DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT **REQUEST FOR CHANGE OF PROVIDER**	POLICY NO. **200.02**	EFFECTIVE DATE **6/3/10**	PAGE **1 of 6**
APPROVED BY: Director	SUPERSEDES	ORIGINAL ISSUE DATE **1/1/03**	DISTRIBUTION LEVEL(S) **2**

PURPOSE

1.1 To provide a formal process for clients to request a change in provider (location) or rendering provider.

1.2 To specify reporting requirements of the Medi-Cal Specialty Mental Health Services Consolidation waiver program from the Centers of Medicare and Medicaid Services (CMS) with regard to children with special mental health needs.

1.3 To comply with the State Department of Mental Health (SDMH) request that Mental Health Plans (MHP) adopt these reporting requirements for **all Medi-Cal** beneficiaries seen through the mental health plan, regardless of age.

DEFINITIONS

2.1 **Children with special mental health care needs are Medi-Cal beneficiaries under the age of 19, if they are:**

2.1.1 Eligible for Medi-Cal based on their eligibility for Supplemental Security Income/Blind/Disabled (SSI) Foster Care programs or Adoption Assistance programs;

2.1.2 Enrolled in Home and Community Based Service Model waiver programs; or

2.1.3 Receiving services from the California Children's Services (CCS) program.

2.2 **Provider:** in this policy, the word "provider" is used interchangeably to mean a specific location and/or rendering provider (defined in section 2.3 below). A request for change addresses both scenarios.

2.3 **Rendering Provider:** Staff who provide services to clients (i.e., psychiatrist, psychologist, psychiatric social worker, case manager, therapist, etc.)

2.4 **Voluntary Change:**

2.4.1 Only changes of provider that are the result of **beneficiary/client requests** constitute "voluntary changes in outpatient specialty mental health providers."

2.4.2 The following occurrences **do not** constitute a "voluntary change of provider."

2.4.2.1 A beneficiary/client changes provider due to staff turnover, staff reorganization or termination of a provider contract;

2.4.2.2 A beneficiary/client moves to a different geographic area within the County and, therefore, changes service locations and providers;

2.4.2.3 A beneficiary/client transitions from a children's provider to an adult provider; and

2.4.2.4 A beneficiary/client is discharged from the system.

2.4 **Grievance:** An expression of dissatisfaction by beneficiary/client.

2.5 **State Fair Hearing (SFH):**

2.6.1 An independent review conducted by the State Department of Social Services

2.6.2 The State Department of Social Services is the final arbiter of grievances for Medi-Cal beneficiaries only.

POLICY

3.1 Los Angeles County-Department of Mental Health (LAC-DMH) recognizes that beneficiaries/clients have the right to request a change of provider (location) and rendering provider (i.e., psychiatrist, psychologist, psychiatric social worker, case manager, therapist, etc.) to achieve maximum benefit from mental health services. Every effort shall be made to accommodate such requests.

3.2 The LAC-DMH shall report to the SDMH, no later than October 1 of each year, the number of Medi-Cal beneficiaries who voluntarily change their outpatient mental health provider during the fiscal year pursuant to Title 9; California Code of Regulations (CCR), Section 1830.225. The report shall be based on data from the prior fiscal year.

3.3 LAC-DMH shall report to the SDMH, no later than October 1 of each year, the number of complaints raised through the MHP's beneficiary problem resolution process, including complaints and grievances as described in Title 9; (CCR), Section 1830.205.

3.4 LAC-DMH's Quality Improvement Division shall review data from the Beneficiary Services Program in the Patients' Rights Office regarding Requests for Change of Provider on a quarterly and annual basis. Appropriate action will be taken based on the data.

PROCEDURE

4.1 Beneficiaries/clients may request a change of provider or rendering provider by completing and submitting the "Request for Change of Provider" form. (Attachment I)

4.1.1 "Request for Change of Provider" forms shall be available in the waiting area of each provider location.

4.1.2 Beneficiaries/clients may request assistance with completing the "Request for Change of Provider" form from any mental health staff or Patients' Rights advocate.

4.1.3 Completed "Request for Change of Provider" forms shall be submitted to clinic staff.

4.1.4 The beneficiary/client shall receive a copy of "Request for Change of Provider" form (Attachment I, Page 1) signed by clinic staff as a receipt.

4.2 Program Manager shall attempt to accommodate all beneficiary/client requests to change providers.

4.2.1 The beneficiary/client is under no obligation to provide any reason for his/her request to change providers. However, in order to improve the quality of programs and understand the nature of the request, Program Managers should attempt to obtain information regarding the request from the beneficiary/client. The program may be able to clarify a misunderstanding or resolve a concern at a level that is satisfactory to the beneficiary/client. The beneficiary/client may, at this time or any other, rescind the request.

4.2.2 Frequent or repeated requests or an insufficient number of providers are examples of reasons why Program Managers may not be able to accommodate a beneficiary/client for a change of provider. Program Managers shall document these reasons in Section 4 of the "Request for Change of Provider" form.

4.3 Within ten (10) working days of receipt of the "Request for Change of Provider" form, the Program Manager shall attempt to verbally notify beneficiary/client of the outcome, followed by the appropriate written confirmation. (Attachments III & IV)

4.3.1 The appropriate written confirmation of notification shall be **maintained in a separate administrative file** and retained for seven years.

4.3.2 If the beneficiary/client is not satisfied with the outcome of the request, he/she may pursue the MHP's Beneficiary Problem Resolution Process (DMH Policy 202.29, "Beneficiary Problem Resolution Process") and file a complaint or grievance. The Medi-Cal beneficiary may file for a State Fair Hearing with the Department of Social Services after completing the MHP's Beneficiary Problem Resolution Process.

4.4 A beneficiary/client requesting to change a Local Mental Health Plan network provider shall contact the Beneficiary Services Program in the Patients' Rights Office.

4.4.1 Within ten (10) working days of receiving the request, Beneficiary Services Program shall provide the beneficiary/client with alternative names of network providers in the area of choice.

4.4.2 Beneficiary Services Program shall maintain a "Request to Change Provider Log" for the requests received from beneficiaries/clients for network providers.

4.4.3 The "Request to Change Provider Log" shall be retained by the Beneficiary Services Program for seven years.

4.5 All submitted "Request for Change of Provider" forms shall be collected by the Program Manager at the end of each working day and **maintained in a separate administrative file.**

4.5.1 "Request for Change of Provider" forms shall be retained by the Program Manager for seven years.

4.5.2 "Request for Change of Provider" forms shall be reviewed by the agency's Quality Improvement Committee to determine if there are any trends present.

4.5.3 In addition to the "Request for Change of Provider" forms, Program Managers shall maintain a "Request to Change Provider Log." (Attachment II).

4.5.3.1 Copies of the logs shall be faxed to the Beneficiary Services program in the Patients' Rights Office at (213) 365-2481 on a monthly basis. The logs shall be due by the tenth (10th) day of the following month for which the log is completed.

4.5.3.2 In the event that the Program does not receive any requests for change of provider for a particular month, the Program Manager shall complete the monthly log to reflect this and may submit the log to the Beneficiary Services Program by fax or via e-mail. **The e-mail communication shall not include any Protected Health Information**. The log shall be due by the tenth (10th) day of the following month for which the log is due. The e-mail address is: patientsrightsoffice@dmh.lacounty.gov.

AUTHORITY

Title 9; California Code of Regulations (CCR), Section 1830.225
Title 9; CCR, Section 1830.205
State Department of Mental Health Information Notice No. 01-05
DMH Policy 202.29, "Beneficiary Problem Resolution Process"

ATTACHMENTS (Refer to links)

Attachment I Request for Change of Provider
Attachment II Request to Change of Provider Log
Attachment III Request to Change Provider; sample text for response letter unable to grant request)
Attachment IV Request to Change Provider; sample text response letter to schedule appointment)

REVIEW DATE

This policy will be reviewed five (5) years following the effective date.

RESPONSIBLE PARTY

LAC-DMH-The Patients' Rights Office

County of Los Angeles – Department of Mental Health
Local Mental Health Plan
REQUEST FOR CHANGE OF PROVIDER
CONFIDENTIAL

To request a change in your current provider, complete this form and submit it to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a decision within 10 working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated or county contracted program, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-4949. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a decision on your request within 10 working days or you disagree with the decision, you may file a formal grievance.

SECTION 1: CURRENT PROVIDER INFORMATION (clients please fill out Section 1 & 2 ONLY)

DATE: _____ SERVICE LOCATION: _____

PROVIDER NAME: _____

SECTION 2: BENEFICIARY /CLIENT INFORMATION

Client Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Are you receiving **Medi/Cal**? ☐ Yes ☐ No

1. I am requesting a change in: ☐ Service Staff ☐ Medical Staff ☐ Program

2. Please select the reason(s) for requesting a change (this information is OPTIONAL)

□ A = Time/Schedule change	□ F = Treatment concerns	□ K = Uncomfortable
□ B = Language	□ G = Medication concerns	□ L = Insensitive/ Unsympathetic
□ C = Age (too old/too young)	□ H = Lack of assistance	□ M = Not professional
□ D = Gender (male/female)	□ I = I want previous provider	□ N = Does not understand me
□ E = Treating family member	□ J = I want 2nd opinion	□ O = Not a good match

□ P = Other – Please describe the reason(s) for requesting the change (this information is OPTIONAL)

_____

□ R = I do not want to give a reason for my request

3. Have you discussed your concerns with your current provider? ☐ YES ☐ NO

If YES, please describe what you have done to try to resolve the problem:

_____

I understand that I will be contacted about this request within 10 working days. I prefer to be contacted by: ☐ Mail ☐ Telephone ☐ Email: _____

If this request is on behalf of a minor or dependent adult; are you the: ☐ Parent ☐ Guardian

Signature of Person making request:_____ Today's Date:_____

SECTION 3: RECEIPT OF CHANGE OF PROVIDER REQUEST

Received by: _____ Date: _____ Copy given to client: ☐ Yes ☐ No

SECTION 4 **AUTHORIZED COUNTY USE ONLY**
Clinical Data

DSM-IV

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Medications – Specify dosage and frequency: _____

_____

_____

REVIEWED BY: _____

DATE: _____

RECOMMENDATION: _____

_____

_____

Referral To: _____

Notified: _____ Date: _____

Appointment: _____

Beneficiary/Client Contacted on: _____ by: _____

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	Name _____ IS# _____ Facility/Practitioner: _____ **Protected Health Information (PHI)** Los Angeles County – Department of Mental Health

Mental Health Plan – Department of Mental Health
REQUEST FOR CHANGE OF PROVIDER

MONTHLY LOG

This log is to be maintained by each Program Manager for the program(s) for which he/she is responsible. A completed entry shall be made for each "Request for Change of Provider" form received during each month. A copy shall be sent to the Beneficiary Services Program in the Patients' Rights Office by the tenth (10th) working day following the month for which the log is completed.

Month: _____ Year: _____

Check here if no requests were received during this month [ ]

Date Received	Date of Request	Consumer's Name	Current Provider	New Provider	Reason(s) for Request (Use Letter Code Below)	Reason Why Request Was Not Granted	Medi-Cal Beneficiary	
							YES	NO

A = Time/Schedule Change
B = Language
C = Age (too old/too young)
D = Gender (male/female)
E = Treating family member
F = Treatment concerns
G = Medication concerns
H = Lack of Assistance
I = I want previous provider
J = I want 2nd opinion
K = Uncomfortable
L = Insensitive/Unsympathetic
M = Not professional
N = Does not understand me
O = Not a good match
P = Other
R = Reason not provided

_____ REPORTING UNIT

_____ PROGRAM MANAGER'S SIGNATURE

_____ DATE

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Program Name: _____

Program Manager's Name: _____

PROTECTED HEALTH INFORMATION (PHI)
Los Angeles County – Department of Mental Health

Request to Change Provider Sample Text for Response Letter Unable to Grant Request

Date

Name
Address
City, State, Zip Code

SUBJECT: REQUEST TO CHANGE PROVIDER

Dear _____:

This is to confirm our recent conversation regarding your request to change providers.

I am not able to grant your request at this time due to the following reason (s):

_____

_____

_____

_____

_____

You currently have an appointment scheduled with (staff name) for (day/date) at (time).

If you have any questions or concerns, please feel free to call me.

Sincerely,

Program Manager

Request to Change Provider Sample Text for Response Letter to Schedule Appointment

Date

Name
Address
City, State, Zip Code

SUBJECT: REQUEST TO CHANGE PROVIDER

Dear _____:

This is to confirm our recent conversation regarding your request to change providers.

Your new provider is (staff name).

An appointment has been scheduled for (day/date) at (time).

If you will not be able to keep this appointment, please notify our office by calling (phone number).

Sincerely,

Program Manager

Condado de Los Ángeles – Departamento de Salud Mental
Plan Local de Salud Mental
SOLICITUD DE CAMBIO DE PROVEEDOR
CONFIDENCIAL —INFORMACIÓN MÉDICA PROTEGIDA (PHI)

Para solicitar el cambio de su proveedor actual, complete este formulario y preséntelo en la oficina del Director del Programa. Se hará todo lo posible por cumplir su solicitud. Usted recibirá un aviso de nuestra decisión dentro de los próximos 10 días hábiles. Si usted es beneficiario de Medi-Cal y recibe atención a través de un proveedor privado de la comunidad que no es parte de un programa del condado, directamente o por contrato, comuníquese con el Programa de Servicios para Beneficiarios de la Oficina de Derechos de Pacientes al teléfono 800-700-9996 o 213-738-4949. El Plan de Salud Mental no puede garantizar que se vaya a cambiar su proveedor. Si no recibe el aviso de nuestra decisión en los próximos 10 días hábiles o no está de acuerdo con la decisión, puede presentar una queja formal.

SECCIÓN 1: INFORMACIÓN SOBRE EL PROVEEDOR ACTUAL (Los clientes deben llenar SOLAMENTE las Secciones 1 y 2)

FECHA: _____ DIRECCIÓN DEL SERVICIO: _____
NOMBRE DEL PROVEEDOR: _____

SECCIÓN 2: INFORMACIÓN DEL BENEFICIARIO/CLIENTE

Nombre del Cliente: _____ Fecha de Nacimiento: _____
Dirección: _____ Ciudad: _____ Estado: _____ Código Postal: _____
Teléfono: (___) _____ ¿Es beneficiario de **Medi/Cal**? ❒ Sí ❒ No

1. Solicito cambio de: ❒ Personal del Servicio ❒ Personal Médico ❒ Programa

2. Por favor seleccione una o más razones para su petición de cambio (información OPCIONAL)

❒ A = Cambios de horarios/citas
❒ B = Idioma
❒ C = Edad (demasiado mayores/jóvenes)
❒ D = Género (hombres/mujeres)
❒ E = Da tratamiento a mis familiares
❒ F = Preocupación por el tratamiento
❒ G = Preocupación por los medicamentos
❒ H = Falta de ayuda
❒ I = Deseo volver al proveedor anterior
❒ J = Deseo una segunda opinión
❒ K = Incomodidad
❒ L = Insensibilidad /Mala atención
❒ M = Falta de profesionalidad
❒ N = Incomprensión por parte del proveedor
❒ O = Mala relación o incompatibilidad
❒ P = No deseo manifestar mis razones
❒ R = Otra – Describa sus razones para solicitar el cambio (información OPCIONAL)

_____

3. ¿Ha hablado con su proveedor actual acerca de sus inquietudes? ❒ SÍ ❒ NO

Si responde SÍ, describa qué hizo para intentar solucionar el problema:

_____

Entiendo que se comunicarán conmigo acerca de esta solicitud dentro de los próximos 10 días hábiles. Prefiero que se comuniquen por: Correo - Teléfono - Correo electrónico: _____

Si esta solicitud se realiza en nombre de un menor o adulto dependiente, usted es: Padre - Tutor

Persona que realiza la solicitud: _____ _____ Fecha: _____
Nombre Firma

SECCIÓN 3: PERSONA QUE RECIBO LA SOLICITUD DE CAMBIO DE PROVEEDOR

Recibida por: _____ Fecha: _____ Se entrega copia al cliente: ❒ Sí ❒ No

SECTION 4 **AUTHORIZED COUNTY USE ONLY**
Clinical Data

DSM-IV

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Medications – Specify dosage and frequency: _____

_____

_____

REVIEWED BY: _____

DATE: _____

RECOMMENDATION: _____

_____

_____

Referral To: _____

Notified: _____ Date: _____

Appointment: _____

Beneficiary/Client Contacted on: _____ by: _____

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ASUNTO: SOLICITUD DE CAMBIO DE PROVEEDOR

Estimado/a _____:

Por medio de la presente confirmamos nuestra reciente conversación sobre su solicitud de cambio de proveedor.

Su nuevo proveedor es: _____.
[Nombre]

Hemos fijado una cita para el día _____ a la hora _____.
[Fecha] [Hora]

Si por algún motivo usted no pudiera asistir a esta consulta, le agradeceremos que llame a nuestras

oficinas al teléfono __(_____)_____ para cancelar la consulta.
[Número de teléfono]

Muy atentamente,

_____
Administrador/a del Programa

ASUNTO: SOLICITUD DE CAMBIO DE PROVEEDOR

Estimado/a_____:

Por medio de la presente confirmamos nuestra reciente conversación sobre su solicitud de cambio de proveedor. Desafortunadamente, en esta ocasión no podemos acceder a su petición debido a los siguientes motivos:

_____

_____

_____

_____

_____

Usted tiene una consulta programada con _____ para el día _____
[Nombre] [Fecha]
a la hora _____
[Hora]

Si tiene alguna pregunta, no dude en comunicarse conmigo.

Muy atentamente,

_____
Administrador/a del Programa