenic Episode, chronic
		295.43	Acute Schizophrenic Episode, subchronic with acute exacerbation
		295.44	Acute Schizophrenic Episode, chronic with acute exacerbation
		295.45	Acute Schizophrenic Episode, in remission
295.60	Schizophrenia, Residual Type	295.60	Residual Schizophrenia, unspecified
		295.61	Residual Schizophrenia, subchronic
		295.62	Residual Schizophrenia, chronic
		295.63	Residual Schizophrenia, subchronic with acute exacerbation
		295.64	Residual Schizophrenia, chronic with acute exacerbation
		295.65	Residual Schizophrenia, in remission
295.70	Schizoaffective Disorder	295.70	Schizophrenic Disorder; Disorganized Type, unspecified
		295.71	Schizophrenic Disorder; Disorganized Type, subchronic
		295.72	Schizophrenic Disorder; Disorganized Type, chronic
		295.73	Schizophrenic Disorder; Disorganized Type, subchronic with acute exacerbation
		295.74	Schizophrenic Disorder; Disorganized Type, chronic with acute exacerbation
		295.75	Schizophrenic Disorder; Disorganized Type, in remission
295.90	Schizophrenia, Undifferentiated Type	295.90	Undifferentiated Schizophrenia, unspecified
		295.91	Undifferentiated Schizophrenia, subchronic
		295.92	Undifferentiated Schizophrenia, chronic
		295.93	Undifferentiated Schizophrenia, subchronic with acute exacerbation
		295.94	Undifferentiated Schizophrenia, chronic with acute exacerbation
		295.95	Undifferentiated Schizophrenia, in remission

296.00	Bipolar I Disorder, Single Manic Episode, Unspecified	296.00	Manic Disorder, single episode, unspecified
296.01	Bipolar I Disorder, Single Manic Episode, Mild	296.01	Manic Disorder, single episode, mild
296.02	Bipolar I Disorder, Single Manic Episode, Moderate	296.02	Manic Disorder, single episode, moderate
296.03	Bipolar I, SME, Severe without Psychotic Features	296.03	Manic Disorder, single episode, severe, without mention of psychotic behavior
296.04	Bipolar I, SME, Severe with Psychotic Features	296.04	Manic Disorder, single episode, specified as with psychotic behavior
296.05	Bipolar I, SME, In Partial Remission	296.05	Manic Disorder, single episode, in partial or unspecified remission
296.06	Bipolar I, SME, In Full Remission	296.06	Manic Disorder, single episode, in full remission
296.20	Major Depressive Disorder, Single Episode, Unspecified	296.20	Major Depressive Disorder, single episode, unspecified
296.21	Major Depressive Disorder, Single Episode, Mild	296.21	Major Depressive Disorder, single episode, mild
296.22	Major Depressive Disorder, Single Episode, Moderate	296.22	Major Depressive Disorder, single episode, moderate
296.23	Major Depressive Disorder, SE, Severe without Psychotic Features	296.23	Major Depressive Disorder, single episode, severe, without mention of psychotic behavior
296.24	Major Depressive Disorder, SE, Severe with Psychotic Features	296.24	Major Depressive Disorder, single episode, specified as with psychotic behavior
296.25	Major Depressive Disorder, Single Episode, In Partial Remission	296.25	Major Depressive Disorder, single episode, in partial or unspecified remission
296.26	Major Depressive Disorder, Single Episode, In Full Remission	296.26	Major Depressive Disorder, single episode, in full remission
296.30	Major Depressive Disorder, Recurrent, Unspecified	296.30	Major Depressive Disorder, recurrent, unspecified
296.31	Major Depressive Disorder, Recurrent, Mild	296.31	Major Depressive Disorder, recurrent, mild
296.32	Major Depressive Disorder, Recurrent, Moderate	296.32	Major Depressive Disorder, recurrent, moderate
296.33	Major Depressive Disorder, Rec., Severe without Psychotic Features	296.33	Major Depressive Disorder, recurrent, severe, without mention of psychotic behavior
296.34	Major Depressive Disorder, Rec., Severe with Psychotic Features	296.34	Major Depressive Disorder, recurrent, specified as with psychotic behavior
296.35	Major Depressive Disorder, Recurrent, In Partial Remission	296.35	Major Depressive Disorder, recurrent, in partial or unspecified remission
296.36	Major Depressive Disorder, Recurrent, In Full Remission	296.36	Major Depressive Disorder, recurrent, in full remission
296.40	Bipolar I Disorder, MRE Manic, Unspecified or Hypomanic	296.40	Bipolar Affective Disorder, manic, unspecified
296.41	Bipolar I Disorder, MRE, Manic, Mild	296.41	Bipolar Affective Disorder, manic, mild
296.42	Bipolar I Disorder, MRE, Manic, Moderate	296.42	Bipolar Affective Disorder, manic, moderate
296.43	Bipolar I Disorder, MRE, Manic, Severe without Psychotic Features	296.43	Bipolar Affective Disorder, manic, severe, without mention of psychotic behavior
296.44	Bipolar I Disorder, MRE, Manic, Severe with Psychotic Features	296.44	Bipolar Affective Disorder, manic, severe, specified as with psychotic behavior
296.45	Bipolar I Disorder, MRE, Manic, In Partial Remission	296.45	Bipolar Affective Disorder, manic, In partial or unspecified remission
296.46	Bipolar I Disorder, MRE Manic, In Full Remission	296.46	Bipolar Affective Disorder manic, In full remission

296.50	Bipolar I Disorder, MRE, Depressed, Unspecified	296.5	Bipolar Affective Disorder, depressed, unspecified
296.51	Bipolar I Disorder, MRE, Depressed, Mild	296.51	Bipolar Affective Disorder, depressed, mild
296.52	Bipolar I Disorder, MRE, Depressed, Moderate	296.52	Bipolar Affective Disorder, depressed, moderate
296.53	Bipolar I Disorder, MRE, Depressed, Severe without Psychotic Features	296.53	Bipolar Affective Disorder, depressed, severe, without mention of psychotic behavior
296.54	Bipolar I Disorder, MRE, Depressed, Severe with Psychotic Features	296.54	Bipolar Affective Disorder, manic, severe, specified as with psychotic behavior
296.55	Bipolar I Disorder, MRE, Depressed, In Partial Remission	296.55	Bipolar Affective Disorder, depressed, In partial or unspecified remission
296.56	Bipolar I Disorder, MRE, Depressed, In Full Remission	296.56	Bipolar Affective Disorder manic, In full remission
296.60	Bipolar I Disorder, MRE, Mixed, Unspecified	296.60	Bipolar Affective Disorder, mixed, unspecified
296.61	Bipolar I Disorder, MRE, Mixed, Mild	296.61	Bipolar Affective Disorder, mixed, mild
296.62	Bipolar I Disorder, MRE, Mixed, Moderate	296.62	Bipolar Affective Disorder, mixed, moderate
296.63	Bipolar I Disorder, MRE, Mixed, Severe without Psychotic Features	296.63	Bipolar Affective Disorder, mixed, severe, without mention of psychotic behavior
296.64	Bipolar I Disorder, MRE, Mixed, Severe with Psychotic Features	296.64	Bipolar Affective Disorder, mixed, severe, specified as with psychotic behavior
296.65	Bipolar I Disorder, MRE, Mixed, In Partial Remission	296.65	Bipolar Affective Disorder, mixed, in partial or unspecified remission
296.66	Bipolar I Disorder, MRE, Mixed, In Full Remission	296.66	Bipolar Affective Disorder, mixed, in full remission
296.7	Bipolar I Disorder, MRE, Unspecified	296.7	Bipolar Affective Disorder, unspecified
296.80	Bipolar Disorder NOS	296.7	Bipolar Affective Disorder, unspecified
296.89	Bipolar II Disorder	296.89	Manic-Depressive Psychosis, Other & Unspecified; Other
296.90	Mood Disorder NOS	296.90	Unspecified Affective Psychosis
297.1	Delusional Disorder	297.9	Unspecified Paranoid State
297.3	Shared Psychotic Disorder	297.3	Shared Paranoid Disorder
298.8	Brief Psychotic Disorder	298.8	Other and Unspecified Reactive Psychosis
298.9	Psychotic Disorder NOS	298.9	Unspecified Psychosis
299.0	Autistic Disorder	299.00	Infantile Autism
299.10	Childhood Disintegrative Disorder	299.10	Disintegrative Psychosis
299.80	Asperger's Disorder/Rett's Disorder/Pervasive Developmental Disorder NOS	299.80	Other Specified Early Childhood Psychoses
300.00	Anxiety Disorder NOS	300.00	Anxiety State, unspecified
300.01	Panic Disorder without Agoraphobia	300.01	Panic Disorder
300.02	Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder

300.11	Conversion Disorder	300.11	Conversion Disorder
300.12	Dissociative Amnesia	300.12	Psychogenic Amnesia
300.13	Dissociative Fugue	300.13	Psychogenic Fugue
300.14	Dissociative Identity Disorder	300.14	Multiple Personality
300.15	Dissociative Disorder NOS	300.15	Dissociative Disorder or Reaction, unspecified
300.16	Factitious Disorder with Predominant Psychological Signs and Symptoms (S&S)	300.16	Factitious Illness with Psychological Symptoms
300.19	Factitious Disorder with Predominant Physical S&S or Combined S&S/Factitious Disorder NOS	300.19	Other and Unspecified Factitious Illness
300.21	Panic Disorder with Agoraphobia	300.21	Agoraphobia with Panic Attacks
300.22	Agoraphobia without History of Panic Disorder	300.22	Agoraphobia without mention of Panic Attacks
300.23	Social Phobia	300.23	Social Phobia
300.29	Specific Phobia	300.29	Other Isolated or Simple Phobias
300.3	Obsessive-Compulsive Disorder	300.3	Obsessive-Compulsive Disorder
300.4	Dysthymic Disorder	300.4	Neurotic Depression
300.6	Depersonalization Disorder	300.6	Depersonalization Syndrome
300.7	Hypochondriasis/Body Dysmorphic Disorder	300.7	Hypochondriasis
300.81	Somatoform Disorder	300.81	Somatization Disorder
300.82	Somatoform Disorder NOS/Undifferentiated Somatoform Disorder	300.82	Undifferentiated Somatoform Disorder
300.9	Unspecified Mental Disorder (Nonpsychotic)	300.9	Unspecified Neurotic Disorder
301.13	Cyclothymic Disorder	301.13	Cyclothymic Disorder
302.2	Pedophilia	302.2	Pedophilia
302.3	Transvestic Fetishism	302.3	Tranvestism
302.4	Exhibitionism	302.4	Exhibitionism
302.6	Gender Identity Disorder in Children/Gender Identity Disorder NOS	302.6	Disorders of Psychosexual Identity
302.70	Sexual Dysfunction NOS	302.70	Psychosexual Dysfunction, unspecified
302.71	Hypoactive Sexual Desire Disorder	302.71	Psychosexual Dysfunction; with inhibited sexual desired
302.72	Female Sexual Arousal Disorder/Male Erectile Disorder	302.72	Psychosexual Dysfunction; with inhibited sexual excitement
302.73	Female Orgasmic Disorder	302.73	Psychosexual Dysfunction; with inhibited female orgasm
302.74	Male Orgasmic Disorder	302.74	Psychosexual Dysfunction; with inhibited male orgasm

302.75	Premature Ejaculation	302.75	Psychosexual Dysfunction; with premature ejaculation
302.76	Dyspareunia (Not Due to a Medical Condition)	302.76	Psychosexual Dysfunction; with functional dyspareunia
302.79	Sexual Aversion Disorder	302.79	Psychosexual Dysfunction; with other specified psychosexual dysfunctions
302.81	Fetishism	302.81	Fetishism
302.82	Voyeurism	302.82	Voyeurism
302.83	Sexual Masochism	302.83	Sexual Masochism
302.84	Sexual Sadism	302.84	Sexual Sadism
302.85	Gender Identity Disorder in Adolescents or Adults	302.85	Gender Identity Disorder of Adolescent or Adult Life
302.89	Frotteurism	302.89	Other Specified Psychosexual Disorders; Other
302.9	Paraphilia NOS/Sexual Disorder NOS	302.9	Unspecified Psychosexual Disorder
303.00	Alcohol Intoxication	303.00	Acute Intoxication with Alcoholism (alcoholism must be documented), unspecified
		303.01	Acute Intoxication with Alcoholism (alcoholism must be documented), continuous
		303.02	Acute Intoxication with Alcoholism (alcoholism must be documented), episodic
		303.03	Acute Intoxication with Alcoholism (alcoholism must be documented), in remission
303.90	Alcohol Dependence	303.90	Other and Unspecified Alcohol Dependence, unspecified
		303.91	Other and Unspecified Alcohol Dependence, continuous
		303.92	Other and Unspecified Alcohol Dependence, episodic
		303.93	Other and Unspecified Alcohol Dependence
304.00	Opioid Dependence	304.00	Opioid Type Dependence, unspecified
		304.01	Opioid Type Dependence, continuous
		304.02	Opioid Type Dependence, episodic
		304.03	Opioid Type Dependence, in remission
304.10	Sedative, Hypnotic, or Anxiolytic Dependence	304.10	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, unspecified
		304.11	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, continuous
		304.12	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, episodic
		304.13	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, in remission
304.20	Cocaine Dependence	304.20	Cocaine Dependence, unspecified
		304.21	Cocaine Dependence, continuous

		304.22	Cocaine Dependence, episodic
		304.23	Cocaine Dependence, in remission
304.30	Cannabis Dependence	304.30	Cannabis Dependence, unspecified
		304.31	Cannabis Dependence, continuous
		304.32	Cannabis Dependence, episodic
		304.33	Cannabis Dependence, in remission
304.40	Amphetamine Dependence	304.40	Amphetamine and Other Psychostimulant Dependence, unspecified
		304.41	Amphetamine and Other Psychostimulant Dependence, continuous
		304.42	Amphetamine and Other Psychostimulant Dependence, episodic
		304.43	Amphetamine and Other Psychostimulant Dependence, in remission
304.50	Hallucinogen Dependence	304.50	Hallucinogen Dependence, unspecified
		304.51	Hallucinogen Dependence, continuous
		304.52	Hallucinogen Dependence, episodic
		304.53	Hallucinogen Dependence, in remission
304.60	Phencyclidine/Inhalant Dependence	304.60	Other Specified Drug Dependence, unspecified
		304.61	Other Specified Drug Dependence, continuous
		304.62	Other Specified Drug Dependence, episodic
		304.63	Other Specified Drug Dependence, in remission
304.80	Polysubstance Dependence	304.80	Combinations of Drug Dependence, excluding opioid type drugs, unspecified
		304.81	Combinations of Drug Dependence, excluding opioid type drugs, continuous
		304.82	Combinations of Drug Dependence, excluding opioid type drugs, episodic
		304.83	Combinations of Drug Dependence, excluding opioid type drugs, in remission
304.90	Other (or unknown) Substance Dependence	304.90	Unspecified Drug Dependence, unspecified
		304.91	Unspecified Drug Dependence, continuous
		304.92	Unspecified Drug Dependence, episodic
		304.93	Unspecified Drug Dependence, in remission
305.00	Alcohol Abuse	305.00	Alcohol Abuse, unspecified
		305.01	Alcohol Abuse, continuous

		305.02	Alcohol Abuse, episodic
		305.03	Alcohol Abuse, in remission
305.10	Nicotine Dependence	305.1	Tobacco Use Disorder
305.20	Cannabis Abuse	305.20	Cannabis Abuse, unspecified
		305.21	Cannabis Abuse, continuous
		305.22	Cannabis Abuse, episodic
		305.23	Cannabis Abuse, in remission
305.30	Hallucinogen Abuse	305.30	Hallucinogen Abuse, unspecified
		305.31	Hallucinogen Abuse, continuous
		305.32	Hallucinogen Abuse, episodic
		305.33	Hallucinogen Abuse, in remission
305.40	Sedative, Hypnotic, or Anxiolytic Abuse	305.40	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, unspecified
		305.41	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, continuous
		305.42	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, episodic
		305.43	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, in remission
305.50	Opioid Abuse	305.50	Opioid Abuse, unspecified
		305.51	Opioid Abuse, continuous
		305.52	Opioid Abuse, episodic
		305.53	Opioid Abuse, in remission
305.60	Cocaine Abuse	305.60	Cocaine Abuse, unspecified
		305.61	Cocaine Abuse, continuous
		305.62	Cocaine Abuse, episodic
		305.63	Cocaine Abuse, in remission
305.70	Amphetamine Abuse	305.70	Amphetamine or Related Acting Sympathomimetic Abuse, unspecified
		305.71	Amphetamine or Related Acting Sympathomimetic Abuse, continuous
		305.72	Amphetamine or Related Acting Sympathomimetic Abuse, episodic
		305.73	Amphetamine or Related Acting Sympathomimetic Abuse, in remission
305.90	Caffeine Intoxication/Inhalant Abuse/Phencyclidine Abuse/Other (or unknown) Substance Abuse	305.90	Other, Mixed, or Unspecified Drug Abuse, unspecified

		305.91	Other, Mixed, or Unspecified Drug Abuse, continuous
		305.92	Other, Mixed, or Unspecified Drug Abuse, episodic
		305.93	Other, Mixed, or Unspecified Drug Abuse, in remission
306.51	Vaginismus (Not Due to a General Medical Condition)	306.51	Psychogenic Vaginismus
307.0	Stuttering	307.0	Stammering and Stuttering
307.1	Anorexia Nervosa	307.1	Anorexia Nervosa
307.20	Tic Disorder NOS	307.20	Tic Disorder, unspecified
307.21	Transient Tic Disorder	307.21	Transient Tic Disorder of Childhood
307.22	Chronic Motor or Vocal Tic Disorder	307.22	Chronic Motor Tic Disorder
307.23	Tourette's Disorder	307.23	Gilles de la Tourette's Disorder
307.3	Stereotypic Movement Disorder	307.3	Stereotyped Repetitive Movements
		307.41	Transient Disorder of Initiating or Maintaining Sleep
307.42	Primary Insomnia/Insomnia Related to...(Indicate Axis I or Axis II Disorder)	307.42	Persistent Disorder of Initiating or Maintaining Sleep
		307.43	Transient Disorder of Initiating or Maintaining Wakefulness
307.44	Primary Hypersomnia/Hypersomnia Related to...(Indicate the Axis I or Axis II Disorder)	307.44	Persistent Disorder of Initiating or Maintaining Wakefulness
307.45	Circadian Rhythm Sleep Disorder	307.45	Phase-shift Disruption of 24-hour Sleep-wake Cycle
307.46	Sleep Terror Disorder/Sleepwalking Disorder	307.46	Somnambulism or Night Terrors
307.47	Dyssomnia NOS/Nightmare Disorder/Parasomnia NOS	307.47	Other Dysfunctions of Sleep Stages or Arousal from Sleep
307.50	Eating Disorder NOS	307.50	Eating Disorder, unspecified
307.51	Bulimia Nervosa	307.51	Bulimia
307.52	Pica	307.52	Pica
307.53	Rumination Disorder	307.53	Psychogenic Rumination
307.59	Feeding Disorder of Infancy or Early Childhood	307.59	Other & Unspecified Disorders of Eating, Other
307.6	Enuresis (Not Due to a General Medical Condition)	307.6	Enuresis
307.7	Encopresis, Without Constipation and Overflow Incontinence	307.7	Encopresis
307.80	Pain Disorder Associated with Psychological Factors	307.80	Psychogenic Pain, site unspecified
307.89	Pain Disorder Associated with Psychological and Medical	307.89	Psychalgia, Other
307.9	Communication Disorder NOS	307.9	Other and Unspecified Special Symptoms or Syndromes, not elsewhere classified

308.3	Acute Stress Disorder	308.3	Other Acute Reactions to Stress
309.0	Adjustment Disorder with Depressed Mood	309.0	Brief Depressive Disorder
309.21	Separation Anxiety Disorder	309.21	Separation Anxiety Disorder
309.24	Adjustment Disorder with Anxiety	309.24	Adjustment Reaction with Anxious Mood
309.28	Adjustment Disorder with Anxiety and Depressed Mood	309.28	Adjustment Reaction with Mixed Emotional Features
309.3	Adjustment Disorder with Disturbance of Conduct	309.3	Adjustment Reaction, with predominant disturbance of conduct
309.4	Adjustment Disorder with Mixed Disturbance Emotion and Conduct	309.4	Adjustment Reaction; with mixed disturbance of emotions and conduct
309.81	Post-Traumatic Stress Disorder	309.81	Prolonged Posttraumatic Stress Disorder
309.9	Adjustment Disorder Unspecified	309.9	Unspecified Adjustment Reaction
310.1	Personality Change Due to General Medical Condition	310.1	Organic pPrsonality Syndrome
311	Depressive Disorder NOS	311	Depressive Disorder, not elsewhere classified
312.30	Impulse-Control Disorder NOS	312.30	Impulsive Control Disorder, unspecified
312.31	Pathological Gambling	312.31	Pathological Gambling
312.32	Kleptomania	312.32	Kleptomania
312.33	Pyromania	312.33	Pyromania
312.34	Intermittent Explosive Disorder	312.34	Intermittent Explosive Disorder
312.39	Trichotillomania	312.39	Disorders of Impulse Control, Not Elsewhere Classified, Other
312.81	Conduct Disorder, Childhood-Onset Type	312.81	Conduct Disorder, childhood onset type
312.82	Conduct Disorder, Adolescent-Onset Type	312.82	Conduct Disorder, adolescent onset type
312.89	Conduct Disorder, Unspecified Onset	312.89	Other Conduct Disorder
312.9	Disruptive Behavior Disorder NOS	312.9	Unspecified Disturbance of Conduct
313.23	Selective Mutism	313.23	Elective Mutism
313.81	Oppositional Defiant Disorder	313.81	Oppositional Disorder
313.82	Identity Problem	313.82	Identity Disorder
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	313.89	Other or Mixed Emotional Disturbances of Childhood or Adolescence; Other
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	313.9	Unspecified Emotional Disturbance of Childhood or Adolescence
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	314.00	Attention Deficit Disorder; without mention of hyperactivity
314.01	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive Impulsive Type or Combined Type	314.01	Attention Deficit Disorder; with hyperactivity

314.9	Attention-Deficit/Hyperactivity Disorder NOS	314.01	Attention Deficit Disorder; with hyperactivity
315.00	Reading Disorder	315.00	Reading Disorder, Unspecified
315.1	Mathematics Disorder	315.1	Specific Arithmetical Disorder
315.2	Disorder of Written Expression	315.2	Other Specific Learning Difficulties
315.31	Expressive Language Disorder	315.31	Developmental Language Disorder
315.32	Mixed Receptive-Expressive Language Disorder	315.32	Receptive Language Disorder (mixed)
315.39	Phonological Disorder	315.39	Developmental Speech or Language Disorder; Other
315.4	Developmental Coordination Disorder	315.4	Coordination Disorder
315.9	Learning Disorder NOS	315.9	Unspecified Delay in Development
316	(Specified Psychological Factor) Affecting...(Indicate Medical Condition)	316	Psychic Factors Associated with Diseased Classified Elsewhere
332.1	Neuroleptic-Induced Parkinsonism	332.1	Secondary Parkinsonism
333.1	Medication-Induced Postural Tremor	333.1	Essential and Other Specified Forms or Tremor
333.7	Neuroleptic-Induced Acute Dystonia	333.7	Symptomatic Torsion Dystonia
333.82	Neuroleptic-Induced Tardive Dyskinesia	333.82	Orofacial Dyskinesia
333.90	Medication-Induced Movement Disorder NOS	333.90	Unspecified Extrapyrmidal Disease and Abnormal Movement Disorder
333.92	Neuroleptic Malignant Syndrome	333.92	Neuroleptic Malignant Syndrome
333.99	Neuroleptic-Induced Acute Akathisia	333.99	Other & Unspecified Extrapyrmidal Diseases & Abnormal Movement Disorders; Other
347	Narcolepsy	347	Cataplexy and Narcolepsy
607.84	Male Erectile Disorder Due to...(Indicate the General Medical Condition[GMC])	607.84	Impotence of Organic Origin
608.89	Male Dyspareunia/Hypoactive Sexual Desire Disorder/Other Male Sexual Dysfunction Due to...(Indicate GMC)	608.89	Other Specified Disorders of Male Genital Organs; Other
625.0	Female Dyspareunia Due to...(Indicate Medical Condition)	625.0	Dyspareunia
625.8	Female Hypoactive Sexual Desire Disorder/Other Female Sexual Dysfunction Due to...(Indicate GMC)	302.79	Psychosexual Dysfunction; with other specified psychosexual dysfunctions
780.09	Delirium NOS	780.09	Alterations of Consciousness, Other
780.52	Sleep Disorder Due to...(Indicate Medical Condition), Insomnia Type	780.52	Other Insomnia
780.54	Sleep Disorder Due to...(Indicate Medical Condition), Hypersomnia Type	780.54	Other Hypersomnia
780.59	Breathing Related Sleep Disorder/Sleep Disorder Due to...(Indicate GMC), Mixed or Parasomnia	780.59	Sleep Disturbances, Other
780.9	Age-Related Cognitive Decline	797	Senility without Mention of Psychosis
787.6	Encopresis with Constipation and Overflow Incontinence	787.6	Incontinence of Feces

799.9	Diagnosis Deferred (code invalid as Secondary/Axis II Diagnosis)	799.9	Other Unknown and Unspecified Cause
995.2	Adverse Effect of Medication NOS	995.2	Unspecified Adverse Effect of Drug Medicinal & Biological Substance
995.52	Neglect of Child (focus on victim)	995.52	Child Neglect (nutritional)
995.53	Sexual Abuse of Child (focus on victim)	995.53	Child Sexual Abuse
995.54	Physical Abuse of Child (focus on victim)	995.54	Child Physical Abuse
995.81	Physical Abuse of Adult (focus on victim)	995.81	Adult Physical Abuse
995.83	Sexual Abuse of Adult (focus on victim)	995.83	Adult Sexual Abuse
V15.81	Noncompliance with Treatment	V15.81	Noncompliance with Medical Treatment
V61.10	Partner Relational Problems	V61.10	Counseling for Marital and Partner Problems, unspecified
V61.12	Physical/Sexual Abuse of Adult (by Partner)	V61.12	Counseling for Perpetrator of Spousal and Partner Abuse
V61.20	Parent-Child Relational Problem	V61.20	Parent-child Problem Unspecified
V61.21	Physical/Sexual Abuse of Child/Neglect of Child	V61.21	Counseling for the Victim of Child Abuse (including neglect)
V61.8	Sibling Relational Problem	V61.8	Other Specified Family Circumstances
V61.9	Relational Problem Related to a Mental Disorder or General Medical Condition	V62.89	Other Psychological or Physical Stress, Not Elsewhere Classified, Other
V62.2	Occupational Problem	V62.2	Other Occupational Circumstances or Maladjustment
V62.3	Academic Problem	V62.3	Education Circumstances
V62.4	Acculturation Problem	V62.4	Social Maladjustment
V62.81	Relational Problem NOS	V62.81	Interpersonal Problems, not elsewhere classified
V62.82	Bereavement	V62.82	Bereavement, uncomplicated
V62.83	Physical or Sexual Abuse of Adult (by non-partner)	V62.83	Counseling for Perpetrator of Physical/Sexual Abuse
V62.89	Phase of Life Problem/Religious or Spiritual Problem	V62.89	Other Psychological or Physical Stress, Not Elsewhere Classified, Other
V65.2	Malingering	V65.2	Person Feigning Illness
V71.01	Adult Antisocial Behavior	V71.01	Adult Antisocial Behavior
V71.02	Child or Adolescent Antisocial Behavior	V71.02	Child or Adolescent Antisocial Behavior
V71.09	No Diagnosis (code invalid as Secondary/Axis III Diagnosis)	V71.09	Other Suspected Mental Condition

**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 or when performing subsequent assessment activities that are documented on an assessment form

Service	Code	Duration of Face- to- Face	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
Psychiatric diagnostic interview	No Code	1-19 min.	\$0.00	\$0.00
Psychiatric diagnostic interview	90801	20-39 min.	\$20.00	\$32.00
		40+ min.	\$40.00	\$53.00
Interactive psychiatric diagnostic interview using play equipment, physical devices, or other non-verbal mechanism of communication	No Code	1-19 min.	\$0.00	\$0.00
Interactive psychiatric diagnostic interview using play equipment, physical devices, or other non-verbal mechanism of communication	90802	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 IS in minutes.
- When working with children or other clients with limited verbal ability, claim in accordance with the predominant intervention modality: 90802 for non-verbal or 90801 for verbal.

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
Psychological Testing Psycho-diagnostic assessment of personality, development assessment and cognitive functioning. For children, referrals are made to clarify symptomology, rule out diagnoses and help delineate emotional from learning disabilities.	96101	60-1200 min.	\$36.00/hr	\$45.00/hr
Psychological Test Interpretation and Report Writing	90889	60-1200 min.	\$18.00/hr	\$18.00/hr
Computer Scoring	90889	1+ min.	\$18.00	\$18.00/hr

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. Documentation for the claim can simply reference the report.

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

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)

Service	Duration of Face-to-Face	Code	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	1-19 min.	No Code	\$0.00	\$0.00
	20-39 min.	90804	\$20.00	\$32.00
	40-74 min.	90806	\$40.00	\$53.00
	75+ min.	90808		
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	1-19 min.	No Code	\$0.00	\$0.00
	20-39 min.	90810	\$20.00	\$32.00
	40-74 min.	90812	\$40.00	\$53.00
	75+ min.	90814		

Note: These services are recorded in the clinical record and reported into the IS 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 reduction as a means of improving functional impairments.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)
WITH EVALUATION AND MANAGEMENT

Service	Duration of Face-to-Face	Code	Rate for MD/DO
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client with evaluation and management.	1-19 min.	No Code	\$0.00
	20-39 min.	90805	\$32.00
	40-74 min.	90807	\$53.00
	75+ min.	90809	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client with evaluation and management.	1-19 min.	No Code	\$0.00
	20-39 min.	90811	\$32.00
	40-74 min.	90813	\$53.00
	75+ min.	90815	

Note: These services are recorded in the clinical record and reported into the IS in minutes.

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

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>Family Psychotherapy with One or More Clients Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client(s). *</p> <p>Note: 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>Collateral (one or more clients represented) 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>Multi-family Group Psychotherapy Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.</p>	90849	2 clients minimum to 9 clients maximum 30+ min.	\$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>Group Psychotherapy Insight orientated, behavior modifying, supportive services delivered at the same time to more than one non-family client.</p>	90853			
<p>Interactive Group Psychotherapy Interactive service using non-verbal communication techniques delivered at the same time to more than one non-family client.</p>	90857			

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.)
- These services are recorded in the clinical record and reported into the IS as minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO AND NP SERVICES

MEDICATION SUPPORT

Service	Code	Duration of Face- to-Face	Rate
<p>Individual Medication Service (Face-to-Face) 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>Note: If more than minimal, supportive psychotherapy is provided; the service must be claimed as an E&M Individual Psychotherapy service.</p>	90862	15+ min.	\$20.00
<p>Brief Medication Visit (usually Face-to-Face) This service typically requires only a brief or problem-focused history including evaluation of safety & 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 IS 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

TEAM CONFERENCE/CASE CONSULTATION

Service	Code	Rate for PhD/PsyD, MFT, LCSW & NP/CNS	Rate for MD/DO
Team Conference/ Case Consultation Interdisciplinary inter/intra-agency conferences to coordinate activities of client care. Client may be present.	1-59 min. 99361	\$36.00	\$53.00
	60+ min. 99362		

Notes:

- These services are recorded in the clinical record and reported into the IS 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)

Service	Type	Code	Duration	Rate
ECT including monitoring	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 IS in minutes.

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

EMERGENCY ROOM SERVICES

This service may only be delivered in an Outpatient Hospital (Place of Service Code 23).

Service	Components	Severity of Presenting Problem(s)	Code	Duration of Face-to-Face	Rate for PhD/PsyD	Rate for MD/DO
A service for the evaluation and management of a client, which requires three components within the constraints of the client's clinical condition and/or mental status	<ul style="list-style-type: none"> Problem focused history Problem focused examination Straightforward decision making 	Self-limited or minor	99281	20-39 min.	\$20.00	\$59.00
				40+ min.	\$40.00	\$59.00
	<ul style="list-style-type: none"> Expanded history Expanded examination Decision making of low complexity 	Low to moderate	99282	20-39 min.	\$20.00	\$59.00
				40+ min.	\$40.00	\$59.00
	<ul style="list-style-type: none"> Expanded history Expanded examination Decision making of moderate complexity 	Moderate	99283	20-39 min.	\$20.00	\$59.00
				40+ min.	\$40.00	\$59.00
	<ul style="list-style-type: none"> Detailed history Detailed examination Decision making of moderate complexity 	High requiring urgent evaluation but do not pose an immediate significant threat to life or psychological function	99284	20-39 min.	\$20.00	\$59.00
				40+ min.	\$40.00	\$59.00
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Decision making of high complexity 	High and poses an immediate significant threat to life or psychological function	99285	20-39 min.	\$20.00	\$59.00
				40+ min.	\$40.00	\$59.00

Note:

- These services are categorized in the data system as Crisis Intervention and are recorded in the clinical record and reported into the IS in minutes.

**INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO AND ADMITTING PHD/PSYD SERVICES**

**INDIVIDUAL PSYCHOTHERAPY
HOSPITAL OR RESIDENTIAL CARE FACILITY**

This service may be delivered at any of these locations:

- Inpatient Hospital (POS* Code 21)
- Skilled Nursing Facility (POS Code 31)
- Nursing Facility (POS Code 32)
- Custodial Care Facility (POS Code 33)
- Intermediate Care Facility/Mentally Retarded (POS Code 54)
- Residential Substance Abuse Treatment Facility (POS Code 55)
- Psychiatric Residential Treatment Center (POS Code 56)

Service	Duration of Face-to-Face	Code	Rate for MD/DO	Rate for PHD/PsyD
Insight oriented, behavior modifying, and/or supportive services delivered to one client.	20-39 min.	90816	\$32.00	\$20.00
	40-74 min.	90818	\$53.00	\$40.00
	75+ min.	90821		
Insight oriented, behavior modifying, and/or supportive services delivered to one client with evaluation and management	20-39 min.	90817	\$32.00	\$20.00
	40-74 min.	90819	\$53.00	\$40.00
	75+ min.	90822		
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	20-39 min.	90823	\$32.00	\$20.00
	40-74 min.	90826	\$53.00	\$40.00
	75+ min.	90828		
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client with evaluation and management	20-39 min.	90824	\$32.00	\$20.00
	40-74 min.	90827	\$53.00	\$40.00
	75+ min.	90829		

* Place of Service

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in minutes.
- While providers may use this code if they are providing psychotherapy to their patients, their service is probably more likely the evaluation and management services.

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>Initial Care 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.</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"> Detailed history Detailed or comprehensive exam Straight-forward or low complexity decision-making 	Low	1-29 min.	99221	\$0.00
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Decision-making of moderate complexity 	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"> Comprehensive history Comprehensive examination Decision-making of high complexity 	High	70+ min.	99223	21+ years of age: \$78.00 20 years of age and under: \$85.00
<p>Subsequent Care, per day, for the evaluation and management of a 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"> Problem focused history Problem focused examination Straight-forward or low complexity decision-making 	Stable, recovering, or improving	1-24 min.	99231	\$20.00
	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused exam Decision-making of moderate complexity 	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"> Detailed history Detailed examination Decision making of moderate to high complexity 	Unstable, Significant complication, or new problem	35+ min.	99233	21+ years of age: \$40.00 20 years of age and under: \$44.00
	<p>All 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 IS 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
Assessment 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"> • Detailed history • Comprehensive examination • Straight-forward or low complexity decision-making 	Stable, recovering, or improving; Affirmation of plan of care required	20-39 min.	99301	\$32.00
	<ul style="list-style-type: none"> • Detailed history • Comprehensive examination • Decision-making of moderate to high complexity 	Significant complication or new problem; New plan of care required	40-49 min.	99302	\$53.00
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision-making of moderate to high complexity 	Creation plan of care required	50+ min.	99303	53.00
Subsequent 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"> • Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making 	Stable, recovering or improving	1-19 min.	99311	\$0.00
	<ul style="list-style-type: none"> • Expanded history • Expanded examination • Decision-making of moderate complexity 	Inadequate response to therapy or minor complication	20-39 min.	99312	\$32.00
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • decision making of moderate to high complexity 	Unstable, Significant complication or new problem	40+ min.	99313	\$53.00
Discharge	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 IS 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><u>New Client</u> 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"> Problem focused history Problem focused examination Straight-forward or low complexity decision making 	Low	99321	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> Expanded history Expanded examination Decision-making of moderate 	Moderate	99322	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> Detailed history Detailed examination Decision-making of high complexity 	High	99323	20-39 min.	\$32.00
				40+ min.	\$53.00
<p><u>Established Client</u> Services for the evaluation and management of an established client that requires at least <u>two</u> of <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"> Problem focused history Problem focused examination Straight-forward or low complexity decision-making 	Stable, recovering, or improving	99331	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> Expanded history Expanded examination Decision-making of moderate complexity 	Inadequate response to therapy or minor complication	99332	20-39 min.	\$32.00
				40+ min.	\$53.00
	<ul style="list-style-type: none"> Detailed history Detailed examination Decision making of high complexity 	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 IS in minutes.

INDIVIDUAL AND GROUP NETWORK PROVIDERS
MD/DO SERVICES

EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES

These services may only be delivered in an Office (Place of Service Code 11).

Service	Components	Severity of Presenting Problem(s)	NEW CLIENT Duration of Face-to-Face w/Client and/or Family and Code	NEW CLIENT Rate	ESTAB. CLIENT Duration of Face-to-Face w/Client and/or Family and Code	ESTAB. CLIENT Rate
<p>Evaluation and management of a client that includes at least the <u>three</u> components.</p> <p>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.</p>	<ul style="list-style-type: none"> Problem focused history Problem focused examination Straightforward medical decision making 	Minor	10-19 min. 99201	\$0.00	No Code	\$0.00
	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused exam Straightforward medical decision making 	Low to Moderate	20-29 min. 99202	\$32.00	10-19 min. 99212	\$0.00
	<ul style="list-style-type: none"> Detailed history Detailed examination Medical decision making of low complexity 	Moderate	30-39 min. 99203	\$32.00	20-24 min. 99213	\$32.00
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Medical decision making of moderate complexity 	Moderate to High	40-59 min. 99204	\$53.00	25-39 min. 99214	\$32.00
	<ul style="list-style-type: none"> Problem focused history Problem focused examination Medical decision making of high complexity 	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 IS 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 <u>three</u> 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.	<ul style="list-style-type: none"> • Problem focused history • Problem focused examination • Straightforward decision making 	Self limited or minor	20-39 min. 99251	20-39 min. 99271	\$20.00	\$32.00
	<ul style="list-style-type: none"> • Expanded problem focused history • Expanded problem focused exam • Straightforward decision making 	Low	40-54 min. 99252	40+ min. 99272	\$40.00	\$53.00
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of low complexity 	Moderate	55-79 min. 99253	40+ min. 99273	\$40.00	\$53.00
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of moderate complexity 	Moderate to high	80-109 min. 99254	80+ min. 99274	\$40.00	\$53.00
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of high complexity 	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.	<ul style="list-style-type: none"> • Problem focused history • Problem focused examination • Straightforward or low complexity decision making 	Stable, recovering, or improving	1-19 min. 99261	1-19 min. 99261	\$0.00	\$0.00
	<ul style="list-style-type: none"> • Expanded problem focused history • Expanded problem focused exam • Decision making of moderate complexity 	Inadequate response to therapy or minor complication	20-39 min. 99262	20-39 min. 99262	\$20.00	\$32.00
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of high complexity 	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 IS 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)
- Outpatient Hospital (POS 22)
- Hospital Emergency Room (POS 23)
- Urgent Care (POS 20)
- 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	<ul style="list-style-type: none"> • Problem focused history • Problem focused examination 	Self Limited or Minor	20-29 min.	99241	\$32.00
	<ul style="list-style-type: none"> • Straightforward decision making 				
	<ul style="list-style-type: none"> • Expanded problem focused history • Expanded problem focused exam • Straightforward decision making 	Low Severity	30-39 min.	99242	\$32.00
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of low complexity 	Moderate Severity	40-59 min.	99243	\$53.00
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of moderate complexity 	Moderate to High Severity	60-79 min.	99244	\$53.00
<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of high complexity 	Moderate to High Severity	80+ min.	99245	\$53.00	

*Place of Service

Note: Services are recorded in the clinical record and reported into the IS in hours: minutes.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND RN 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 (§1810.204). These codes should be used when completing an Initial Assessment or when performing subsequent assessment activities that are documented on an assessment.

Service	Code	Duration of Face- to- Face	Rate
Psychiatric diagnostic interview	No Code	1-19 min.	\$0.00
Psychiatric diagnostic interview	90801	20-39 min. 40-50 min.	\$1.08 per min.
Interactive psychiatric diagnostic interview using play equipment, physical devices, or other non-verbal mechanism of communication	No Code	1-19 min.	\$0.00
Interactive psychiatric diagnostic interview using play equipment, physical devices, or other non-verbal mechanism of communication	90802	20-39 min. 40-50 min.**	\$1.08 per min.

** Maximum reimbursement is for 50 minutes of service.

Notes:

- These services are recorded in the clinical record and reported into the IS in minutes.
- When working with children or other clients with limited verbal ability, claim in accord with the predominant intervention modality: 90802 for non-verbal, 90801 for verbal.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO AND PHD/PSYD SERVICES**

PSYCHOLOGICAL TESTING

All psychological testing performed by network providers and claimed to Medi-Cal must have prior authorization.

Service	Code	Duration of Face- to- Face	Rate
Psychological Testing Psych-diagnostic assessment of personality, development assessment and cognitive functioning. For children, referrals are made to clarify symptomology, rule out diagnosis and help delineate emotional from learning disabilities	96101	60-1200 min.	\$1.08 per min
Psychological Test Interpretation and Report Writing	90889	1-30 min.	\$.60 per min
Computer Scoring	90889	1-30 min.	\$.60 per min

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. Documentation for the claim can simply reference the report.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND RN SERVICES**

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)

Service	Duration of Face-to-Face	Code	Rate
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	0-19 min.	No Code	\$0.00
	20-39 min.	90804	\$1.08 per min.
	40-50 min.**	90806	\$1.08 per min.
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	0-19 min.	No Code	\$0.00
	20-39 min.	90810	\$1.08 per min.
	40-50 min.**	90812	\$1.08 per min.

** Maximum reimbursement is for 50 minutes of service.

Note: These services are recorded in the clinical record and reported into the IS 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 Service Plan.
- The service focuses primarily on symptom reductions as a means of improving functional impairments.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO SERVICES**

**INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY)
WITH EVALUATION AND MANAGEMENT**

These services should be used by physicians when providing medication prescription services in association with more than minimal therapy.

Service	Duration of Face-to-Face	Code	Rate
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client with evaluation and management.	0-19 min.	No Code	\$0.00
	20-39 min.	90805	\$1.08 per min.
	40-50 min.**	90807	\$1.08 per min.
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client with evaluation and management.	0-19 min.	No Code	\$0.00
	20-39 min.	90811	\$1.08 per min.
	40-50 min.**	90813	\$1.08 per min.

** Maximum reimbursement is for 50 minutes of service.

Note: These services are recorded in the clinical record and reported into the IS in minutes.

ORGANIZATIONAL NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND RN SERVICES

FAMILY AND GROUP SERVICES
(EXCEPT MED SUPPORT GROUP)

Service	Code	Duration of Face-to-Face	Rate
<p>Family Psychotherapy with One or More Clients Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. *</p> <p>Note: 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.	\$1.08 per min.
		40-59 min.**	\$1.08 per min.
<p>Collateral (one or more clients represented) 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	60-90 min.**	\$1.08 per min.
<p>Multi-family Group Psychotherapy Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.</p>	90849	2 clients minimum to 9 clients maximum	<p>\$1.08 per min. Sample: 60 min session x \$1.08=\$64.80 divided: 2 clts:30 min each=\$32.40 each 3 clts:20 min each=\$21.60 each 4 clts:15 min each=\$16.20 each 5 clts:12 min each=\$12.96 each 6 clts:10 min each=\$10.80 each 7 clts :9 min each=\$9.26 each 8 clts :8 min each=\$8.10 each 9 clts :7 min each=\$7.19 each</p>
<p>Group Psychotherapy Insight orientated, behavior modifying, supportive services delivered at the same time to more than one non-family client.</p>	90853	Organizational: # of min. divided by # of clients present from 2-9 clients	
<p>Interactive Group Psychotherapy Interactive service using non-verbal communication techniques delivered at the same time to more than one non-family client.</p>	90857		

* If 2 or more clients of family members are seen together, only one family therapy unit can be reimbursed regardless of the number of clients in the session. Use the name of any one client to bill for the entire session. Refer to Clarification of Family Therapy for more information).

** Maximum reimbursement is for 59 minutes of family psychotherapy and 90 minutes of collateral.

Notes:

- These services are recorded in the clinical record and reported into the IS as minutes.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.

ORGANIZATIONAL NETWORK PROVIDERS
MD/DO AND NP SERVICES

MEDICATION SUPPORT

Service	Code (Modifier)	Duration of Face-to-Face	Rate
<p>Individual Medication Service (Face-to-Face) This service requires expanded problem-focused or detailed history and medical decision-making of low to moderate complexity for prescribing, adjusting, or monitoring meds. Note: If more than minimal, supportive psychotherapy is provided; the service must be claimed as an E&M Individual Psychotherapy service.</p>	90862	15-50 min. **	\$1.37 per min.
<p>Brief Medication Visit (usually Face-to-Face) This service typically requires only a brief or problem-focused history including evaluation of safety & effectiveness with straightforward decision-making regarding renewal or simple dosage adjustments. The client is usually stable.</p>	M0064	7-50 min. **	\$1.37 per min.

** Maximum reimbursement is for 50 minutes of medication support services.

Note: These services are recorded in the clinical record and reported into the IS in minutes.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO, PHD/PSYD, LCSW, MFT AND RN SERVICES**

OTHER SERVICES

Service	Code	Duration	Rate
<p>Targeted Case Management (TCM) Services needed to access medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services, whether face-to-face, by phone, or through correspondence, provide for the continuity of care within the mental health system and related social service systems. Services include linkage and consultation, placement, and plan development.</p>	T1017	1-60 min. **	\$.70 per min.
<p>Team Conference/Case Consultation Interdisciplinary inter/intra-agency conference to coordinate activities of client care. Client may be present.</p>	99361	1-50 min. **	\$1.08 per min.

** Maximum reimbursement is for 60 minutes for TCM service and 50 minutes for Team Conference/Case Consultation.

Notes:

- These services are recorded in the clinical record and reported into the IS in minutes.
- TCM Medi-Cal Lockout: Except for the day of admission or for placement services provided during the 30 calendar days immediately prior to the day of discharge for a maximum of three nonconsecutive periods of 30 days, TCM may not be reimbursed by Medi-Cal on the same day as any of the following services are claimed: psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services. These facilities include institutions for mental disease (IMDs).
- Team Conference/Case Consultation: The time of the conference determines the code, but that time should NOT be equated with claimable time. Face-to-face time must always be zero because this is not a service directed toward the client and would distort the amount of appropriate reimbursable time. Other time should only include the actual time a staff person contributed to the conference (listening and learning are not included) and any other time a staff person actually spent related to the conference, such as travel or documentation.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO AND PHD/PSYD SERVICES**

EMERGENCY ROOM SERVICES

This service may only be delivered in a Hospital Emergency Room (Place of Service 23).

Service	Components	Severity of Presenting Problem(s)	Code	Duration of Face-to-Face	Rate
A service for the evaluation and management of a client, which requires <u>three</u> components within the constraints of the client's clinical condition and/or mental status	<ul style="list-style-type: none"> • Problem focused history • Problem focused examination • Straightforward decision making 	Self-limited or minor	99281	1-45 min.**	\$1.68 per min.
	<ul style="list-style-type: none"> • Expanded history • Expanded examination • Decision making of low complexity 	Low to moderate	99282	1-45 min.**	\$1.68 per min.
	<ul style="list-style-type: none"> • Expanded history • Expanded examination • Decision making of moderate complexity 	Moderate	99283	1-45 min.**	\$1.68 per min.
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of moderate complexity 	High requiring urgent evaluation but do not pose an immediate significant threat to life or psychological function	99284	1-45 min.**	\$1.68 per min.
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of high complexity 	High and poses an immediate significant threat to life or psychological function	99285	1-45 min.**	\$1.68 per min.

** Maximum reimbursement is for 45 minutes of service.

Note: These services are categorized in the data system as crisis intervention and are coded in the clinical record and reported into the IS in minutes.

**ORGANIZATIONAL 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 32)
- Intermediate Care Facility/Mentally Retarded (POS 54)
- Residential Substance Abuse Treatment Facility (POS 55)
- Psychiatric Residential Treatment Center (POS 56)

Service	Components	Severity of Condition and/or Plan Requirements	Duration of Face-to-Face Or on Unit	Procedure Code	Rate
Assessment 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"> • Detailed history • Comprehensive examination • Straight-forward or low complexity decision-making 	Stable, recovering, or improving; Affirmation of plan of care required	20-39 min.	99301	\$1.08 per min.
	<ul style="list-style-type: none"> • Detailed history • Comprehensive examination • Decision-making of moderate to high complexity 	Significant complication or new problem; New plan of care required	40-49 min.	99302	\$1.08 per min.
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision-making of moderate to high complexity 	Creation plan of care required	50 minutes **	99303	\$1.08 per min
Subsequent 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"> • Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making 	Stable, recovering, or improving	1-19 min.	99311	\$0.00
	<ul style="list-style-type: none"> • Expanded history • Expanded examination • Decision-making of moderate complexity 	Inadequate response to therapy or minor complication	20-39 min.	99312	\$1.08 per min.
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of moderate to high complexity 	Unstable, Significant complication or new problem	41-50 min.**	99313	1.08 per min.
Discharge	All services on day of discharge	N/A	20-39 min.	99315	\$1.08 per min.
			41-50 min.**	99316	\$1.08 per min.

* Place of Service

** Maximum reimbursement is for 50 minutes 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 IS in minutes.

**ORGANIZATIONAL 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 33).

Service	Components	Severity of Presenting Problem	Procedure Code	Duration of Face-to-Face	Rate
<p><u>New Client</u> 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"> • Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making 	Low	99321	20-39 min.	\$1.08 per min.
				40-50 min.**	\$1.08 per min.
	<ul style="list-style-type: none"> • Expanded history • Expanded examination • Decision-making of moderate 	Moderate	99322	20-39 min.	\$1.08 per min.
				40-50 min.**	\$1.08 per min.
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision-making of high complexity 	High	99323	20-39 min.	\$1.08 per min.
				40-50 min.**	\$1.08 per min.
<p><u>Established Client</u> 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"> • Problem focused history • Problem focused examination • Straight-forward or low complexity decision-making 	Stable, recovering, or improving	99331	20-39 min.	\$1.08 per min.
				40-50 min.**	\$1.08 per min.
	<ul style="list-style-type: none"> • Expanded history • Expanded examination • Decision-making of moderate complexity 	Inadequate response to therapy or minor complication	99332	20-39 min.	\$1.08 per min.
				40-50 min.**	\$1.08 per min.
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of high complexity 	Significant complication or new problem	99333	20-39 min.	\$1.08 per min.
				40-50 min.**	\$1.08 per min.

** Maximum reimbursement is for 50 minutes 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 IS in minutes.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO SERVICES**

**EVALUATION AND MANAGEMENT
(OFFICE OR OTHER OUTPATIENT SERVICES)**

This service may only be delivered in an Office (Place of Service 11).

Service	Components	Severity of Presenting Problem(s)	NEW CLIENT Duration of Face-To-Face W/Client and/or Family and Code	NEW CLIENT Rate	ESTAB. CLIENT Duration of Face-To-Face W/Client and/or Family and Code	ESTAB. CLIENT Rate
Evaluation and management of a client that includes at least the three components noted in the next column.	<ul style="list-style-type: none"> Problem focused history Problem focused examination Straightforward medical decision making 	Minor	1-19 min. 99201	\$0.00	No Code	\$0.00
	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused exam Straightforward medical decision making 	Low to Moderate	20-39 min. 99202	\$1.08 per minute	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"> Detailed history Detailed examination Medical decision making of low complexity 	Moderate	20-39 min. 99203	\$1.08 per minute	20-39 min. 99213	\$1.08 per min.
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Medical decision making of moderate complexity 	Moderate to High	40-50 min.** 99204	\$1.08 per minute	20-39 min. 99214	\$1.08 per min.
	<ul style="list-style-type: none"> Problem focused history Problem focused examination Medical decision making of high complexity 	Moderate to High	40-50 min.** 99205	\$1.08 per minute	40-50 min.** 99215	\$1.08 per min.

** Maximum reimbursement is for 50 minutes of services.

Note: These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in minutes.

**ORGANIZATIONAL 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 22).

Service	Components	Severity of Presenting Problem	Initial Consult Code	Initial Consult Rate	Confirmatory Consult	Rate
<p>Initial Inpatient or Nursing Facility Service for the evaluation and management of a new or established client that requires three components.</p> <p>Confirmatory Service to a new or established client to confirm an existing opinion regarding services.</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"> Problem focused history Problem focused examination Straightforward decision making 	Self limited or minor	20-39 min. 99251	\$1.08 per min.	20-39 min 99271	\$1.08 per min.
					40 + min** 99271	\$1.08 per min
	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused exam Straightforward decision making 	Low	40-50 min.** 99252	\$1.08 per min.	20-39 min 99272	\$1.08 per min.
					40 + min** 99272	\$1.08 per min.
	<ul style="list-style-type: none"> Detailed history Detailed examination Decision-making of low complexity 	Moderate	40-50 min.** 99253	\$1.08 per min.	20-39 min 99273	\$1.08 per min.
					40 + min** 99273	\$1.08 per min.
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Decision-making of moderate complexity 	Moderate to high	80-109 min. 99254	Not reimbursed	20-39 min 99274	\$1.08 per min.
					40 + min** 99274	\$1.08 per min.
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Decision-making of high complexity 	High	110+ min. 99255	Not reimbursed	20-39 min. 99275	\$1.08 per min.
					40 + min** 99275	\$1.08 per min.
<p>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>two of three</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.</p>	<ul style="list-style-type: none"> Problem focused history Problem focused examination Straightforward or low complexity decision-making 	Stable, recovering, or improving	1-19 min. 99261	Not reimbursed	1-19 min. 99261	Not reimbursed
	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused exam Decision-making of moderate complexity 	Inadequate response to therapy or minor complication	20-39 min. 99262	\$1.08 per min.	20-39 min. 99262	\$1.08 per min.
	<ul style="list-style-type: none"> Detailed history Detailed examination Decision making of high complexity 	Significant complication or new problem	20-39 min.** 99263	\$1.08 per min.	20-39 min. 99263	\$1.08 per min.

Note: These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in minutes.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO AND ADMITTING PHD/PSYD SERVICES**

**INDIVIDUAL PSYCHOTHERAPY
HOSPITAL OR RESIDENTIAL CARE FACILITY**

This service may be delivered at any of these locations:

- Inpatient Hospital (POS* Code 21)
- Skilled Nursing Facility (POS 31)
- Nursing Facility (POS 32)
- Custodial Care Facility (POS 33)
- Intermediate Care Facility/Mentally Retarded (POS 54)
- Residential Substance Abuse Treatment Facility (POS 55)
- Psychiatric Residential Treatment Center (POS 56)

Service	Duration of Face-to-Face	Code	Rate
Insight oriented, behavior modifying, and/or supportive services delivered to one client.	20-39 min.	90816	\$1.08 per min.
	40-50 min.**	90818	
	N/A	90821	\$0.00
Insight oriented, behavior modifying, and/or supportive services delivered to one client with evaluation and management	20-39 min.	90817	\$1.08 per min.
	40-50 min.**	90819	
	N/A	90822	\$0.00
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	20-39 min.	90823	\$1.08 per min.
	40-50 min.**	90826	
	N/A	90828	\$0.00
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client with evaluation and management	20-39 min.	90824	\$1.08 per min.
	40-50 min.**	90827	
	N/A	90829	\$0.00

* Place of Service

** Maximum reimbursement for 50 minutes or service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in minutes.
- While physicians may use this code if they are providing psychotherapy to their patients, their service is probably more likely the evaluation and management services.

**ORGANIZATIONAL NETWORK PROVIDERS
MD/DO SERVICES**

EVALUATION AND MANAGEMENT - INPATIENT HOSPITAL SERVICES

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

Service	Components	Severity of Condition	Duration of Face-to-Face or on Unit	Procedure Code	Rate
Initial Care 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.	<ul style="list-style-type: none"> Detailed history Detailed or comprehensive exam Straight-forward or low complexity decision-making 	Low	1-29 min.	99221	Not reimbursed
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Decision-making of moderate complexity 	Moderate	30-45 min.**	99222	\$1.68 per min.
	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Decision-making of high complexity 	High	30-45 min.**	99223	\$1.68 per min.
Subsequent Care, per day, for the evaluation and management of a client that requires at least <u>two of 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"> Problem focused history Problem focused examination Straight-forward or low complexity decision-making 	Stable, recovering, or improving	1-24 min.	99231	\$1.37 per min
	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused exam Decision-making of moderate complexity 	Inadequate response to therapy or minor complication	25-34 min.	99232	1.68 per min
	<ul style="list-style-type: none"> Detailed history Detailed examination Decision making of moderate to high complexity 	Unstable, Significant complication or new problem	35-45 min.**	99233	\$1.68 per min
	Discharge	All services on day of discharge	N/A	1-24 min.	99238
25-45 min.**				99239	\$1.68 per min

** Maximum reimbursement is for 45 minutes 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 IS in minutes.

**ORGANIZATIONAL 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)
- Outpatient Hospital (POS 22)
- Hospital Emergency Room (POS 23)
- Urgent Care (POS 20)
- 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	<ul style="list-style-type: none"> • Problem focused history • Problem focused examination • Straightforward decision making 	Self Limited or Minor	20-29 min.	99241	\$1.08 per min.
	<ul style="list-style-type: none"> • Expanded problem focused history • Expanded problem focused examination • Straightforward decision making 	Low Severity	30-39 min.	99242	
	<ul style="list-style-type: none"> • Detailed history • Detailed examination • Decision making of low complexity 	Moderate Severity	40-59 min.	99243	
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of moderate complexity 	Moderate to High Severity	60-79 min.	99244	Not Reimbursed
	<ul style="list-style-type: none"> • Comprehensive history • Comprehensive examination • Decision making of high complexity 	Moderate to High Severity	80+ min.	99245	

* Place of Service

SECTION IX – 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 (CRC) and the Compliance Program Office (CPO); and
- Immediate notification to the LMHP of any investigations 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.

The *General Administrative Profile* and *Chart Review Checklist* (Attachments I and II) are mandatory self-assessment tools sent to 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. Network providers are required to return the self-assessment tools to the LMHP upon completion.

The Medi-Cal Professional Services and Authorization Division routinely selects network providers for site visits and clinical chart reviews. The purpose of the site visit and clinical chart review is to validate the information provided on the self-assessment tools and to evaluate compliance with the LMHP legal agreement and Medi-Cal requirements directly at the provider's service location.

Prior to the site visit the network provider will receive a letter informing the provider of the date of the site visit. A list of the clinical charts for review is included with the letter. Within one month after the site visit the provider will receive a report summarizing the site visit and clinical chart review. Recommendations and a request for a Plan of Correction will be included in the report when actions are required to correct deficiencies. A follow-up site visit may be scheduled to confirm implementation of the Plan of Correction.

COMPLIANCE PROGRAM AUDITS

The LMHP CPO conducts reviews and audits of LMHP programs, providers and contractors to ensure compliance with Federal, State and County statutes, rules, regulations and policies. The purpose of the audit is to discover and correct compliance related issues and to combat fraud, waste and abuse.

A memo from the Director of Mental Health to network providers dated February 14, 2008 (Attachment III) provided notification that the CPO would be conducting audits of network providers based on established payment threshold amounts, 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.

Network providers selected for a CPO audit will receive a notification letter from the CPO with detailed information including the audit date and time.

COMPLAINTS

Complaints regarding the clinical quality of care rendered by network providers received from beneficiaries, family members, governmental agencies or other concerned parties, will be thoroughly evaluated by the LMHP. Quality of care concerns may result in a site visit and clinical chart review, a referral to the CRC, and/or a referral to the CPO.

REPORTING ADVERSE CLINICAL INCIDENTS

All network providers must report adverse clinical incidents to the LMHP. Such incidents 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.

Upon determining that an adverse clinical incident has occurred, network providers must determine if the clinical incident is critical or non-critical.

CRITICAL INCIDENTS

Critical clinical incidents are events which generate community-wide governmental or media attention or that may require a report to the Board of Supervisors by the Director of Mental Health.

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, Page 1 of the *Clinical Incident Report* form (Attachment IV), 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, 12th Floor
Los Angeles, CA 90020
Fax: (213) 386-1297

Before the *Clinical Incident Report* form 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.

NON-CRITICAL INCIDENTS

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* form (Attachment IV) within 48 hours of the incident to:

Department of Mental Health
Office of the Medical Director
Roderick Shaner, M.D.
550 S. Vermont Ave, 12th Floor
Los Angeles, CA 90020
Fax: (213) 386-1297

CLINICAL INCIDENT TYPES No. 3 THROUGH No. 10

If the critical or non-critical clinical incident type is No. 3 through No. 10 on Page 1 of the *Clinical Incident Report* form, the network provider is to complete Page 2 of the *Clinical Incident Report* form and send the report within 30 days of the incident to:

Department of Mental Health
Clinical Risk Manager
Mary Ann O'Donnell
550 S. Vermont Ave., 12th floor
Los Angeles, CA 90020

CLINICAL INCIDENT REPORTING ELEMENTS

Network providers are to adhere to the clinical incident reporting elements on the *Clinical Incident Report* form. 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* form may be kept by the network provider in a separate file.

The *Clinical Incident Report* form and additional information regarding clinical indigent reporting requirements are available online at <http://www.rshaner.medem.com>. Scroll down to “Clinical Risk Management” for several links to this information.

Network providers may also contact the Clinical Risk Manager at (213) 738-4440 for additional information and questions regarding Clinical Incident Reporting.

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH

GENERAL ADMINISTRATIVE PROFILE

Self Assessment

Individual and Group Network Providers

Page 1 of 8

PROVIDER INFORMATION

Provider Name: _____
Provider Discipline: [] MD; [] DO; [] Ph.D.; [] Psy.D.; [] LCSW; [] MFT; [] RN
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 []

Check Appropriate Box

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 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. In accordance with your contract, are you knowledgeable about the child, dependent adult and elder abuse reporting laws and the reporting requirements? Yes No
- d. 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
- e. 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
- f. 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

Check Appropriate Box

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

4. 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? Yes No
- 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 each time 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 of the Medi-Cal Specialty Mental Health Services Provider Manual? Yes No
- 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 until 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

Check Appropriate Box

retained at least one year after such minor has reached the age of 18, but never less than seven years?

Yes No

- 4) Are records of minors that have audits or legal action pending retained until the issues have been settled, the client's 19th birthday or seven years, whichever is longer?

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).

5. What percentage of your Medi-Cal clients are registered with the Department? **Include only those individuals seen as part of your contract with DMH**

6. What percentage of the above number have client ID numbers?

7. Do you maintain a file of Client ID numbers?

8. How many requests for treatment authorizations were made during the last fiscal year for clients seen as part of your contract with DMH?

9. How many were approved?

C. NOTIFICATION

1. Are Notices of Action (NOA-A) issued when services are denied based on medical necessity criteria?

Yes No

2. 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

3. Are "your Mental Health Benefits" brochures in appropriate

Check Appropriate Box

- languages? Yes No
4. Are "Your Mental Health Benefits" brochures, in the appropriate languages, displayed in an area in ready view of the beneficiaries? Yes No
5. Are "Complaint and Grievance Procedure" pamphlets in appropriate languages? Yes No
6. Are "Complaint and Grievance Procedure" pamphlets, in appropriate languages, displayed in an area in ready view of the beneficiaries? Yes No
7. Do you notify/inform beneficiaries of the LMHP's complaint and grievance procedures? 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 designee? Yes No
- c. Are medications administered only under the direct supervision of the prescribing physician? 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 of Physician Yes No
- Is a new log used each time the office stock is replenished? Yes No
- e. Are the completed log sheets maintained for at least three (3) years after the date of the last entry? Yes No
- f. Are multi-dose vials dated and initialed when opened? Yes No

2. PHARMACEUTICAL SAMPLES

Check Appropriate Box

- 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

Check Appropriate Box

- j. Are contaminated or deteriorated drugs kept, including "sample" drugs Yes No
- k. 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

E. BILLING

- 1. Do you submit your DMH Medi-Cal billings within six (6) months of service date? Yes No
- 2. Are you aware that you will not be paid if billings are not submitted within six (6) months of service date? Yes No
- 3. Do you feel comfortable with your knowledge regarding submitting a correct/complete claim? Yes No
 - a. Do you or your staff need/require additional training regarding claiming procedures? Yes No
- 4. Do you know how to correct the Error Correction Reports (ECR)? Yes No
 - a. Do you or your staff need/require additional training regarding ECR corrections? Yes No

F. CLIENT INFORMATION (FOR MEDI-CAL 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. Of the total number of open cases, list the diagnostic categories and the percentages of each category, i.e.,	_____ _____	_____ _____	_____ _____

Check Appropriate Box

	Bipolar Illness, Schizophrenia, Major Depression, etc.	_____	_____	_____
		_____	_____	_____
3.	How many clients are dually diagnosed, substance abuse/mentally ill?	_____	_____	_____
4.	How many clients are dually diagnosed, mental retardation/ mentally ill?	_____	_____	_____
5.	To the best of your knowledge, how many clients are HIV+ or have AIDS?	_____	_____	_____
6.	How many clients are wards or dependents of the courts?	_____	_____	_____
7.	How many forensic clients are part of your caseload?	_____	_____	_____
8.	Please provide the following specific client data:			
	a. 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	Secondary	Tertiary
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?	_____	_____	_____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHART REVIEW CHECKLIST

INDIVIDUAL AND GROUP NETWORK PROVIDERS

NAME OF REVIEWER:

DATE:

PROVIDER'S NAME:

PROVIDER'S ADDRESS:

I. AGENCY/PROGRAM CLIENT RECORD SYSTEM

- A. Number of charts reviewed
- B. Method of selection
 - 1. Case numbers selected YES __ NO__
 - 2. Random Selection YES __ NO__
- C. Charts are accessible to authorized persons only. YES __ NO__
- D. Charts are locked and/or under supervision. (County) YES __ NO__

Rating Scale Y= Meets all requirements; N= Does not meet requirements; NA= Not Applicable; * See comments					
IDENTIFICATION OF CASES REVIEWED	ID#	ID#	ID#	ID#	ID#
ENTER DMH CLIENT ID NUMBER					
II. GENERAL ISSUES: (apply to all charts unless specifically noted)					
A. ADMINISTRATION/REQUIRED FORMS					
1. A Consent for Services is signed during the first contact with the beneficiary.					
2. The Consent for Services contains:					
2 a. Name of practitioner, group or organization					
2 b. Types of services provided:					
2 b 1 There is explicit language that describes the type of service and the services that may be delivered, such as psychological testing, psychological/counseling, medication, laboratory tests, and/or diagnostic procedures.					
2 c. General Information, including that :					
2 c 1 the beneficiary has the right to be informed and to participate in the selection of treatment services;					
2 c 2 treatment services are voluntary;					
2 c 3 the beneficiary may request a change of service provider (agency or treating clinician);					
2 c 4 the clinical information contained in the record can be accessed by those who, under W & I Code 5328, either have a statutory right to know even in the absence of a person's consent, i.e., treating clinician or agency within the LA County Mental Health Plan system, or to anyone to whom the person consents.					
2 d. Signatures of:					
2 d 1 beneficiary with date or a notation that the individual is unable or unwilling to sign consent;					
2 d 2 witness attests confirmation of signature with date;					
2 d 3 affirmation that consent of minor has been completed for under-aged children;					
2 d 4 translator's signature and date, if applicable.					

Rating Scale Y= Meets all requirements; N= Does not meet requirements; NA= Not Applicable; * See comments					
IDENTIFICATION OF CASES REVIEWED	ID#	ID#	ID#	ID#	ID#
A. ADMINISTRATION/REQUIRED FORMS CONT.					
ENTER DMH CLIENT ID NUMBER					
3. Consent of Minors. (COMPLETE ONLY IF APPLICABLE)					
3 a. emancipated:					
3 a 1 a copy of the person's Department of Motor Vehicle emancipated minor ID card;					
3 b. self-sufficient:					
3 b 1 no official designated documents; provider must weigh and document evidence presented by minor;					
3 c. married:					
3 c 1 a copy of the marriage certificate;					
3 d. military:					
3 d 1 a copy of the minor's military ID;					
3 e. in need of mental health services:					
3 e 1 the treating clinician must note and attest to the five requirements noted on the Department's "Consent for Minor" form.					
4. A completed and signed Use and Disclosure of Protected Health Information (PHI) Requiring Authorization form is present before using or disclosing PHI.					
(if present) <i>The consent contains: (WIC 5328.7)</i>					
4 a. name and address of facility/agency to whom information is being released;					
4 b. name, address and birth date of beneficiary;					
4 c. requestor's name and requestor's agency's name, address and telephone number;					
4 d. purpose for which information is being released;					
4 e. specific information and date range of the services being released;					
4 f. effective dates of authorization and date of expiration (usually 90 days, but never exceeding a year)					
4 g. signature and date of authorizing beneficiary (if a minor, only for the clinical services to which the minor can lawfully consent);					
4 h. signature of witness to authorizing beneficiary;					
4 i. mechanism to revoke authorization with beneficiary's signature and date.					

Rating Scale Y= Meets all requirements; N= Does not meet requirements; NA= Not Applicable; * See comments					
IDENTIFICATION OF CASES REVIEWED	ID#	ID#	ID#	ID#	ID#
ENTER DMH CLIENT ID NUMBER					
B. INTAKE EVALUATION					
1. The intake evaluation contains:					
1 a. Presenting problem(s) and relevant conditions affecting the client's physical and mental health status, i.e., living situation, daily activities, social support; (Medi-Cal)					
1 b. Presenting problems which indicate a functional deficit; (Medi-Cal)					
1 c. A mental health history including: (Medi-Cal)					
1 c 1) previous treatment dates;					
1 c 2) previous and present mental health providers;					
1 c 3) previous therapeutic interventions and responses;					
1 c 4) relevant family information;					
1 c 5) relevant lab reports, consultations and sources of clinical data;					
1 c 6) past and present use of tobacco, alcohol and caffeine, as well as illicit, prescribed and over-the-counter drugs.					
1 d. For children and adolescents, pre-natal and peri-natal events and complete developmental history.					
1 e. A brief psychosocial history.					
1 f. A relevant mental status examination.					
1 g. A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, consistent with presenting problems, history, mental status evaluation and/or other assessment data. (Medi-Cal)					
1 h. A medical summary is present and contains a brief relevant medical history.					
1 i. History of psychiatric medications that have been prescribed, including:					
1 i 1) dosages of each medication;					
1 i 2) dates of initial prescription and refills. If client does not remember, this is documented.					
1 j. Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities are clearly documented.					
1 k. Client's strengths in achieving client plan goals;					
1 l. Special status situations that present a risk to the client are documented and updated as appropriate.					

Rating Scale Y= Meets all requirements; N= Does not meet requirements; NA= Not Applicable; * See comments						
IDENTIFICATION OF CASES REVIEWED					ID#	ID#
D.	PROGRESS NOTES	ENTER DMH CLIENT ID NUMBER				
1.	There is a Progress Note for each contact.					
2.	Chart entries are legible.					
3.	Minimum documentation includes: (Medi-Cal)					
3 a.	date of service, properly documented;					
3 b.	type of services delivered;					
3 c.	relevant clinical decisions and interventions;					
3 d.	signature of person providing the service, the person's professional degree, licensure and relevant identification number;					
3 e.	referrals to community resources and other agencies, as appropriate;					
3 f.	follow-up care, as appropriate;					
3 g.	discharge summary, as appropriate.					
4.	If the client receives psychotropic medications prescribed by a physician in the program, there is documentation in the chart that the client has been informed of the right to accept or refuse such medication(s). <i>(Title 9, 851) (Recommended for clients age 14 and older)</i>					
5	The information received from the prescribing physician includes, but need not be limited to: <i>(Title 9, 851) (Recommended for clients age 14 and older)</i>					
5 a.	nature of the client's mental condition;					
5 b.	the reason(s) for taking the medication(s);					
5 c.	reasonable alternative treatments, if available;					
5 d.	type, range, frequency, amount, and method and duration of taking medication(s);					
5 e.	probable side effects which commonly occur and any particular side effects which are likely to occur with this client;					
5 f.	possible side effects which may occur if medication is taken beyond three months.					

Rating Scale Y= Meets all requirements; N= Does not meet requirements; NA= Not Applicable; * See comments						
IDENTIFICATION OF CASES REVIEWED					ID#	ID#
D.	PROGRESS NOTES	ENTER DMH CLIENT ID NUMBER				
6.	There is a written Consent for Medication form, signed by the client, indicating that the above information has been discussed with the client or the above information is found in a progress note. ²					
7.	If medication is prescribed by the provider/organization the chart contains: (Medi-Cal)					
7 a.	the name of the medication; (Medi-Cal) ³					
7 b.	the dosage of the medication;					
7 c.	quantity of medications;					
7 d.	frequency of administration					
7 e.	route of administration					
8	There is documentation at each visit of:					
8 a.	side effects;					
8 b.	response(s) to medication, both positive and adverse;					
8 c.	client's compliance with the medication regime.					
9.	An MD signs all medication orders.					
Discussion/Comments (Refer to DMH Client ID Number):						
D. PROGRESS NOTES						

Revised: 6/2009

²There is no requirement in the Department for a written consent for medication. However, the physician must indicate in the progress note that the client has been informed about the medication as indicated above, and the right to refuse or accept the medication(s) and has consented to the medication(s) administration.

³Identify all current medications prescribed to the client in the comment section. Include the name of the medication, dosage and how frequently the medication is taken.

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.

Individual Fee-For-Service Network Providers
February 14, 2008
Page 2

The purpose of these audits is to ensure that in the event the DOJ or HHS OIG question payments made by DMH as to their appropriateness, DMH will be able to ensure that there is a strong compliance program in place ensuring the integrity of public expenditures.

However, DMH wants to emphasize that the establishment of payment thresholds does not preclude the audits of those under threshold. Audits of providers under threshold may be conducted at random.

Providers will be contacted for purposes of scheduling audits via certified mail.

Questions and concerns may be directed to Judith Miller, Compliance Officer, at (213) 639-6391 or Donna Warren-Kruer, Medi-Cal Professional Services and Authorization Division at (213) 738-2095.

MJS:JM:dw

c: Roderick Shaner, M.D.
Robin Kay, Ph.D.
Judith Miller
Roger Heilman, M.D.
Pansy Washington
Donna Warren-Kruer

Revised 11-27-07 LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH CLINICAL INCIDENT REPORT (DMH Policy #202.18 Attachment I, Pg. 1) You may complete this report on a computer or print, but <u>do not e-mail</u> this report.					
1. Client's Name:		2. Date of Birth		3. Sex:	4. MIS #:
5. Incident Date			6. Time:		
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 http://dmh.lacounty.gov/Clinical_Issues.asp .					
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 ⁴ 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., 12th 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., 12th 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 & 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 X – THE PROVIDER RELATIONS UNIT

The Provider Relations Unit provides technical, administrative and clinical assistance to Local Mental Health Plan (LMHP) network providers and their billing agents to aid in the delivery of quality specialty mental health services. Network providers must complete and submit the *Consent to Release Claiming Information Form* (Attachment I) to allow the release of claiming information to billing agents, staff and/or designees. Mail the form to the address listed at the end of this section or fax to (213) 351-2024.

The Provider Relations Unit 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 Integrated System (IS) 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 IS reports;
- Provide computer-illustrated production lab demonstrations on electronic enrollment, eligibility checks and submission of Medi-Cal beneficiary claims in the IS; and
- Direct network providers and billing agents to appropriate resources, internal and external to the LMHP.

ADMINISTRATIVE FUNCTIONS

- Provide information and assistance to mental health providers on the application, credentialing and contracting process;
- 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 ISSUES

- 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;
- Manage the clinical appeal process; and
- Provide information to network providers regarding clinical records and consent standards.

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

Department of Mental Health
Provider Relations Unit
550 S. Vermont Ave., Room 704A
Los Angeles, CA 90020
(213) 738-3311
Fax: (213) 351-2024



CONSENT TO RELEASE CLAIMING INFORMATION FORM

AUTHORIZATION AGREEMENT TO RELEASE CLAIMING INFORMATION

This Consent to Release Claiming Information Form authorizes the Local Mental Health Plan to release network provider claiming information to the following billing agents, staff and/or designees:

NAME	ADDRESS	TELEPHONE	FAX

Print Network Provider Name: _____

Network Provider Signature: _____

Network Provider Address: _____

Number and Street, Suite or Room Number

City, State, Zip: _____

Telephone: _____

Area Code and Number

Fax: _____

Area Code and Number

SECTION XI – FINANCIAL & 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.

CLAIMING OVERVIEW

There are three options available for submitting HIPAA-compliant claims in the IS: Direct Data Entry (DDE), Electronic Data Interchange (EDI)/Secure File Transfer (SFT) and hiring a billing agent/service or clearinghouse to submit claims to the IS via DDE or EDI/SFT.

1. FIRST OPTION - DIRECT DATA ENTRY

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://dmh.lacounty.info/hipaa/ffs_GettingStarte.htm

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. The 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.

HOW TO APPLY FOR DIRECT DATA ENTRY

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://dmh.lacounty.info/hipaa/ffs_home.htm. Select “IS Forms” and click on the “DDE/EDI Application Processing Checklist.” The DDE/EDI Application Processing Checklist (Attachment I) itemizes the nine forms required for DDE. After determining the forms required for DDE, revert back to the website listed above, download and complete the respective forms and mail them to the following address:

Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 S. Vermont Ave., 6th Floor
Los Angeles, CA 90005

The normal processing time to obtain an RSA SecurID card/token is three to four 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 Relations Unit at (213) 738-3311 for DDE forms assistance.

TRAINING – DIRECT DATA ENTRY PRODUCTION LAB AND ASSISTANCE

A Production Lab is a computer-illustrated training session conducted by a Provider Relations Unit 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 Provider Relations Unit at (213) 738-3311 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.

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 who will contact applicants after the forms have been approved. 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 VIII: 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.

Network providers who choose this option are recommended to contact a billing agent/service, clearinghouse or software vendor to handle LMHP technical specifications. Refer to Attachment II for a complete listing of billing agents/services, clearinghouses and vendors.

APPLYING FOR ELECTRONIC DATA INTERCHANGE/SECURE FILE TRANSFER

Network providers, billing agents/services and clearinghouses must have their software HIPAA certified from an outside third-party vendor before applying for EDI/SFT, as indicated above. The third-party vendor will provide a certificate that must be submitted with EDI/SFT application documents. A Third-Party HIPAA Certification Vendor List (Attachment III) provides a number of outside software vendors available for network providers, billing agents/services and clearinghouses to use that may require a fee.

HOW TO APPLY FOR ELECTRONIC DATA INTERCHANGE/SECURE FILE TRANSFER

Network providers, billing agents/services and clearinghouses may apply for EDI/SFT via the "Outpatient Fee-For-Service" website address: http://dmh.lacounty.info/hipaa/ffs_home.htm. Select "IS Forms", and click on the "DDE/EDI Application Processing Checklist." The DDE/EDI Application Checklist (Attachment I) itemizes the eleven forms required for EDI/SFT. After determining the forms required for EDI/SFT, revert back to the website listed above, download and complete the respective forms and mail them to the following address:

Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 S. Vermont, 6th Floor
Los Angeles, CA 90005

The normal processing time to receive an RSA SecurID card is three to four 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 Relations Unit at (213) 738-3311 for EDI/SFT forms assistance.

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://dmh.lacounty.info/hipaa/ffs_home.htm. Select the "Secure File Transfer" link. Under the Secure File Transfer link, refer to the "Frequently Asked Questions: EDI for FFS", "Companion Guides" and "Transaction Samples."

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 Relations Unit at (213) 738-3311 for an explanation of the denial reasons and codes received on IS Reports.

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 Training – DDE Production Lab and Assistance on the pg. 2 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.

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.

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 VIII, 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 VIII, 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 IV), 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.

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 (Attachment II) who currently submit HIPAA-compliant claims to the LMHP and have agreed to be included on the published list.

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 VIII for information on HIPAA-compliant procedure and diagnosis codes.

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.

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) Group providers are required to furnish their group's type II and their rendering providers' type I NPI numbers; and 3) Organizational providers are required to furnish their organization's type II and their mental health employee's 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 VIII: Procedure Codes, Diagnosis Codes and Rates.)
- For organizational providers, settlement to actual allowable costs or negotiated rates will occur at fiscal year's end.
- 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 the *Payor Financial Information* (PFI) form (Attachment V).
- 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. 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. A valid HIPAA Delay Reason Code [Late Codes] (Attachment IV) must be entered on claims over the six month billing limitation but under the one year billing limit to be accepted for adjudication in the IS.
- The LMHP recommends network providers to submit claims bi-weekly and promptly review IS reports to correct and resubmit all denied claims that are eligible for correction.

- 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 encouraged to actively monitor the IS reports to reconcile and determine the status of claims that have been received and adjudicated in the IS.
- Network providers who experience denials will need all of the six month period to allow for correction and resubmission, or risk loss of reimbursement for their services.
- Contact the Provider Relations Unit at (213) 738-3311, Monday through Friday from 8:00 a.m. to 5:00 p.m., for electronic claim status inquiries.

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.

DENIAL REASON EDIT CODES

The "Denial Reason Edit Codes" (Attachment VI) 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. 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 Relations Unit at (213) 738-3311 for questions regarding denial edits and claim status.

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 VII A and VII B).

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 VIII 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

The IS Codes Manual includes various updates and information related to the State's revision for the use of HIPAA Delay Reason Codes (Late Codes) (Attachment IV). A complete and updated copy of the IS Codes Manual may be accessed at the following website address: http://dmh.lacounty.info/hipaa/ffs_uis_procedure.htm. 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://dmh.lacounty.info/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.

Contact the Provider Relations Unit at (213) 738-3311 for issues regarding the "find client" functionality.

INTEGRATED SYSTEM ISSUES WEBSITE

Network providers, billing agents/services and clearinghouses who possess an RSA SecurID card/token may access the IS Issues Website via the Internet. Individuals who are interested in accessing the IS Issues website but do not possess an RSA SecurID card/token must complete the forms listed on the DDE/EDI Application Processing Checklist (Attachment I) and ensure the following roles are entered on the Application Access Form: ADM01, ADM02, RPTPROV and GEN01. The forms may be downloaded at http://dmh.lacounty.info/hipaa/ffs_ISForms.htm. Once completed, mail the forms to the following address:

Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 S. Vermont, 6th Floor
Los Angeles, CA 90005

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 Web based Issues Database is provided to allow immediate access to IS related issues.

ACCESSING ISSUES SITE

Instructions for accessing the IS Issues Website are listed below:

Copy and paste the application website address: <https://dmhapps.co.la.ca.us/ISIssues/> into the Browser and click "Go."

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.

RSA SecurID : Log In - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Search Favorites Media Print

Address <https://dmhapps.co.la.ca.us/ISIssues/> Go Links

 **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.**

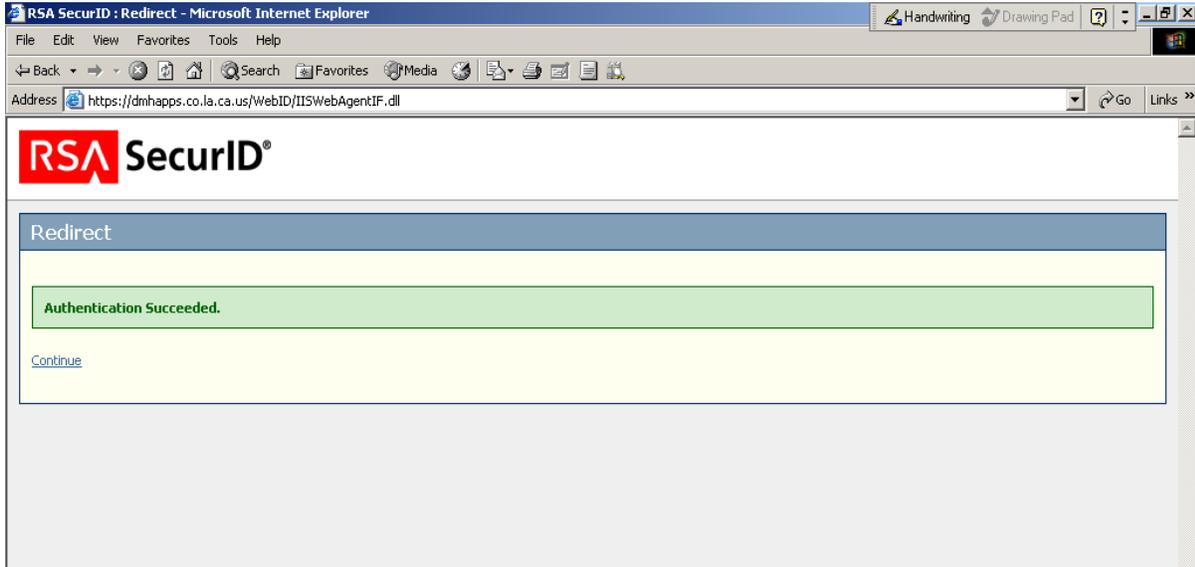
Logon ID:

Passcode:

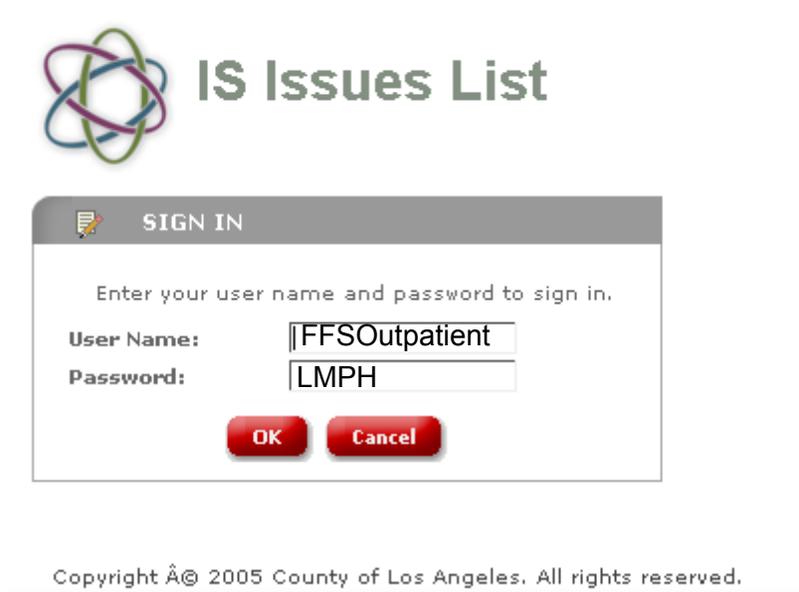
Your Passcode is your PIN + the number displayed on your token (the Tokencode).

Done Internet

☐ Click “Continue”



Enter User Name and Password. Then click “OK” to log in



Viewing Issues

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.)



Click to view issue details

Page 1 of 1 Page Size 10 Go

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.

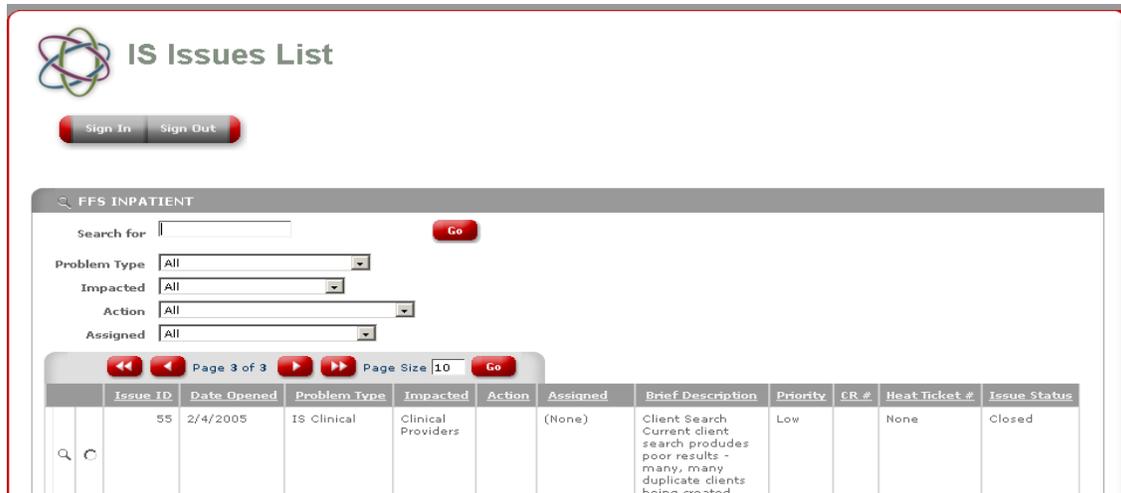
Click **OK** to exit Issue

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

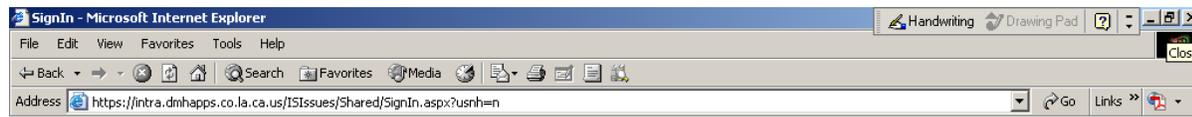
Click “Sign Out”



Click “OK”



Click “X” to close browser and completely sign out



Thanks for visiting the IS Issues website.

You may contact the Provider Relations Unit at (213) 738-3311 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://dmh.lacounty.info/hipaa/ffs_home.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 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.

INSTRUCTIONS FOR ACCESSING INTEGRATED SYSTEM REPORTS – CLINICAL OPERATIONS

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 12. 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.

INSTRUCTIONS FOR ACCESSING INTEGRATED SYSTEM REPORTS - CLINICAL REPORT EXPORTS

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 Relations Unit at (213) 738-3311 if you have any questions or need additional assistance.

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 form
2. Financial Obligation Agreement
3. Department of Public Social Services/Social Security Administration (SSA) Referral Card
4. Lifetime Extended Signature Authorization
5. Insurance Authorization and Assignment of Benefits
6. Re-evaluation Follow-Up Letter
7. Verification of employment, income, allowable expenses and assets
8. Photocopy of identification, Social Security Card, paycheck stubs and health insurance cards
9. Any correspondence to or from the Medi-Cal beneficiary/payor
10. Photocopy of the Medi-Cal beneficiary's Benefit Identification Card (BIC)

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).

The California Department of Mental Health (SDMH) 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.

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 V). 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.

The SDMH 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

LIQUID ASSETS	
Savings	\$ _____
Checking Accounts	\$ _____
IRA, CD, Market Value of stocks, bonds and mutual funds.	\$ _____
TOTAL LIQUID ASSETS	\$ _____
Less Asset Allowance	\$ _____
Net Asset Valuation	\$ _____
Monthly Asset Valuation (Divide Net Asset By 12)	\$ _____
(5) VERIFICATION OBTAINED [] YES [] NO	

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 SDMH 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

ALLOWABLE EXPENSES	
Court ordered obligations paid monthly	\$ _____
Monthly child care payments (necessary for employment)	\$ _____
Monthly dependent support payments	\$ _____
Monthly medical expense payments	\$ _____
Monthly mandated deductions from income for retirement plans. (Do not include Social Security)	\$ _____
TOTAL ALLOWABLE EXPENSES	\$ _____
VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

ADJUSTED MONTHLY INCOME	
Gross Monthly Family Income	\$ _____
Self/Payor	\$ _____
Spouse	\$ _____
Other	\$ _____
TOTAL	\$ _____
Add monthly asset valuation	\$ _____
TOTAL	\$ _____
Subtract total expenses	\$ _____
Adjusted monthly income	\$ _____
VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	

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)

OTHERLine 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.

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.

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.

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://dmhweb/dmhpolicy/>.

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



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR

MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION
Provider Relations Unit

Date:

TO: Department of Mental Health
CIOB - Attn: Systems Access Unit
695 S. Vermont Avenue, 6th Floor
Los Angeles, CA 90005

FROM: _____
Network Provider, Billing Agent/Service or Clearinghouse Name

SUBJECT: __ DDE / __ EDI APPLICATION PROCESSING CHECKLIST

Attached for processing are the forms required to submit claims electronically in the Integrated System via DDE only or DDE and EDI. The following method is checked below:

Provider Name _____ Provider Number _____

<input type="checkbox"/> <input checked="" type="checkbox"/> ← DIRECT DATA ENTRY ONLY	<input type="checkbox"/> <input checked="" type="checkbox"/> ← DDE/ELECTRONIC DATA INTERCHANGE
1. Applications Access Form 3	1. Applications Access Form 3
2. MIS Confidentiality Oath	2. MIS Confidentiality Oath
3. Downey Data Center Registration	3. Downey Data Center Registration
4. SecurID Card Agree't f/Acceptable Use...(AUP)	4. SecurID Card Agree't f/Acceptable Use...(AUP)
5. Rendering Provider Registration Form	5. Rendering Provider Registration Form
6. Rendering Provider Registration Form Attachment (Network Provider Groups & Organizational Only)	6. Rendering Provider Registration Form Attachment (Network Provider Groups & Organizational Only)
7. Individual Authorized to Sign CIOB Forms	7. Individual Authorized to Sign CIOB Forms
8. DDE/EDI Selection General Req. Agreement	8. DDE/EDI Selection General Req. Agreement
9. Trading Partner Agent Authorization Form	9. Trading Partner Agent Authorization Form
	10. Trading Partner Agreement Form
	11. Trading Partner Digital Certification Request

If you have any questions or need additional information, you may contact _____
at _____.

KSJ:ksj
Claiming Application Ltr 2 KSJ
9/24/2008

Attachments ____

**CERTIFIED NETWORK PROVIDER'S EDI/SFT BILLING AGENT/
SERVICE, CLEARINGHOUSE OR SOFTWARE VENDOR LIST**

EDI/SFT AGENCIES FOR NETWORK PROVIDERS	OWNER/AGENT FULL NAME	JOB TITLE	OFFICE TELEPHONE	EMAIL ADDRESS
Alpha Medical Billing Services	Anna Golovchinsky	Billing Agent	(818) 789-6290	annagol@roadrunner.com
Classic Data Service	Art Cross	Manager Software Vendor & Billing Service	(323) 751-1174	ClassicData@att.net
Custom Medical Billing	Rose Udem	Billing Agent	(805) 524-0695	raudem@sbcglobal.net
Diana's Billing Service	Diana Hambarsoomian	Billing Agent	(818) 767-5220	Hambarsoomian@comcast.net
DP Medical	Dan Healy	Manager	(310) 514-3960	dfhealy@pacbell.net
Eden Mann	Eden Mann	Billing Agent	(310) 550-0335	Edenmann5127@yahoo.com
El Dorado Community Service Center	Pramesh Sharma	Office Manager	(661) 254-6630	americanhealthservices@msn.com
Elite Physician Services	Ronna Velaidan	Billing Agent	(310) 766-0600	purplepoof@aol.com
ET & T Clearinghouse	Debbie Sterling	Billing Agent	(480) 325-0901	frankh@ettch.com
Faina Zlatogorov, M.D.	Olga Berberyan	Office Manager	(323) 650-9675	fzlatogorov@sbcglobal.net
G. J. Brown Enterprises	Gloria Brown	Billing Agent	(310) 527-5223	Gloriabrown2400@sbcglobal.net
In-Psytt Billing Services	Helene Pine	Billing Agent	(818) 880-5212	Inpsytt@sbcglobal.net
Kristina Evans	Kristina Evans	Billing Agent	(626) 974-9210	kevans22@msn.com
M/D Systems, Inc.	Dianne Pugh	Manager	(800) 272-3285	jasonk@mdsystems.net
M. J. Groves	Marva Groves	Billing Agent	(310) 668-4041	mwgroves@msn.com
NJ Enterprises	Norma Jones	Billing Service	(760) 241-0149	jamron217@verizon.net
On-Line Billing	Kathy Joseph	Billing Agent	(310) 793-9159	Kjoseph@olbmedical.com
Synergy Management Solutions, LLC	Mary Ellen Johnson Jessica Johnson	CEO, Billing Service VP, Billing Service	(818) 343-0322	synergymanagementsolutions@yahoo.com
Tech-Med Billing Service	Trupti Patel	Administrator	(818) 972-2626	trupti@tech-med.com
Tena R. Denman Billing Service	Tena Denman	Owner	(323) 931-4252	ldytah@sbcglobal.net
Terri Carpentier	Terri Carpentier	Billing Agent	(562) 938-9598	askdrdave@earthlink.net
Ultra-Med Systems	William Hoover	Billing Service, Software Vendor	(818) 232-3125	ultramed@linkline.com
Veri-Care	Donna Becker	Accounts Manager, Billing Service	(858) 454-3610 x119	jkoon@VeriCare.com

THIRD-PARTY HIPAA CERTIFICATION VENDOR LIST

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
CHIEF INFORMATION OFFICE BUREAU**

DMH Integrated System HIPAA EDI Service Provider List

No warranty is stated or implied and inclusion in this document does not constitute an endorsement. Please note that to be an EDI trading partner, a digital certificate issued by DMH is required. Digital certificates can only be issued after the trading partner has had error free transaction testing and a certification has been issued by a testing and certification service.

CLAREDI WWW.CLAREDI.COM	
CERTIFICATION	TRANSACTION TESTING
Included with transaction testing	Secure subscription
Pricing includes unlimited testing and certifications	

Claredi provides the most comprehensive HIPAA EDI transaction testing and certification solutions to help healthcare providers, payers and clearinghouses become HIPAA-compliant. Our ClarediSM Classic, FacilediSM and CommunedSM services offer the easiest, most efficient path to HIPAA EDI compliance.

1 EDI Source WWW.1EDISOURCE.COM	
CERTIFICATION	TRANSACTION TESTING
N/A	\$5000 Secure Software License
This vendor offers a full HIPAA solution, please contact vendor for certification/pricing.	

1 EDI Source, Inc., **HIPAA Product:** using **EDI Complete-HIPAA Edition**, healthcare providers can meet HIPAA requirements and, at the same time, make fundamental changes in the way they communicate and exchange information. **EDI Complete-HIPAA Edition** takes the numerous benefits contained in this software and tailors them to the healthcare industry. In addition to full inbound and outbound data mapping functionality, high-performance translation and complete EDI/application systems integration EDI Complete-HIPAA Edition will allow the following: claim submission for services rendered; patient eligibility and benefits verification; update patient coverage information; and, obtain authorization for treatment.

EDIFECs WWW.EDIFECs.COM	
CERTIFICATION	TRANSACTION TESTING
FREE	FREE
This free service includes unlimited testing and certifications.	

Edifecs for HIPAA - X-Engine, Commerce Desk and Spec Builder. The Edifecs HIPAA enablement solution empowers healthcare organizations to quickly reach HIPAA compliance and to then maintain it in the face of ongoing change. Together the Edifecs HIPAA solution set provides the most complete set of HIPAA enablement technologies available. The world's leading validation technology for Testing & Certification. HIPAA translator has an embeddable component for processing inbound and outbound HIPAA transaction data. A web based self-service partner enablement service for testing & validation. Contains a complete development environment for authoring, extending, customizing and maintaining HIPAA transaction sets and allows Test Data Generation for testing with trading partners & internal systems.

EDIFECs WWW.HCCOCERTIFICATION.COM	
CERTIFICATION	TRANSACTION TESTING
\$199	FREE
This free service includes unlimited testing and certifications. This organization is a non-profit entity provided by the healthcare community.	

The HIPAA Conformance Certification Organization (HCCO), a non-profit partnership among the nation's leading HIPAA solutions providers and covered entities, is pleased to announce the implementation of our HIPAA Transactions and Code Sets EDI Validation and Certification testing community. Provided to the healthcare community free of charge, the new testing engine will standardize validation of vendor products and streamline transaction compliance for covered entities. The testing engine will use compliance edits resulting from HCCO's Common Conformance Assessment Program (CCAP) as an industry baseline and provides testing for all recommended WEDI SNIP testing types.

ORION HEALTH SYSTEMS (RAPSODY) WWW.ORIONHEALTH.COM

CERTIFICATION

TRANSACTION TESTING

N/A

FREE

This vendor offers a full HIPAA solution. Please contact vendor for certification pricing.

Orion Systems International Limited ("Orion") now offers a free online HIPAA transaction validation service using the Rhapsody™ Interface Engine. Upload any HIPAA transaction to our site, and Rhapsody™ will immediately validate your transaction and produce a report. The report indicates how the transaction measured up to the current HIPAA standard and also contains a TA1 (997) acknowledgement for your transaction. This site also demonstrates how Rhapsody™ can map from any other EDI or XML standard like UB92 and NSF to HIPAA. Orion offers this service free of charge and free of obligation. Follow the instructions on the website.

ViaTrack Systems WWW.VIATRACK.COM

CERTIFICATION

TRANSACTION TESTING

N/A

\$299 Secure Software License

This vendor offers a custom HIPAA software design. Please contact vendor for pricing.

ViaTrack offers a range of software tools & professional services to help your system create & send HIPAA-compliant files. ViaTrack specializes in providing IT developers and healthcare administrators with professional software tools and services specifically designed for building, testing and analyzing HIPAA-based X12 data structures.

REDIX INTERNATIONAL WWW.REDIX.COM

CERTIFICATION

TRANSACTION TESTING

N/A

\$19,000 Secure Software License

This vendor offers a full HIPAA solution, please contact vendor for certification pricing.

Redix International, Inc., incorporated in August of 1994, specializes in the development, marketing and support of B2B, XML, EDI, DTD, Schema, HIPAA and Electronic Commerce software. Redix International, Inc., has an HIPAA/EDI package dedicated to the HealthCare industry.

This package includes the following:

1. Redix AnyTo Any Format Converter Engine;
2. Redix Format Converter GUI Mapper with Authoring Tools;
3. HIPAA database, which incorporates all the HIPAA transaction sets: 270/271, 276/277, 278, 820, 834, 835, 837 (Institutional, Dental, Professional);
4. Supports Six Levels of Testing recommended by WEDI/SNIP;
5. Supports version 4010, 4020 and 4030 X12 databases;
6. Supports the HIPAA syntax rules and code definitions;
7. HCFA databases, which includes the NSF Version 2.0 and 3.1, and the UB92 standard Version 5.0 and 6.0;
8. Pre-defined maps between the HIPAA Professional Transaction Set and the HCFA NSF standard;
9. Pre-defined maps between the HIPAA Institutional Transaction Set and the HCFA UB92 standard;
10. Pre-defined maps between the HIPAA 835 Transaction Set and the HCFA ERA standard;
11. The proprietary UB92 format, such as the state specific Medicare/Medicaid UB92 and is also mapped to a HIPAA 837 transaction set in a pre-defined map;
12. Pre-defined maps between the Interactive Eligibility Request (IHCEBI) and the HIPAA Transaction Set; and,
13. Pre-defined maps between the Interactive Eligibility Response (IHCEBR) and the HIPAA 271 Transaction Set.

XML Global WWW.XMLGLOBAL.COM

CERTIFICATION

TRANSACTION TESTING

N/A

\$25,000 Site software license

This vendor offers a full HIPAA solution. Please contact vendor for certification pricing.

XML Global is certified and ready to help healthcare organizations comply with government HIPAA regulations. The XML Global HIPAA solution enables businesses to integrate HIPAA transactions both inbound; receives an EDI HIPAA document from another organization and validates its contents; maps data to virtually any database, packaged application, or back-end system, and outbound; and, generates valid HIPAA transactions from the same array of back-end systems. A rules engine ensures both the validity of incoming and outgoing HIPAA transactions and that any unique business rules are followed. Added to the smooth handling of HIPAA transactions is the easy integration with a myriad of channels through which these transactions may be received - FTP, email, MQ Series, JMS, file system, SonicMQ, SOAP (Web Services), HTTP, OracleAQ and ebXML Message Services. One may roll their own HIPAA solution with the incorporation of an embeddable Data Transformation Engine and Java APIs.

HIPAA 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 (not accepted by the State)
4	Delay in Certifying Provider (FFS 2 providers – Do not use)
5	Delay in Supplying Billing Forms (not accepted by the State)
6	Delay in Delivery of Custom-made Appliances (not accepted by the State)
7	Third-party Processing Delay (FFS 2 providers – Do not use)
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules (not accepted by the State)
10	Administration Delay in the Prior Approval Process (not accepted by the State)
11	Other (FFS 2 TAR delay use only)

(not accepted by the State) – Do not use any of these codes.

Note: The most up-to-date HIPAA Delay Reason Codes (Late Codes) may be accessed at:

http://dmh.lacounty.info/hipaa/downloads/CODESMANUAL_IS1_Version_3.3.pdf

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 **NO THIRD PARTY PAYOR**

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 \$ _____		Total Allowable Expenses \$ _____		Add monthly asset valuation \$ _____
	Monthly Asset Valuation (Divide Net Asset by 12) \$ _____		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	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD 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 DATE			

County of Los Angeles - Department of Mental Health
Office of the Medical Director
Medi-Cal Professional Services and Authorization Division

Provider Relations Unit

CODE #	DENIAL REASON EDIT CODES
1	PROVIDER NUMBER IS MISSING OR INVALID
2	RECIPIENT NUMBER IS MISSING OR INVALID
3	SEX CODE IS MISSING OR INVALID
4	PRIOR AUTHORIZATION NUMBER IS INVALID
5	DATE OF SERVICE IS MISSING OR INVALID
6	PRIMARY DIAGNOSIS CODE IS MISSING OR INVALID
7	PLACE OF SERVICE IS MISSING OR INVALID
8	QUANTITY IS MISSING OR INVALID
9	PROCEDURE CODE IS MISSING OR INVALID
10	THE BEGIN SERVICE DATE DOES NOT MATCH THE END SERVICE DATE; BLOCK BILLING IS NOT ALLOWED
11	LA CO RECIPIENT MIS NUMBER IS MISSING OR INVALID
12	PROVIDER SIGNATURE IS MISSING OR CLAIM IS NOT AN ORIGINAL
13	HOSPITAL PRIOR AUTHORIZATION NUMBER IS INVALID
15	LINE AMOUNT (CHARGES) IS MISSING
16	CLAIM RECEIVED AFTER THE SIX MONTH BILLING LIMITATION
17	FORMER CCN ON ADJUSTMENT IS INVALID
18	DATE OF SERVICE IS GREATER THAN THE JULIAN DATE OF CCN
19	CLAIM RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CLAIM WITH A LATE BILLING INDICATOR
20	LINE AMOUNT (CHARGES) IS INVALID (LESS THAN \$10.00)
100	BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE
101	BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE
102	BILLING PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
103	RENDERING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE

104	RENDERING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE
105	RENDERING PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
106	RENDERING PROVIDER TYPE IS NOT RELATED TO THE BILLING GROUP PROVIDER TYPE
107	RENDERING/STAFF PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE
108	RENDERING/STAFF PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE
109	RENDERING/STAFF PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
110	RENDERING/STAFF PROVIDER IS NOT REGISTERED TO PROVIDE SERVICES WITH THIS BILLING PROVIDER
111	PLACE OF SERVICE IS NOT VALID FOR THE PROVIDER TYPE
200	RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE
201	RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE
202	RECIPIENT MIS NUMBER ON CLAIM DOES NOT MATCH THE MIS NUMBER ON THE LA CO MIS FILE
203	RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES
204	RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE
205	RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE
206	RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER
207	RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER
300	PROCEDURE CODE IS NOT FOUND ON THE LA CO PROCEDURE FILE
301	PROCEDURE CODE IS NOT FOUND ON THE LA CO PROCEDURE FILE FOR DATE OF SERVICE
302	THE PROVIDER OF THIS SERVICE IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED
303	PROCEDURE CODE IS INVALID FOR AGE OF RECIPIENT; JUSTIFICATION REQUIRED
304	PROCEDURE CODE REQUIRES AN LA CO PRIOR AUTHORIZATION NUMBER
305	PROCEDURE CODE IS AN INVALID ORGANIZATIONAL PROVIDER SERVICE
306	RENDERING/STAFF PROVIDER IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED
307	RENDERING PROVIDER IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED
308	PROCEDURE CODES 99222 AND 99232 CANNOT BE BILLED WITH A PLACE OF SERVICE 22
309	AN ORGANIZATIONAL PROVIDER PROCEDURE CODE BILLED ON OR AFTER SEPT. 1. 2000 WAS USING THE OLD RATE
400	PRIMARY DIAGNOSIS CODE IS NOT FOUND ON THE LA CO DIAGNOSIS FILE
401	PRIMARY DIAGNOSIS CODE IS INVALID FOR AGE OF RECIPIENT
402	SECONDARY DIAGNOSIS CODE IS NOT FOUND ON THE LA CO DIAGNOSIS FILE
403	SECONDARY DIAGNOSIS CODE IS INVALID FOR AGE OF RECIPIENT
500	PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE

501	RECIPIENT NUMBER ON THE CLAIM DOES NOT MATCH THE RECIPIENT NUMBER ON THE LA CO PRIOR AUTHORIZATION FILE
502	PROVIDER NUMBER ON THE CLAIM DOES NOT MATCH THE PROVIDER NUMBER ON THE LA CO PRIOR AUTHORIZATION FILE
503	PROCEDURE CODE ON THE CLAIM DOES NOT MATCH THE PROCEDURE CODE ON THE LA CO PRIOR AUTHORIZATION FILE
504	DATE OF SERVICE ON THE CLAIM DOES NOT MATCH THE DATE OF SERVICE ON THE LA CO PRIOR AUTHORIZATION FILE
505	PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE - THE CLAIM WILL RECYCLE
520	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE
521	DATE OF SERVICE ON THE CLAIM DOES NOT MATCH THE DATE OF SERVICE ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE
522	DATE OF SERVICE IS DENIED ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE
531	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 9 MORE WEEKS
532	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 8 MORE WEEKS
533	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 7 MORE WEEKS
534	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 6 MORE WEEKS
535	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 5 MORE WEEKS
536	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 4 MORE WEEKS
537	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 3 MORE WEEKS
538	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 2 MORE WEEKS
539	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE ONE MORE WEEK
600	MEDI-CAL FEE-FOR-SERVICE CLAIM IS NOT PAYABLE BY LA CO LMHP
601	EMERGENCY CLAIM REQUIRES A PROCEDURE CODE OF 99284 OR X9502 OR X9500 WHEN USING POS 23
602	EMERGENCY CLAIM REQUIRES AN 'Y' IN THE EMERGENCY CLAIM INDICATOR FIELD WHEN USING POS 23 FOR PC 99284 OR X9500 OR X9502
603	NO NAME BECAUSE OF NO ELIGIBILITY. EXAMINER WILL ENTER THE NAME FROM THE CLAIM.
700	NO HISTORY WAS FOUND FOR THIS ADJUSTMENT
701	THE ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT
702	THIS IS AN EXACT DUPLICATE OF A PREVIOUS CLAIM
703	THIS IS A POSSIBLE DUPLICATE OF A PREVIOUS CLAIM
704	PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE

705	THE PROCEDURE CODE BILLED EXCEEDS THE OCCURRENCES APPROVED ON THE LA CO PRIOR AUTHORIZATION FILE
706	DISCHARGE SUMMARY IS NOT PAYABLE WHEN BILLED WITH A HOSPITAL VISIT
707	HOSPITAL VISIT IS NOT PAYABLE WHEN BILLED WITH A DISCHARGE SUMMARY
708	SELECTED PSYCHIATRIC SERVICES LIMITED TO 8 VISITS IN A 4 MONTH TRIMESTER WITHOUT AN APPROVED LA CO PRIOR AUTHORIZATION
710	ONLY ONE SERVICE IS ALLOWED PER DAY DURING AN INPATIENT HOSPITAL STAY FOLLOWING THE DAY OF ADMISSION
803	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED (WITH A 103 OR 204) FROM 11-15-99 TO 1-7-00
804	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED (WITH AN 011 OR 202) FROM 11-15-99 TO 2-1-00
805	THIS CLAIM REPROCESSES A CLAIM WITH A VALID HPA NUMBER THAT PREVIOUSLY RECEIVED A 520 DENIAL
806	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 305 DENIAL
807	THIS CLAIM REPROCESSES A CLAIM BILLED FOR MULTIPLE UNITS BUT PAID FOR A QUANTITY OF ONE
808	THIS CLAIM REPROCESSES A CLAIM WITH A 90811 PROCEDURE CODE THAT PREVIOUSLY RECEIVED A 301 DENIAL FROM 1-17-00 TO 4-21-00
809	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 303 DENIAL FROM 11-15-99 TO 5-1-00
810	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 200. 201. OR 205 DENIAL FROM 2-1-02 TO 4-19-02
811	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY PAID TO A RENDERING PROVIDER FROM 7-1-02 TO 9-30-02
901	PROCESSED AMOUNT ADJUSTED TO MAXIMUM ALLOWABLE
902	QUANTITY BILLED EXCEEDED MAXIMUM ALLOWED BY LA COUNTY MENTAL HEALTH; PROCESSED AMT ADJUSTED TO MAXIMUM QUANTITY ALLOWED
906	PAYMENT REDUCED BECAUSE OF OTHER INSURANCE PAYMENT
908	PAYMENT REDUCED BECAUSE OF PATIENT LIABILITY (SHARE OF COST)
971	LA COUNTY MENTAL HEALTH PAYMENT VOID
972	LA COUNTY MENTAL HEALTH PROVIDER INITIATED ADJUSTMENT AS A RESULT OF AN OVERPAYMENT
973	LA COUNTY MENTAL HEALTH PROVIDER INITIATED ADJUSTMENT AS A RESULT OF AN UNDERPAYMENT
974	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT BILLING PROVIDER
975	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT RENDERING PROVIDER
976	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT PROCEDURE CODE
977	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT DATE OF SERVICE
978	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT MEDS ID
979	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT AMOUNT PAID
980	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT QUANTITY

**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):

--	--	--	--	--	--	--	--	--

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Specialty Mental Health Services at:

(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 (19th) 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

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 XII – THE ALTERNATE DISPUTE RESOLUTION PROCESS FOR RESOLVING 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 an Informal Appeal, a First Level Appeal and/or a Second Level Final Appeal to resolve small claims presented to the LMHP by network providers. The 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. Network providers may initiate any one of the three appeal processes within one-year from the date of service.

INFORMAL APPEAL PROCESS

Network providers and billing agents may contact the Provider Relations Unit at (213) 738-3311 to request the informal appeal process for disputed claims. The informal appeal process involves an informal telephone discussion between the network provider and a Provider Relations Unit staff to reconsider the original claim denial or unresolved issue.

The Provider Relations Unit staff will research electronic claiming systems and resource documents in an attempt to facilitate a resolution for the network provider. A Provider Relations Unit staff will respond to resolve concerns, problems, and disputes within ten business days from the date the informal appeal is received. The network provider retains the right to initiate the First Level Appeal and/or Second Level Final Appeal process if an informal appeal claim dispute is not resolved to the network provider's satisfaction.

PRINCIPLES OF THE ALTERNATE DISPUTE RESOLUTION PROCESS

1. Establishment of a process to resolve small claims, which are defined as less than \$5,000 in the aggregate, per network provider, per year. Annual amounts that exceed this level will require approval by the Board of Supervisors.
2. While there will be no commitment to pay all claims, this process will offer an expeditious administrative review of denied claims and, where it is determined the LMHP or its agent(s) are fully or partially at fault, a commitment to a reasonable settlement resolution.
3. 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.
4. Perfection in any settlement resolution is not to be expected. It is the belief of the LMHP that all parties are better off with a reasonable resolution in a comparatively short period of time.
5. Time is of the essence in this process and network providers should take all steps necessary to present claims within the timeframes established for State reimbursement. Delays attributable to network providers that result in State denials will lead to the denial of otherwise valid claims under the ADR process.

GENERAL STEPS IN THE ALTERNATE DISPUTE RESOLUTION PROCESS

1. Network providers and billing agents must ensure timely submission of the initial electronic claim.
2. If the claim is denied, a timely submission of a corrected electronic claim using the appropriate HIPAA Delay Reason Code (Late Code), if applicable, is required. Refer to the IS Codes Manual at the following website address to obtain a complete listing of Late Codes: http://dmh.lacounty.info/hipaa/downloads/CODESMANUAL_IS1_Version_2.9.pdf
3. Network providers and billing agents have 12 months from the date of service to complete steps one and two above. If 11 months have expired and the denial is not resolved, proceed to step four for filing a First Level Appeal or step five for filing a Second Level Final Appeal.
4. The First Level Appeal must be submitted to the LMHP after the six month, and before the 12 month, billing limitation expires. If the denial of a claim is upheld in the First Level Appeal, filing a Second Level Final Appeal is the next and only option available. If the provider does not check the appeal box on the form to indicate the appeal level, the appeal will be processed as a Second Level Final Appeal.
5. The Second Level Final Appeal must be submitted to the LMHP within 15 months of the date of service per the ADR process.
6. 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.
7. Denial by the LMHP after the ADR review is final.

FIRST LEVEL AND SECOND LEVEL FINAL APPEAL INSTRUCTIONS AND DOCUMENTATION REQUIREMENTS

FIRST LEVEL AND SECOND LEVEL FINAL APPEAL TIMELINE INSTRUCTIONS

All documentation for the First Level Appeal is to be received by the LMHP after the six month billing limitation and before the 12 month billing limitation expires. All documentation for the Second Level Final Appeal is to be received by the LMHP after the 12 month billing limitation expires and no later than 15 months from the date of service.

FIRST LEVEL APPEAL

Example:

- If the date of service was January 1, 2008, the network provider or billing agent must have attempted to resolve the denied claim by correcting and resubmitting the electronic claim by June 15, 2008, before proceeding to the First Level Appeal. The LMHP must receive the First Level Appeal no later than December 1, 2008.

SECOND LEVEL FINAL APPEAL

Example:

- If the date of service was August 1, 2008, the network provider or billing agent must have attempted to resolve the denied claim by: a) correcting and electronically resubmitting a new claim using the appropriate late code, if applicable, within the one-year billing limitation, b) if not resolved, proceed to file a First Level Appeal by July 31, 2009, and c) if the denial is upheld in the First Level Appeal process, filing a Second Level Final Appeal is the next and only option available. The LMHP must receive the Second Level Final Appeal no later than November 1, 2009. The decision made in the second level process is final and there is no other recourse for appeal.

GENERAL CLAIMING INSTRUCTIONS

1. Prepare and submit an electronic claim for payment as soon as possible after providing the service. Check the IS reports for claim disposition no later than three days after IS claim submission. Network providers are strongly encouraged to submit and reconcile claims weekly and no later than one month after the date of service.
2. Claim denial reason codes should be immediately accessed to determine whether a claim is eligible for correction. Prepare and submit a new and corrected electronic claim as soon as possible. Include the appropriate late code, if applicable, for all claims over the six-month billing limitation and within the one-year billing limitation.
3. Network providers may submit an Informal Appeal, First Level Appeal or Second Level Final Appeal if steps one and two above do not result in provider reimbursement.

DOCUMENTATION REQUIREMENTS FOR THE FIRST LEVEL AND SECOND LEVEL FINAL APPEAL

Network providers who wish to submit a First Level or Second Level Final 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* (Attachment I), indicating whether the appeal is a First Level or Second Level Final Appeal (i.e., check the appropriate box);
- 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;
- Claiming history of disputed claim(s); and
- Copy of an approved outpatient treatment authorization request (OTAR aka prior authorization [PA]) print-outs or hospital treatment authorization request (HTAR aka hospital prior authorization [HPA]), if applicable.

The First Level Appeal, Second Level Final Appeal Form (Attachment I) and the documents listed on the previous page are to be mailed to the following address:

Department of Mental Health
Provider Relations Unit
550 S. Vermont Ave., Room 704A
Los Angeles, CA 90020

INSTRUCTIONS FOR COMPLETION OF THE FIRST LEVEL AND SECOND LEVEL FINAL APPEAL FORM

Each item below refers to an area on the *Appeal Form* (Attachment I).

<u>Item</u>	<u>Description</u>
-------------	--------------------

- | | |
|----|---|
| A. | Appeal Number. Appeal tracking number to be assigned by the LMHP. |
| B. | Appeal Reference Number. For LMHP use only. |
| C. | Network Provider Name/Address. Enter contracted individual, group or organizational 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 Final Appeal. |
| H. | Statement of Appeal. Network provider's attestation statement. |
| I. | Client's Name. Enter up to the first ten letters of the client's last 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 to treat the client. |
| L. | IS Claim ID #. Enter the Integrated System claim ID number obtained from one of the IS adjudication detail reports that displays the disputed claim(s). |
| M. | POS (Place of Service). Select 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 (hospital 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, 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 the *Appeal Form*.

OVERVIEW OF THE ALTERNATE DISPUTE RESOLUTION REVIEW PROCESS

All appeal packages are reviewed applying the same set of rules. A sampling method is employed in some cases due to the size of some appeal packages.

The appeal review process is as follows:

- Packages are clocked 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.

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 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.

Deductions are made due to the following reasons:

1. 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.

2. 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).
3. Follow-up (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. Impossible to review without this information.

Once the electronic review is complete, the revised total dollar amount of the remaining valid claim is multiplied by the average approval percentage for the entire appeal. That dollar figure represents the amount the LMHP agrees to pay the network provider, and represents the review committee's opinion of the amount of responsibility the LMHP bears for the denial of the appealed claims

SETTLEMENT AND RELEASE FORM

Upon resolution of an appeal by the LMHP under the ADR guidelines, a copy of the Settlement and Release form showing the amount of the settlement will be sent to the provider for signature and returned to the LMHP. A signature on this document is required for disbursement of ADR funds.

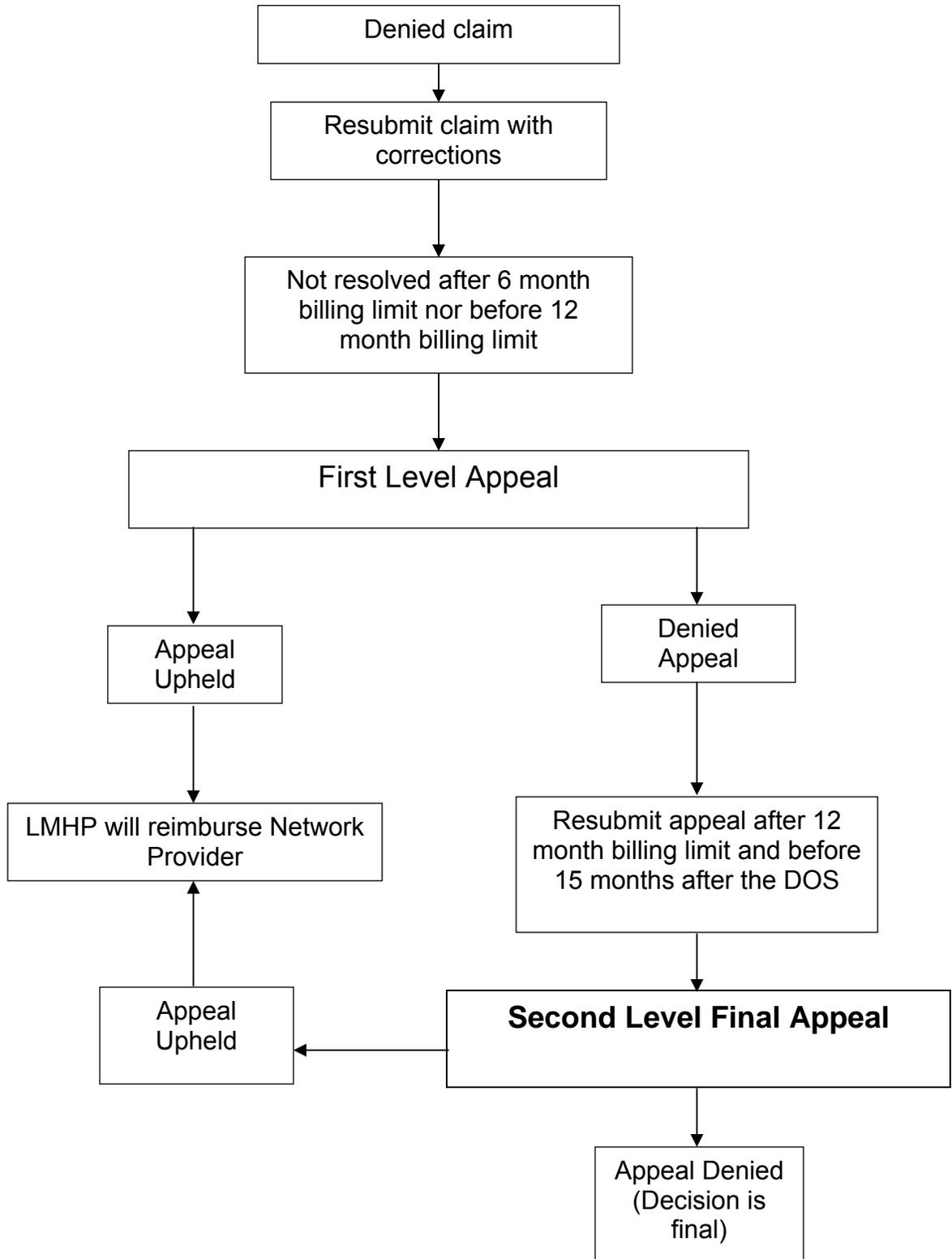
PAYMENT

Upon completion of the ADR process, and upon receipt of the network provider's signed Settlement and Release Form, the LMHP will disburse the funds to the network provider. The Chief of the Accounting Division is authorized by the Board of Supervisors to approve ADR disbursements up to \$5,000 per network provider, per fiscal year.

The payment is mailed to the network provider with the County Counsel approved Settlement and Release Form.

FIGURE B:

**Alternate Dispute Resolution Process
FLOW CHART**



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 Final 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 [] (3rd 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 _____

SECTION XIII – CARE COORDINATION BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH PROVIDERS

Communication between primary health care physicians (PCP) 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. (Refer to Attachment I for Health Net and L.A. Care contact information.) 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 PCPs how to make referrals to the LMHP. The *Physical and Mental Health Care Coordination – Exchange of Information Forms* (Attachment II-A & II-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.

A consent form (Attachment III) for the release of information by the Medi-Cal beneficiary is included in the care coordination packet. 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 your convenience, a HIPAA compliant fax sheet (Attachment IV) is included in this section. For more information on HIPAA refer to the following website address: 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 and not have 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

- PCPs 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:
 - ♦ 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.

*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"> L.A. Care 	Medi-Cal Referral Information: (877) 431-2273 Fax: (213) 438-5777 Pharmacy Prior Authorization: (800) 788-2949
<ul style="list-style-type: none"> Anthem Blue Cross 	Member Services: (888) 285-7801
<ul style="list-style-type: none"> Community Health Plan 	Member Services: (800) 440-1561 TTY: (866) 816-2479 Pharmacy Prior Authorization: (888) 256-6132
<ul style="list-style-type: none"> Kaiser Permanente 	Member Services: (800) 464-4000
<ul style="list-style-type: none"> Care 1st 	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"> Health Net 	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"> Molina Medical 	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

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 XIV – 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 Relations Unit 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.
- Mail or fax the OTAR form and supporting documentation to:

Department of Mental Health
Central Authorization Unit
550 S. Vermont Ave., Room 703A
Los Angeles, CA 90020
Fax: (213) 351-2495
(213) 487-9658
(213) 351-2024

- 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 XVI: 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 OTAR. Net website at <https://dmhapps.co.la.ca.us/OTAR>. Providers will need their Integrated System (IS) logon ID and password to access this system.
- The CAU will review the documentation, and approve, deny or modify the request via OTAR.Net. The network provider will view and print out results of their requests by

accessing OTAR.Net. Contact the CAU at (213) 738-2466 for a Users Manual for OTAR.Net and 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 client's Medi-Cal Number/CIN and the individual or group network provider number must be identical on both the OTAR form and the electronically submitted claim. Electronically submitting claims with Medi-Cal numbers and provider numbers that are different from what was submitted and approved on the OTAR form will result in a denial of the claim.

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 XVI: Notice of Action.) The network provider may request an informal appeal of a denied or modified request within 90 days of receipt of the NOA-B by notifying the Provider Relations Unit by mail, telephone or fax. The Provider Relations Unit 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 Provider Relations Unit within 15 calendar days of the informal decision. 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 provider relations specialist 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.

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* form (Attachment II) 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 provider relations specialist 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
Provider Relations Unit
550 S. Vermont Ave., Room 704A
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 IV: 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>Client Name: _____ Birth date: _____</p> <p>Medi-Cal #: _____ DMH Client ID # _____</p> <p>Facility/Provider: _____</p> <p>MC Provider #: _____</p> <p>Los Angeles County – Department of Mental Health</p>
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CLIENT PLAN / OVER-THRESHOLD AUTHORIZATION REQUEST (OTAR)

SECTION XV – PSYCHOLOGICAL TESTING AUTHORIZATION UNIT

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 Psychological Testing Authorization Unit (PTAU). 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 UNIT

- 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 PSYCHOLOGICAL TESTING 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 or 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.

Note: The PTAU 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 PTAU 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 PTAU. The 5005 form must also be signed by the CSW's Supervising Children's Social Worker (SCSW).

OBTAINING AUTHORIZATION FOR PSYCHOLOGICAL TESTING

The network provider must submit a completed PTAR form by fax or mail to:

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

The PTAU will approve, conditionally approve, pend or deny PTARs. Only the PTAU psychologists are authorized to select and assign testing to a network provider. However, the referring party may suggest a network provider.

The PTAU 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 PTAU, 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 XVI: 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 days of the date of the notification. The request for reconsideration may be initiated through an Informal Appeal, Level I Formal Appeal, or Level II Formal Appeal.

The referring party/provider may initiate an Informal Appeal for denial or modification of psychological testing by contacting the PTAU at (213) 738-6151 to request reconsideration of the decision. The PTAU will reconsider the informal appeal and attempt to facilitate a resolution within five working days.

The referring party/provider may submit a Level I *Formal Provider Appeal* form (Attachment III) either within 15 calendar days after the Informal Appeal is denied or within 90 of the initial notification of modification or denial of psychological testing. In addition to the completed *Formal Provider Appeal* form, 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.

The referring party/provider may contact the Provider Relations Unit at (213) 738-3311 to initiate a Level I Formal Appeal. A Level I Formal Appeal may also be initiated by submitting the completed *Formal Provider Appeal* form and supporting documentation to:

Department of Mental Health
Provider Relations Unit
550 S. Vermont Ave., Room 704A
Los Angeles CA 90020
Fax: (213) 351-2024

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 Appeal. If approval is based upon the same documentation submitted prior to the decision of the PTAU, 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 PTAU, the approval date will coincide with the CMRC decision date.

If the Level I Formal Appeal does not result in an amended decision from the CMRC, the referring party/provider may file a Level II *Formal Appeal* form (Attachment III) to the LMHP Medical Director within 30 days of notification of the Level I Formal Appeal denial. The documentation is to be forwarded to the Provider Relations Unit. The Level II Formal Appeal is to include a cover letter requesting a Level II Formal Appeal and 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. The Level II Appeal decision of the Medical Director is final.

PSYCHOLOGICAL TESTING REPORT

The network provider must send all completed psychological test reports to the PTAU at:

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

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 PTAU psychologists will perform a standardized review of the test reports to promote and ensure report quality acceptability. Within five working days, the PTAU will notify the network provider whether reports have been approved for reimbursement. Only reports meeting quality standards will be approved for reimbursement.

The PTAU 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 PTAU 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 PTAU 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 PTAU 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 PTAU expects that network providers will answer referral questions that are within the scope of practice for a licensed psychologist. Furthermore, the PTAU 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 PTAU 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 Codes criteria, or, offer diagnoses that do not meet the definition of mental disorders found in the ICD-9 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 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 PTAU 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 PTAU 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 PTAU 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 PTAU. 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 PTAU 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.

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

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential 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.

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: _____

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential 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.

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.

REFERRAL QUESTIONS ARE SPECIFIC AND UNIQUE	4 3 2 1
---	----------------

- Specific referral questions are listed
- Referral questions are unique to this beneficiary

REFERRAL QUESTIONS ARE SPECIFIC AND UNIQUE	4 3 2 1
---	----------------

- 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

DATA ARE APPROPRIATELY INTERPRETED	4 3 2 1
---	----------------

- 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

CONCLUSIONS INTEGRATE DATA FROM MULTIPLE SOURCES	4 3 2 1
---	----------------

- 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
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- 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
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- 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
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SECTION XVI – 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 LMHP provider takes an action which results in the modification, reduction, denial or termination of specialty mental health services. The NOA also informs the beneficiary of the right to appeal the LMHP action by requesting a State Hearing within 90 days after receipt of the NOA.

NOA-A (Attachment I) and NOA-Back (Attachment II)

- 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 he or she 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
Provider Relations Unit
550 S. Vermont Ave., Room 704A
Los Angeles, CA 90020

NOA-B (Attachment III) and NOA-Back

- 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) and NOA-Back

- 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 service rendered to the Medi-Cal beneficiary, as described to the LMHP by the beneficiary's provider, did not meet medical necessity criteria for psychiatric inpatient hospital services;
 - ◆ The service rendered to the Medi-Cal beneficiary, as described to the LMHP by the beneficiary's provider, 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) and NOA-Back

- 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) and NOA-Back

- An NOA-E is issued to the Medi-Cal beneficiary when the LMHP has not provided services timely, from the date of the initial service request.
- The completed NOA-E form is sent to the beneficiary. A copy is retained in the LMHP record.

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 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 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 V 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 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, contacting the State at (800) 952-5253 or submitting the request in writing to:

Administrative Adjudications Division
California Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

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 LMHP is 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 LMHP receives a notice that the Medi-Cal beneficiary has requested an Appeal or State Fair Hearing, the LMHP is responsible for determining if the hearing request involved APP. If the criteria specified above for APP are met, the Mental Health Plan is 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 _____ 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 service 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 1830.205(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 1830.205(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 _____ or write to:

_____.

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 _____ or write to: _____.

_____.

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.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at _____ or write to: _____.

_____.

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.

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 1st 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.

SECTION XVII – 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
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
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 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 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
 - www.cahealthadvocates.org
 - www.calmedicare.org
 - www.wclp.org
 - www.healthlaw.org
 - www.nsclc.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"> L.A. Care 	Medi-Cal Referral Information: (877) 431-2273 Fax: (213) 438-5777 Pharmacy Prior Authorization: (800) 788-2949
<ul style="list-style-type: none"> Anthem Blue Cross 	Member Services: (888) 285-7801
<ul style="list-style-type: none"> Community Health Plan 	Member Services: (800) 440-1561 TTY: (866) 816-2479 Pharmacy Prior Authorization: (888) 256-6132
<ul style="list-style-type: none"> Kaiser Permanente 	Member Services: (800) 464-4000
<ul style="list-style-type: none"> Care 1st 	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"> Health Net 	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"> Molina Medical 	Main number: (800) 526-8196 Ext. 127854 Fax: (866) 508-6445 Prior Authorization: (800) 526-8196 Ext. 126400 Fax: (800) 811-4804

SECTION XVIII: MEDICAL TRANSPORTATION SERVICES

All requests for client transportation services, such as ambulances or medical vans, are processed through the Local Mental Health Plan (LMHP) 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 st	(800) 605-2556
Kaiser Permanente	(800) 464-4000

Health Net Plan Partners

Molina Medical	(800) 526-8196
Universal Care	(888) 665-4621

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. 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 XIX – 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) 739-2334.

ADULTS

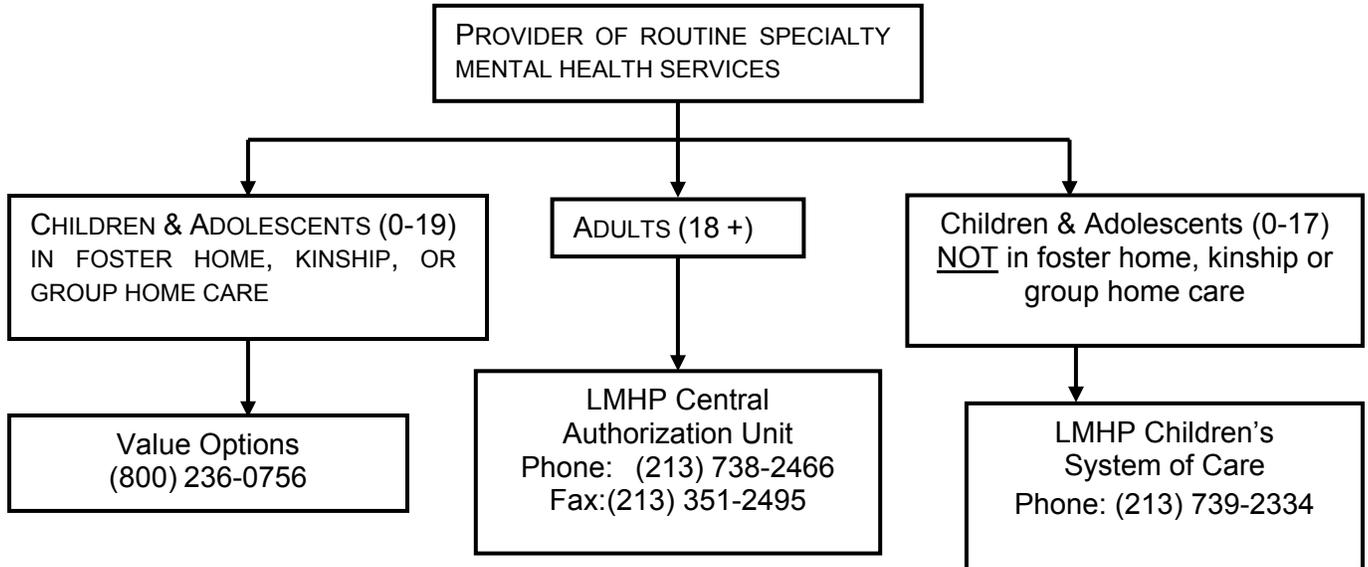
Out-of-county routine services to Los Angeles County Medi-Cal beneficiaries, 18 years of age and older, are subject to the authorization requirements of the LMHP Central Authorization Unit (CAU). Pre-authorization is required **before** the service is delivered in order for a provider to receive reimbursement. The CAU can be reached by calling (213) 738-2466 or by faxing to (213) 351-2495.

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**

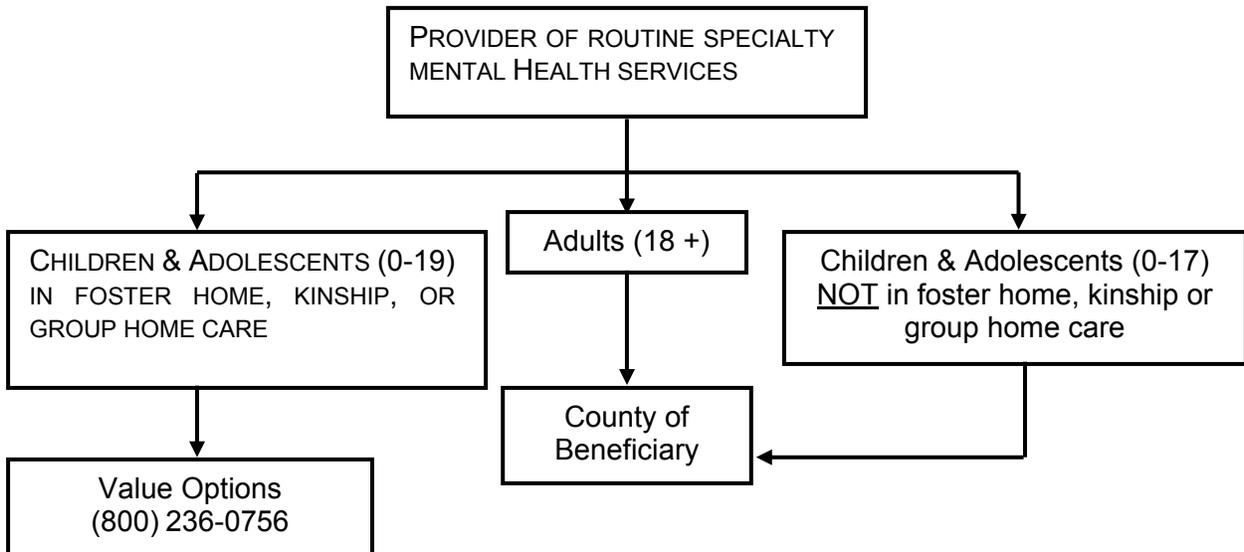


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