Fresno County Mental Health Plan

Provider Manual

June 2021

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Fresno County Mental Health Plan

Managed Care Contact Information

Providers (currently contracted or interested in contracting) seeking information about services or processes regarding the Fresno County Mental Health Plan (FCMHP) may contact the Managed Care Division Monday through Friday, 8:00 A.M. to 5:00 P.M. (except holidays). Please ask for a Provider Relations Specialist. Contact information for Managed Care is listed below. For any questions related to your specific contract/contract terms, please contact your assigned contract analyst.

For **Individual and Group Providers still submitting paper claims,** CMS-1500 claim forms may be sent in via mail to the Managed Care Division's P.O. Box (see below) or dropped off in person at the Managed Care office. Claims must be handed directly to Managed Care staff.

Managed Care Division

Office Address: **1925 E. Dakota Ave Suite G, Fresno, CA 93726**
Mailing Address: **P.O. Box 45003, Fresno CA, 93718**
Main Phone: **(559) 600-4645**
E-mail: **mcare@FresnoCountyCA.gov**
Fax: **(559) 455-4633**

If your clients have inquiries about other services or information about the FCMHP, please direct them to the FCMHP Access Line, **1 (800) 654-3937**. This access line is available 24 hours a day, 7 days a week.

Please see Section 17, County Resources, for additional useful phone numbers. Other contact information and phone numbers are provided throughout this manual as appropriate.

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FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH MISSION STATEMENT

The Department of Behavioral Health, in partnership with our diverse community, is dedicated to providing quality, culturally responsive, behavioral health services to promote wellness, recovery and resiliency for individuals and families in our community

Welcome, and thank you for your decision to become a provider for the Fresno County Mental Health Plan (FCMHP). With your participation, Fresno County's Medi-Cal beneficiaries who need mental health services will enjoy improved and expanded access to care. Our beneficiaries are the reason for the existence of the FCMHP, and so are regarded as the most important people in the FCMHP. With this in mind, the FCMHP commits to the delivery of the community oriented, culturally sensitive, least restrictive and high-quality mental health care that our Fresno County Medi-Cal beneficiaries deserve.

This Provider Manual contains important information about the FCMHP. It outlines the process through which a Medi-Cal beneficiary seeking mental health treatment can access our services, as well as the processes a provider must follow in order to submit claims for payment. This manual also describes the problem resolution system, the FCMHP's Quality Improvement Standards, HIPAA observance, Fresno County's cultural and linguistic standards, and other resources and information valuable to a new provider.

Again, thank you for choosing to become one of our providers. If you have any questions or need assistance, please feel free to call the Managed Care Division at (559) 600-4645, and a Utilization Review Specialist or a Provider Relations Specialist will be happy to assist you. We look forward to working with you.

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Medi-Cal Managed Care Plans in Fresno County

Physical Health

Medi-Cal is California's implementation of the Federal Medicaid program. It provides for the health care of low-income individuals and families. Many enrollees are enrolled with Medi-Cal automatically because they are receiving Supplemental Security Income (SSI), or California Work Opportunity and Responsibility to Kids (CalWORKs), which is California's implementation of the Federal Temporary Assistance for Needy Families (TANF) program. Others apply for Medi-Cal directly because their income is below the Federal Poverty Level or they have a chronic disabling physical or mental health condition.

California's implementation of the 2010 Patient Protection and Affordable Care Act has seen Medi-Cal coverage expanded to cover all age groups. Prior to the passage of the Affordable Care Act, only children under the age of 21, their parents, and elderly/blind/disabled persons were eligible for Medi-Cal benefits. The State Department of Health Care Services now finances or organizes health coverage for nearly 1 out of 3 Californians. Medi-Cal is an invaluable form of health insurance for people who would otherwise not have coverage.

In Fresno County, the State has contracted with two health care plan providers, Anthem Blue Cross and CalViva Health, to meet the physical health care needs of Fresno County residents receiving Medi-Cal. Medi-Cal recipients can choose one of these two health care plans when they are approved for Medi-Cal benefits. Having two competing managed care health plans improves and expands access to preventive and primary care services for beneficiaries and reduces the need for emergency and hospital-based care. These changes benefit Medi-Cal beneficiaries and help control the overall cost of health care.

Mental Health

Historically, there have been two separate Medi-Cal funded mental health systems. One is the Short-Doyle Medi-Cal system, or County operated mental health program. The other is the Fee-For-Service system, which is composed of private hospitals, psychiatrists, and psychologists who bill the State for the services they provide. These two systems have had separate providers, separate billing processes, separate rules for reimbursable services, and different rates or fees for reimbursement. The same beneficiary could receive services from each system, with some limitations under the Fee-For-Service system.

To improve Medi-Cal beneficiaries' access to quality and coordinated services, the State of California moved to a Managed Care model of service delivery. The Short-Doyle and Fee-For-Service Medi-Cal mental health programs were consolidated into a single system. On January 1, 1995, Phase I of the managed

care plan consolidated inpatient services. Counties entered into an agreement with the Department of Mental Health to manage Fee-For-Service and Short-Doyle inpatient services. This change resulted in a single and coordinated system and decreased dollar expenditures.

On April 1, 1998, the Fresno County Mental Health Plan (FCMHP) implemented Phase II Consolidation for all Specialty Mental Health Services (SMHS) provided under the Short-Doyle and Fee-For-Service system. The FCMHP is responsible for providing Specialty Mental Health Services to Medi-Cal beneficiaries who meet medical necessity criteria and have a serious mental illness (SMI), through contracted providers or through the various Fresno County mental health program sites.

Physical and Mental Health Interface

The funding for the FCMHP is "carved out" of the overall health care plan funds and managed separately. Anthem Blue Cross and CalViva Health provide physical health care, laboratory, and pharmacy services to all their members, but only provide mental health services to beneficiaries who have mild to moderate impairments in regard to their mental health.

The FCMHP established a Memorandum of Understanding (MOU) with Anthem Blue Cross and CalViva Health to ensure coordinated and seamless delivery of services between plans. The MOU also provides for the availability of clinical consultation between plans, and exchange of critical medical record information within mental health confidentiality guidelines.

Fresno County Mental Health Plan Values

The FCMHP is guided by clearly stated principles that direct implementation activities at all levels of client service. In the provision of Specialty Mental Health Services, the following are especially relevant:

- Emphasis is on serving adults with serious and persistent mental illness and youth with serious emotional disturbances through a comprehensive, community-based, coordinated system of care.

- For less serious, enduring conditions, the emphasis is on problem-focused treatment at all levels of service.

- Services are flexible, client and family-centered, and culturally sensitive. Within the spectrum of specialty mental health services, there are sufficient levels of language and cultural skills to serve the clients of the county.

Introduction

- Services provide, to the greatest extent appropriate, opportunities for client/family preferences and choice. In order for services to be truly client driven and family focused, there must be client/family involvement in the planning and delivery of services.

- The system is user friendly with easy and expanded access for clients. The single point of responsibility in service delivery and sufficient coordination and linkage within the system appear seamless from the client's point of view.

- The system is accountable for defined outcomes as a way of measuring system effectiveness and efficiency.

- The system is responsive to the client through measurement of client satisfaction and a process for dealing with client complaints and grievances.

CLIENT RIGHTS

- Be treated with respect and with due consideration for their dignity, and privacy.

- Receive information on available treatment options and alternatives presented in a manner appropriate to their condition and ability to understand.

- Participate in decisions regarding their health care, including the right to refuse treatment.

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

- Request and receive a copy of their medical records, and request that they be amended or corrected.

- Ask for a provider who can communicate in their language.

- Whenever possible, receive mental health services at times and places that are convenient for them.

- Be told what their diagnosis means and get answers to questions.

- Get a second opinion when the first assessment indicates no need for treatment.

- Know the benefits, risks, and costs of treatment before giving permission for services.
- File a grievance about the services received or about the way that they were treated.
- Choose another person to represent them in the grievance process.
- Have their mental health records and personal information kept private.
- Be told about program rules and changes.
- File an appeal when the FMCHP makes an adverse benefit determination.
- Have access to the client handbook and materials on how to file a grievance, appeal, and State Fair Hearing.
- Receive mental health services in accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.206 through 438.210, which cover requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, coverage and authorization of services and to receive information in accordance with Title 42, CFR, Section 438.10, which describes information requirements.

SECTION 1: ACCESS AND REFERRAL

The Fresno County Mental Health Plan (FCMHP) is an open access system. Timely access to services, responsiveness and sensitivity to cultural and language differences, age, gender, and other specialized needs of Fresno County Medi-Cal beneficiaries are important components of the FCMHP. These guidelines outline procedures for obtaining Specialty Mental Health Services (SMHS) and other information regarding access to mental health services.

The goal of the FCMHP service delivery system is a seamless system of care that affords equal access to all eligible persons based on individual treatment needs. In order to assure this access for individuals, the FCMHP works closely with providers at all levels of care, including acute psychiatric inpatient hospital services, coordinated outpatient mental health programs, Fee for Service (FFS) providers, and the two physical healthcare Medi-Cal Managed Care Plans operated by Anthem Blue Cross and CalViva Health. This collaboration is done at the individual treatment provider level, the specific agency level, and through more formal collaboration and arrangements.

All Fresno County Mental Health Plan provider sites are access points to the FCMHP. A beneficiary may select a provider from the FCMHP Provider Directory and request to be seen for an assessment to determine the proper level of care and establish whether medical necessity criteria are met for Medi-Cal SMHS through the FCMHP. All FCMHP providers can verify a beneficiary's Medi-Cal eligibility and help the beneficiary receive the care that they need. A Medi-Cal beneficiary does not need prior authorization to begin receiving treatment with a FCMHP provider. For the most up-to-date FCMHP list of providers, please access the Fresno County Mental Health Plan Provider Directory online: https://www.co.fresno.ca.us/departments/behavioral-health/managed-care/provider-directory

1.0 Provider Access

Providers seeking information about services or processes regarding the FCMHP may contact their assigned Provider Relations Specialist (PRS) directly, or the Managed Care main line by calling **(559) 600-4645** Monday through Friday, 8:00 A.M. to 5:00 P.M. (except holidays).

Access and Referral

1.1 Points of Access

1.1.1 24-Hour Access Line

The County-wide Behavioral Health Access Line **(1-800-654-3937)** is available 24-hours a day, 7 days a week for all requests for specialty mental health services (SMHS), including urgent services.

A beneficiary may request SMHS in person, by telephone or in writing.

For beneficiaries with hearing impairment, dial 711 to reach the California Relay Service.

1.1.2 Fresno County Mental Health Plan Service Sites

When a beneficiary or client requests mental health services in person or by phone, staff will:

Obtain *Demographic Information*.

Perform a *Clinical Screening* to determine the mental health need.

If a mental health need is indicated, schedule a *Clinical Assessment* to determine medical necessity for mental health services.

During the initial intake process, if the beneficiary presents with an urgent/emergent mental health need, the Admitting Interviewer (AI) or designated staff may call 9-1-1, or if deemed safe, refer the beneficiary to the Exodus Crisis Stabilization Center. SMHS provided to a beneficiary to treat an urgent condition do not require pre-authorization.

Before a clinical assessment is scheduled, staff will obtain consent for treatment and initiate a financial eligibility evaluation.

Whenever possible, beneficiary/client will be given two choices for a provider preference. Gender, ethnicity, geographical location, or other factors important to the beneficiary may influence choices.
If the information obtained during the first assessment is insufficient to formulate the beneficiary's plan of care, the assessing clinician has the option to conduct an expanded assessment.

1.1.3 Contract Provider Sites

If a Fresno County resident calls regarding or requests SMHS at a contract provider site, after verifying client's Medi-Cal eligibility, the provider may begin providing services to the client.

1.2 Timely Access to Care

Every Fresno County resident seeking SMHS will be given an opportunity for a mental health assessment. The contract provider may perform a mental health assessment without prior authorization from the FCMHP. Mental health assessments may be done by an in-house or contract provider who is a licensed or registered clinician at a Fresno County MHP service site or a contract provider site. If the provider serves both Medi-Cal beneficiaries and beneficiaries with commercial coverage, the provider's hours of operation offered to Medi-Cal beneficiaries must be no less than the hours of operation offered to commercial beneficiaries or comparable Medicaid fee for service (FFS).

Mental Health Access Form

The FCMHP is required to demonstrate network adequacy, in part, through providing timely access to care. To document compliance with this requirement, FCMHP must submit an assessment record to the Department of Health Care services monthly. For this reason, all providers within the FCMHP must collect and submit assessment records utilizing a Mental Health Access Form or the equivalent of the form generated from DBH's Electronic Health Record System.

Assessment records must be submitted when a beneficiary is 1) New to the FCMHP, 2) Returning to the FCMHP after 12 months of no billable service, 3) If the request is urgent, or 4) If the beneficiary had an incomplete or unsuccessful assessment process. For more information on the current Mental Health Access Form submission process, individual and group providers may contact Managed Care via phone (559-600-4645) or email (mcareaccessform@fresnocountyca.gov). Contract Organizations may contact their Contract Analyst.

Timeliness

For FCMHP to meet timely access to care, providers must offer a beneficiary an assessment appointment within the following timeframes:

- Within 10 business days of the request date for a non-urgent non-psychiatry mental health.
- Within 15 business days of the request date for a non-urgent psychiatry.
- Within 48 hours of the request date for urgent care that does not require prior authorization.
- Within 96 hours of the request date for urgent care that does require prior authorization.

Failure to meet timely access to care will obligate all FMCHP providers to issue the beneficiary a Notice of Adverse Benefit Determination – Timely Access Notice. Refer to Section 8.1.2 – Notice of Adverse Benefit Determination for more information.

Choice of Practitioner

After the initial assessment, if medical necessity criteria are met, the beneficiary will be offered a choice of several providers whenever possible. In these cases, a request for a service provider with appropriate cultural and linguistic competence will be explored and documented.

The FCMHP will provide beneficiaries an opportunity to change providers at any time during the course of treatment. If the beneficiary requests a change of provider, the beneficiary will complete a *Request for Change of Service Provider* form. This form, as well as stamped, self-addressed envelopes, are available at all provider sites. The FCMHP staff will begin investigating the request in a timely manner. Criteria for accommodation of request will include, but not be limited to, the beneficiary's diagnostic and clinical issues and the impact of the change on treatment and plan of care goals; provider's ability to deliver the service (e.g., time conflicts with appointment availability), and the provider's treatment style and/or specialty.

Second Opinions

If any FCMHP provider completes an assessment and determines that medical necessity criteria are not met, the provider, at the time of the assessment, must inform the beneficiary of their right to a Second Opinion. If the beneficiary requests a Second Opinion, the provider must provide the beneficiary with an appeal form to make the request, then ensure Managed Care receives the request within one business day of their receipt.

The provider must also issue the beneficiary a Notice of Adverse Benefit Determine – Delivery System. Refer to Section 8.1.2 - Notice of Adverse Benefit Determination for more information.

Information Provided to Persons with Visual or Hearing Impairments

The Fresno County MHP utilizes the State TTY relay service, (7-1-1), as needed, for hearing impaired beneficiaries. Beneficiary informational materials are available in alternate forms (i.e., large print and online videos with audio for the visually impaired.)

1.2.1 Out of County Access

Fresno County beneficiaries requiring specialty mental health services when outside of Fresno County will call (800) 654-3937 for information on how to access services. If the beneficiary's mental health condition is urgent, they may call 9-1-1, or go to the nearest psychiatric or medical facility for emergency treatment. Specialty Mental Health Services provided to treat an urgent condition do not require FCMHP pre-authorization.

1.3 Interagency and Outside Referrals

The access point for all interagency and outside referrals is through the Access Line (800) 654-3937 or the FCMHP Managed Care Division (559) 600-4645. Referrals for Therapeutic Behavioral Services, Psychological or Neuropsychological testing are directed to a Utilization Review Specialist (URS) for screening. The URS will determine if there is need for referral to a provider who can provide these specialized services.

Referrals and Coordination with Other Providers

Referrals to the MHP for SMHS may be received through beneficiary or client self-referral or through referral by another person or organization including, but not limited to:

- Physical Health Care Providers
- Schools
- County Welfare Departments
- Other Mental Health Plans
- Conservators, Guardians, or Family Members
- Law Enforcement Agencies

If a potential referral is indicated, The URS will request a copy of the client's most recent mental health assessment and plan of care. After

review by the URS, and if the service is indicated, the URS will refer the beneficiary to a provider for an assessment, with an option for an expanded assessment.

1.4 Fresno County Mental Health Plan – Urgent Care and Emergency Access Points

Urgent Care Wellness Center (Adults)

The Urgent Care Wellness Center (UCWC) strives to provide mental health treatment services that are client-centered, strength based, culturally competent, and co-occurring mental health and substance abuse capable. Services are based in the Wellness and Recovery model as we believe that everyone can improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Services provided are mental health assessment, client centered treatment planning, group therapy, limited individual therapy, crisis evaluation, and linkage and consultation with client support systems such as: primary care, psychiatric services, government agencies, private providers, and natural support systems such as family, friends, and faith communities. The UCWC is available for adults 18 years and over, on a walk-in or appointment basis, at the following location:

4441 E. Kings Canyon Road, Fresno, CA 93702
(559) 600-9171
8:00 a.m. to 6:00 p.m., Monday – Friday (Except Holidays)

Youth Wellness Center (Children and Youth 0-17 yrs.)

The Youth Wellness Center (Center) welcomes children and parents/guardians seeking mental health treatment services for youth ages 0-17 who are experiencing behavioral challenges. The youth must be eligible for Medi-Cal or have no health insurance coverage. The Center triages clients based on their individual conditions. Children in crisis can be seen the same day, while children with less urgent conditions may be scheduled for an assessment. The service begins with a mental health assessment by a therapist who meets with the child and the parent/guardian to determine the behavioral needs and the level of care that is appropriate. A case manager may assist the therapist with linking the youth for ongoing treatment services and identify resources that are available to meet other needs the youth and family may have identified.

The Center also provides follow-up services for youth that have experienced a mental health crisis, but who are not receiving ongoing

outpatient mental health treatment. The goal is to avoid repeated crisis episodes by linking the client quickly to ongoing mental health treatment services with Children's Mental Health or a community resource based upon the severity of the youth's behavioral health needs. The Center recognizes the strengths of our youth and families and provides the mental health and support services to best promote wellness and resiliency.

1.4.1 24-Hour Availability of Services to Address Emergency Conditions-In County

The FCMHP Access Line offers 24-hour availability of services with linguistic capability, seven days a week. The toll-free line provides information on access to SMHS, including urgent and emergent care. The FCMHP Access Line is operated by a contracted provider. Access Line staff members with mental health training, certification, and/or licensure receive the calls and determine the nature of each call. If the caller requires language assistance, the call is coordinated with United Language Group, the County's contracted language interpretation service.

Staff triage the caller to determine the most appropriate level of care and referral type needed and provide the appropriate linkage. Callers with urgent or emergent conditions will be transferred to 9-1-1 for emergency assistance or, if determined to be safe, be advised to enter the system as a walk-in through one of the following sites as most appropriate:

Adults (18 yrs. +)

Exodus Crisis Stabilization Center
Provides 24-hour OUTPATIENT services for adults with severe mental illness in crisis.

4411 E. Kings Canyon Road
Fresno, CA 93702
(559) 453-1008
24 hours per day, 7 days per week

Exodus Psychiatric Health Facility (PHF)

Provides 24-hour INPATIENT hospitalization services for adults with severe mental illness in crisis.

4411 E. Kings Canyon Road
Fresno, CA 93702
(559) 600-7180
24 hours per day, 7 days per week

Children & Youth (0-17 yrs.)

Exodus Youth Crisis Center (0-17 yrs.)

Provides 24-hour OUTPATIENT services for children and adolescents with severe mental illness in crisis.

4411 E. Kings Canyon Road
Fresno, CA 93702
(559) 512-8700

Central Star Youth Psychiatric Health Facility (PHF) (12-17 yrs.)

Provides 24-hour INPATIENT hospitalization services for children and adolescents with severe mental illness in crisis.

4411 E. Kings Canyon Road, Bldg. #319
Fresno, CA 93702
(559) 600-2382

1.4.2 24-Hour Availability of Services to Address Urgent Conditions-Out of County

The FCMHP ensures that Medi-Cal beneficiaries, when out of the county, will have adequate access to SMHS. Out of county beneficiaries may include children adopted from Fresno County, or placed in guardianship with family, or in foster care; children or adults in residential placement, or beneficiaries who are visiting another county or recently changed county of residence. Beneficiaries who require urgent or emergent mental health services may call the FCMHP toll-free Access Line, (800) 654-3937, to request information on how to access SMHS out of county. If the beneficiary has an urgent mental health need or is in crisis, the beneficiary may go to the nearest psychiatric or medical hospital or facility for

assessment and crisis stabilization. No pre-authorization is necessary for crisis services.

1.5 Fresno County Mental Health Plan In-House Access Points-Fresno/Clovis Area

A Fresno County Medi-Cal beneficiary may access specialty mental health services by calling the client toll-free Access Line at (800) 654-3937. Access staff will provide the most appropriate linkage per the beneficiary's request and needs. Beneficiaries may also call one of the following access points directly, during business hours:

1.5.1 Adult Services

Metro Area Outpatient Clinic

The Metro Area Outpatient Clinic provides outpatient mental health services and case management through the Clinical Team, and medication support services through the Adult Medical Team, to mental health clients 18 years of age and older.

4441 E. Kings Canyon Road
Fresno, CA 93702
(559) 600-4099

Older Adult Mental Health Clinic

The Older Adult Mental Health Clinic provides mental health, medication support, case management, rehabilitation, and crisis intervention services to mental health clients 60 years of age and older. The clinic works collaboratively with several nearby Department of Social Services agencies and programs, including Adult Protective Services and In-Home Supportive Services, as well as the County Ombudsman and physical healthcare providers.

2025 E. Dakota Avenue, 2nd Floor, Suite 230
Fresno, CA 93726
(559) 600-5755

Conservatorship Team

The Conservatorship Team assists adult clients requiring psychological and/or psychiatric assessments for conservatorship determination. Clients are referred by designated acute psychiatric facilities (Exodus Psychiatric Health Facility, Community Behavioral

Health Center, and the VA Inpatient Facility) as well as by the court for clients that are in the Fresno County jail.

4411 E. Kings Canyon Road
Fresno, CA 93702
(559) 600-1500

Latino Team

The Latino Team provides culturally appropriate individual rehabilitation, case management, individual therapy, rehabilitation/therapy groups, and medication services with an emphasis on family, when possible. Services are provided in the office, community, and at clients' residences.

4441 E. Kings Canyon Road
Fresno, CA 93702
(559) 600-4099

Perinatal Program

The Perinatal program provides mental health services to pregnant and postpartum mothers and their babies. The multidisciplinary team can provide services in the office or home. Clients can self-refer or request their doctor to refer them.

West Fresno Regional Center, Edison Plaza
142 E. California Avenue
Fresno CA 93706
(559) 600-1033
Fax: (559) 600-1101

Pathways to Recovery

Pathways to Recovery services support the recovery of women, men, and their children in their Substance Abuse Track, Therapeutic Children's Services and Mental Health Track. Services focus on treating all thinking, feeling, behavior, and/or substance use challenges that the client is experiencing. Pathways to Recovery uses a client/child focused, strength-based wellness and recovery model.

515 S. Cedar Avenue
Fresno, CA. 93702
Phone: (559) 600-6075
Fax: (559) 600-6090

1.5.2 Children/Youth Services

Children's Outpatient Program

Outpatient services are provided to youth 0 - 17 years of age, and infant mental health for voluntary or court-ordered 0-3-year-olds. Services include mental health assessments and evaluations, case management, transitional services, medication services through the Children's Medical Team, collateral interventions, individual and family therapy, family advocacy, community based services as needed, substance abuse prevention and interventions, parenting groups in English and Spanish, groups for pre-adolescents and adolescents girls, Boys Coping Skills group, trauma focused mental health treatment, attachment-based family and child therapy.

3133 N. Millbrook Ave
Fresno, CA 93703
(559) 600-8918

Metro School-Based Program
The Metro School-Based Program is designed to deliver outpatient specialty mental health services to school age students that have been identified by school administration or other designated staff that they may benefit from school-based mental health treatment. Because of transportation, payment or family challenges, these students are not able to access services in the clinic setting. This program is available in school sites within Fresno, Central and Clovis Unified School Districts.
3147 N. Millbrook Avenue
Fresno, CA 93703
(559) 600-6750

1.6 Fresno County Mental Health Plan Access Points-Rural

Fresno County contracts with an organizational provider to operate clinics at rural sites throughout the county. Services include mental health services, intensive case management, crisis outreach services, medication evaluation, peer support, and supported independent permanent housing for adults with serious mental illness and children with severe emotional disturbance in Fresno County. These clinics serve multiple levels of severity, offer therapy, case management and psychiatric services at the following locations:

275 Madera Avenue, Kerman, CA 93606
(855) 225-7604 (Kerman location only)

3111 Coalinga Plaza, Coalinga, CA 93210
40 E. Minarets, Pinedale, CA 93650
1311 11th Street, Reedley, CA 93654
225 Academy Ave, Sanger, CA 93657
3800 McCall Avenue, Selma, CA 93622
(855) 343-1057 (Coalinga, Pinedale, Reedley, Sanger, & Selma locations)

Rural School-Based Program

The Rural School-Based program is designed to deliver outpatient specialty mental health services to school-age students that have been determined by school administration or other designated staff as potentially benefitting from school-based mental health treatment. The focus of treatment is on wellness, resiliency and recovery to assist the entire family who may benefit from specialty mental health services. The program enables students and their families to access services by reducing the barriers to care due to the lack of resources, transportation, language, ability to pay, or other family challenges.

3147 N. Millbrook Ave
Fresno, CA 93703
(559) 600-6892

Rural Resource Guide

The FCMHP has identified mental health resources in Fresno County rural areas. Please follow this link for more information: http://www.co.fresno.ca.us/home/showdocument?id=2877

1.7 Multi-Agency Access Program (MAP)

DBH provides an integrated MAP intake process connecting individuals and families facing homelessness/housing challenges, substance use disorders, or physical health and/or mental health-related challenges to supportive service agencies in Fresno County. DBH seeks to streamline access processes to ensure that all individuals in need of behavioral health care have timely, personal, relevant, clear and understandable paths to care. By integrating behavioral health into other systems such as physical health care settings, justice settings including courts and probation, schools, and other service delivery organizations, DBH can significantly increase access to care and improve the total health and wellness in the community.

The MAP Point is a Collaborative of an experienced team of three partners: Kings View Corporation, Centro La Familia Advocacy Services, and Poverello House. Community Regional Medical Center is a project participant and will provide a MAP site at its Ambulatory Care Center, but is not a formal, funded partner. Together this team has developed a proposal to serve Fresno County through eight fixed sites and a mobile truck. The project includes three sites in urban Fresno and five rural sites, plus mobile unit stops. The plan draws upon the experience of the Poverello House at its current MAP Point at Poverello program, enhanced by the experience of Kings View Corporation and Centro La Familia Advocacy Services in serving the target populations.

The MAP provides an integrated intake process that connects individuals facing various challenges to supportive services, matching individuals and families to the right resources at the right time at the right location. This is accomplished through an established and formalized screening process, collaboration of service providers, leveraging existing community resources, eliminating barriers and assisting clients' access to supportive services.

In collaboration with the Hospital Council's Community Conversations and the Fresno-Madera Continuum of Care, Fresno's first pilot of a MAP, MAP Point at the Poverello House (Pov), opened February 17, 2015. MAP Point at the Pov is supported by full-time staff physically located on-site coupled with the coordinated efforts of multiple community partners rotating in on a daily schedule. Intakes/screenings are completed by on-site staff or a community partner.

Once the intake and assessment are completed, each agency will work within a centralized system for placement. The overall goals of the MAP Point project are as follows:

- Provide clients with a single point of entry in urban and rural communities where people may access health care and social services that promote their health, financial, and social well-being in the community.

- Support the client's resiliency and sustainability through appropriate linkages.

- Using best practices, engage the client in completing the Community Screening Tool and other appropriate tools to assist in the development of their linkage plan goals.

- Respect each client's ethnicity, gender, and belief system by utilizing cultural humility in all interactions.

The MAP Point Collaborative proposes to serve all clients who come to one of the MAP points, and to leverage partner resources to create community awareness of MAP services. Partners develop conservative estimates of initial duplicated contacts based on their experience at each of the sites.

1.8 Provider Transition Plan

Should a contract provider choose to terminate their contract with the FCMHP or should a contract provider have their contract with the FCMHP plan terminated, that contract provider is responsible to assist in the transition of a beneficiary under their care to another provider who is contracted with the FCMHP. The terminating provider must contact the FCMHP as soon as possible and provide a list of all Fresno County beneficiaries under their treatment. The FCMHP will ensure that the beneficiary receives the same level of service from a provider of their choice during the transition.

1.9 Procedure for Requesting Other Mental Health Services

When a contract provider determines that the beneficiary needs additional mental health services, (such as Medication services) but these services are beyond the provider's capability or scope of practice to provide, the provider may contact a Utilization Review Specialist by calling (559) 600-4645, and provide the following documents:

- Copies of the Assessment and Plan of Care
- Completed Release of Information form
- Completed Medication Referral form (Refer to Section 15 for form information.)

Once the required forms are received, Managed Care will refer the beneficiary accordingly.

Section 1:

Access and Referral

Forms and Attachments

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CLINIC FACE SHEET

THERAPIST _____ DATE OF INTAKE _____ SITE _____

CLIENT NAME _____ D.O.B. _____ SS# _____

CLIENT'S BIRTH NAME _____ MOTHER'S FIRST NAME _____

RESIDENCE ADDRESS _____ PHONE# _____
STREET # CITY ZIP

MAILING ADDRESS _____ PRIMARY LANGUAGE _____
(IF DIFFERENT THAN RESIDENCE)

EMPLOYER _____ HIGHEST GRADE COMPLETED ____
(SCHOOL OF ATTENDANCE **IF MINOR**)

EMPLOYMENT STATUS (✓ ONE)
- ❑ FULL TIME (> 35 HOURS WEEKLY) COMPETITIVE JOB MARKET
- ❑ PART TIME (< 35 HOURS WEEKLY) COMPETITIVE JOB MARKET
- ❑ FULL TIME-NONCOMPETITIVE JOB MARKET
- ❑ PART TIME-NONCOMPETITIVE JOB MARKET
- ❑ UNEMPLOYED
- ❑ NOT IN LABOR FORCE (DISABLED)
- ❑ STUDENT
- ❑ UNKNOWN

ETHNICITY_____
(LIST SINGLE OR MULTIPLE ETHNICITIES)

PLACE OF BIRTH _____
(COUNTY IN CA, OR STATE IF NOT CA, OR COUNTRY IF NOT US)

GROSS MONTHLY INCOME $_____
(EARNED INCOME OR UNEMPLOYMENT ONLY)

MARITAL STATUS (✓ ONE)
- ❑ NEVER MARRIED
- ❑ MARRIED, REMARRIED, LIVING TOGETHER
- ❑ WIDOWED
- ❑ DIVORCED
- ❑ SEPARATED
- ❑ UNKNOWN

SPOUSE'S NAME _____ D.O.B. _____

REFERRAL SOURCE (IF ANY) _____
(I.E.; PHYSICIAN, SOC SVC, CVRC, POLICE, PROBATION, MH CLINICIAN. ETC.)

FOR MINOR CONSUMERS ONLY:

FATHER'S NAME _____ DOB _____ NATURAL, STEP-PARENT, ADOPTIVE, OTHER (CIRCLE ONE)

MOTHER'S NAME _____ DOB _____ NATURAL, STEP-PARENT, ADOPTIVE, OTHER (CIRCLE ONE)

FAMILY COMPOSITION	DOB	RELATIONSHIP	DMH NUMBER

YES NO
MEDI-CAL ( ) ( ) (ATTACH COPY OF CARD)

YES NO
PRIVATE INSURANCE ( ) ( ) (ATTACH COPY OF INSURANCE ID CARD)

GRANT AMOUNT $ _____
(TANF, SSI, SOC SEC)

MEDICARE ( ) ( ) (ATTACH COPY OF CARD)

COMMENTS: _____
_____
_____

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SECTION 2: SERVICES REQUIRING AUTHORIZATION

The Fresno County Mental Health Plan (FCMHP) is strongly committed to providing quality services to its beneficiaries, while supporting a philosophy of brief, problem solving treatment, utilizing specific treatment goals. The FCMHP's authorization processes are driven by this philosophy.

Pre-authorization of services is only required for Therapeutic Behavioral Services, Day Treatment/Day Rehabilitation, and for minors who are court dependents of other counties placed in foster care or group homes in Fresno County. The FCMHP does not require pre-authorization for any other services.

2.0 Service Authorization Requests

The Service Authorization Request (SAR) Process is an authorization process for minors who are court dependents of other counties placed in foster care or group homes in Fresno County.

2.0.1 Requests for SARs

In order to bill for mental health services provided to minors who are court dependents of other counties and are placed in foster care or group homes in Fresno County, permission to treat must be received from the County of Financial Responsibility (CFR).

The provider must check the minor's Medi-Cal eligibility and if the county indicated as the county of financial responsibility is not county 10, Fresno, the provider must check the Medi-Cal aid code to determine eligibility for the SAR process.

SAR eligible aid codes are:

Adoptive Aid: 03, 04, 06, 07
Kinship Guardianship: 4F, 4G, 4K, 4S, 4T
Foster Care: 4H, 4L, 4N, 40, 42, 43, 46, 49, 5K

The provider may contact the SAR Coordinator at (559) 600-4645 for consultation or questions about an Assessment or Plan of Care. The provider must fax or mail the Assessment and Plan of Care as soon as possible to the SAR Coordinator for service authorization review.

2.0.2 Requesting an initial SAR:

If the minor has a SAR eligible aid code, the following information needs to be sent to the SAR Coordinator in the Managed Care Division:

- Client Name
- Client DOB
- SSN or CIN
- Copy of the minute order or other form of court order that authorizes mental health assessment and continuing services as needed.
- Copy of the JV220-JV223 if medications have already been approved by the court.
- Brief summary of the problems/behavioral concerns that have caused the client to seek treatment.
- Residence Address and Phone #
- Caregiver Name
- Social Worker/Probation Officer
- Social Worker/Probation Officer Phone #

The FCMHP SAR Coordinator will complete an initial Service Authorization Request (SAR) for assessment and plan development and fax it to the County of financial responsibility (CFR).

When an approved SAR is received from the CFR, a copy will be faxed to the provider and a copy will be retained in the Managed Care file to allow cross checking of claims received for the minor.

The provider may provide and bill for any services approved on the initial SAR during the approved date range using the claiming process described in Section 4, Eligibility and Claims, of this manual.

2.0.3 Requesting an ongoing SAR:

After assessing the minor, the contracted provider must fax a copy of the completed assessment and treatment plan to the Managed Care Department.

The FCMHP SAR Coordinator will complete an ongoing Service Authorization Request (SAR) for the ongoing services the contracted provider has indicated on the treatment plan. The ongoing SAR, assessment, and treatment plan will be faxed to the County of Financial Responsibility (CFR).

When an approved ongoing SAR is received from the CFR, a copy will be faxed to the provider and a copy will be retained in the Managed Care file to allow cross checking of claims received for the minor.

The contracted provider may provide and bill for any services approved on the ongoing SAR during the approved date range using the claiming processes described in the Eligibility and Claims section of this manual.

2.1 Procedure for Psychiatric Inpatient Hospital Professional Services

- The FCMHP **does not** require pre-authorization of psychiatric inpatient hospital professional services.

- The medical necessity criteria for psychiatric inpatient hospital professional services follow the reimbursement criteria for psychiatric inpatient hospital services. (Refer to Section 3 for medical necessity criteria for inpatient services.)

- Billing for psychiatric inpatient hospital professional services follows the same process outlined in Section 6, Eligibility and Claims, except that claims for professional fees can be submitted up to 60 days beyond the billing month.

- Billing for psychiatric inpatient hospital professional services may be denied if documentation does not support medical necessity for inpatient acute or administrative stay.

- Billing for psychiatric inpatient hospital professional services may be denied if the duration of the service does not match the duration noted in the patient's hospital progress note, or if a duration is not noted on either the claim or the progress note.

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SECTION 3: MEDICAL NECESSITY CRITERIA

3.0 Definition of Medical Necessity

Medical necessity is the principal criteria by which the Fresno County Mental Health Plan (FCMHP) decides to accept and approve payment of claims. Medical necessity for specialty mental health services must exist before and during on-going treatment in order for claims to be eligible for reimbursement.

3.1 Specialty Mental Health Services

Specialty Mental Health Services are:

- Rehabilitative services, including mental health services, medication support services, day treatment intensive, day treatment rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.
- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatrist services
- Psychologist services
- EPSDT supplemental specialty mental health services
- Psychiatric nursing facility services

3.2 Medical Necessity for Specialty Mental Health Services

3.2.1 Included Diagnoses

The beneficiary must have one of the following DSM V diagnoses, which will be the primary focus of the intervention being provided:

- Pervasive Developmental Disorders, except Autistic Disorder
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders

- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnosis.

A beneficiary diagnosed with an included diagnosis is considered to have serious mental illness (SMI). This qualifies the beneficiary to receive services from the FCMHP.

3.2.2 Excluded Diagnoses

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunction
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions That May Be a Focus of Clinical Attention, except Medication Induced Movement Disorders which are included

3.2.3 Impairment Criteria

The beneficiary must have one of the following as a result of the mental disorder(s) identified in the diagnostic criteria (3.2.0); Must have one, 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or

3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated (current DHS EPSDT regulations also apply).

3.2.4 Intervention Related Criteria

Additionally, all three criteria below (1, 2, & 3) must be met:

1. The focus of proposed intervention is to address the condition identified in impairment criteria above,
2. It is expected that the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would not be responsive to physical health care based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty mental health treatment goals.

3.3 Medical Necessity for Psychiatric Inpatient Hospital Services

For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fifth Edition, published by the American Psychiatric Association:

- Pervasive Developmental Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence

- Cognitive (only Dementias with Delusions, or Depressed Mood)
- Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Intermittent Explosive Disorder
- Pyromania
- Adjustment Disorders
- Personality Disorders

(2) A beneficiary must have both (A) and (B):

(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

   - Represent a current danger to self or others, or significant property destruction.

   - Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

   - Present a severe risk to the beneficiary's physical health.

   - Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

   - Further psychiatric evaluation.
   - Medication treatment.

   - Other treatment that can reasonably be provided only if the patient is hospitalized.

(3) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

- Continued presence of indications, which meet the medical necessity criteria.
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
- Presence of new indications that meet medical necessity criteria.
- Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

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SECTION 4: SERVICE DEFINITIONS

Individual and Group Providers are providers of Specialty Mental Health Services (SMHS), contracted under the Fresno County Mental Health Plan (FCMHP) Individual and Group Provider Master Agreement. Individual and Group Providers provide services to beneficiaries utilizing licensed or registered Mental Health staff members.

Organizational Providers are also providers of SMHS but are contracted separately with the FCMHP through their own distinct agreements, usually through a bidding/RFP process. An Organizational Provider provides services to beneficiaries utilizing licensed, registered, or waivered non-licensed Mental Health staff members. Both types of providers provide services other than psychiatric inpatient hospital services or psychiatric nursing facility services, which are distinct service types intended to be provided by different providers.

4.0 Definitions of Service Providers

Under an organizational set up, the following mental health staff may provide specialty mental health services as defined within their scope of practice:

- Licensed Mental Health staff member

  Any mental health professional licensed in the State of California as a Psychiatrist, Psychologist, Clinical Social Worker, Marriage, Family Therapist, or a Registered Nurse.

- Registered/Waivered Mental Health staff member

  Any mental health professional who has a waiver of psychologist licensure issued by the State Department of Mental Health or has registered with the applicable state licensing authority to obtain supervised clinical hours for Marriage, Family Therapist or Social Worker licensure.

- Non-licensed Mental Health staff member

  A mental health staff member who has a bachelor's degree or four years' experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment, but is not licensed or registered/waivered, is considered to be a non-licensed mental health staff member. Up to two years of graduate professional education may be substituted for the experience on a year-to-year basis; up to two years of post-associate

arts clinical experience may be substituted for the required education.

4.1 Service Types

Organizational providers can provide **rehabilitative** and **case management** services as defined below:

Rehabilitative Mental Health Services

These are medical and remedial services recommended by a physician or other licensed mental health practitioners, within their scope of practice under state law, for the maximum reduction of mental disability and restoration of the client to the best possible functional level, when provided by local public community mental health agencies and other mental health service providers licensed or certified by the State of California. These services are provided in the least restrictive setting appropriate for reducing psychiatric impairment, restoration of functioning consistent with the requirements for learning and development, and/or independent living and enhanced self-sufficiency.

Case Management

These activities are provided by program staff to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services for eligible individuals.

4.2 Service Activities

4.2.1 Mental Health Services

Mental Health Services are those individual or group therapies and interventions that are designed to reduce mental disability and improve or maintain functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. They are not provided as a component of the adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive services. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral.

Site and contact requirements for mental health services:

Mental health services may be either face-to-face or by telephone with the client or significant support person(s), and may be provided at any location in the community.

Billing unit:

The billing unit is by minute based on staff time.

Billing requirements based on minutes of time:

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

When a person provides service to, or on behalf of, more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides the service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed will not exceed the actual time utilized for claimable services.

When two or more providers are billing for the same service at the same time for the same beneficiary, all staff who provided the service must document separately the specific intervention provided, justifying the need for each staff's presence. Each staff involved may bill individually for the entire time spent in rendering the service. The FCMHP will disallow claims if there is no documented justifiable reason or intervention for each staff member who billed for the service. An example of a justifiable reason is a crisis situation where the presence of two staff is necessary for the safety of the beneficiary and staff.

The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

Lockouts:

Mental Health Services are **NOT REIMBURSABLE** in the following situations:

- On days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facilities are reimbursed, except on the day of admission;
- When provided by Day Treatment Intensive staff during the same day that Day Treatment Intensive services are being provided;

- When provided by Day Rehabilitation staff during the same day that Day Rehabilitation services are being provided;

- Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time;

  OR

- When provided during the same times that Crisis Stabilization-Emergency Room or Urgent Care is provided.

Direction of Services:

Co-signature requirement: Within county scope of practice guidelines, mental health services provided by unlicensed staff without a bachelor's degree in a mental health related field or four years of experience delivering mental health services must have all progress notes co-signed by one of the following professional staff, until the experience/education requirement is met:

- Physician
- Licensed/waivered Psychologist
- Licensed/registered Clinical Social Worker
- Licensed/registered Marriage Family Therapist
- Registered Nurse

4.2.1.1 Assessment

An assessment is a service activity that may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavior disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

4.2.1.2 Plan Development

Plan development is a service activity that consists of development and approval of the client's plan, and/or monitoring of the client's progress.

4.2.1.3 Therapy

Therapy is a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. This service activity may be delivered to a client or group of clients, and may include family therapy where the client is present.

4.2.1.4 Rehabilitation

Rehabilitation is a service activity that includes assistance in improving, maintaining, or restoring a client or group of clients' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and medication education.

4.2.1.5 Collateral

Collateral is a service activity to a significant support person in a client's life with the intent of improving or maintaining the mental health status of the beneficiary. Collateral services include, but are not limited to, helping significant support persons to understand and accept the client's condition and involving them in service planning and implementation of the Plan of Care. Family counseling or therapy, which is provided on behalf of the client, may be considered collateral.

4.2.1.6 Therapeutic Behavioral Services

See Section 5 for a detailed description.

4.2.1 Medication Support Services:

Medication support services are those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The services may also include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, medication education and plan development related to the delivery of the service and/or assessment of the client.

Site and contact requirements:

Services may be either face-to-face or by telephone with the client or significant support person(s), and may be provided at any location in the community.

Billing unit:

The billing unit is by minute, based on time. Medication Support Services that are provided within a residential or day program shall be billed separately from those services.

Lockouts:

A maximum of four (4) hours of Medication Support Services per calendar day is reimbursable. Medication Support Services are **NOT REIMBURSABLE** on days when Inpatient Services or Psychiatric Health Facility Services are reimbursed except for the day of admission to these services.

Staffing:

Medication Support Services shall be provided within the provider's scope of practice as a Physician, Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician, and/or Pharmacist.

4.2.2 Crisis Intervention

Crisis Intervention is a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities may include, but are not limited to, assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis

stabilization or who are eligible but deliver the service at a site other than a provider site that has been certified by the State Department of Mental Health or a Mental Health Plan to provide crisis stabilization.

Site and Contact Requirements:

Crisis Intervention may either be face-to-face or by telephone with the beneficiary or significant support person(s) and may be provided anywhere in the community.

Billing Unit:

The billing unit is by minute, based on staff time.

Lockouts:

Crisis Intervention is **NOT REIMBURSABLE** on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

Claims must be submitted with supporting documentation. Provider must submit crisis intervention progress notes with the claims when claiming crisis intervention hours. The FCMHP will reimburse provider for crisis intervention visits only when the service is provided to resolve an immediate mental health crisis.

Providers should refer beneficiaries to the County's contracted 23-hour crisis stabilization center (for both Adults and Adolescents), located at 4411 East Kings Canyon Road, Fresno, CA 93702, if their mental health crisis may potentially continue beyond two hours. Provider may also need to reassess the appropriateness of current mental health services received by beneficiary if the need for crisis intervention services occurs on a daily (or very frequent) basis.

Staffing:

Crisis intervention services may be provided by:

- Physicians
- Psychologists or related waivered/registered professionals
- Licensed/Registered Clinical Social Worker

- Licensed/Registered Marriage, Family Therapist
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Staff with a bachelor's degree in a mental health related field

4.2.3 Case Management

Case Management means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Site and Contact Requirements:

Case Management may be either face-to-face or by telephone with the beneficiary or significant support person(s) and may be provided in-office, or anywhere in the community.

Billing Unit:

The billing unit is by minute, based on staff time.

Lockouts:

Case Management is **NOT REIMBURSABLE** on days when the following services are reimbursed, except for a day of admission or for placement services as provided in the following:

- Psychiatric Inpatient Hospital Services
- Psychiatric Health Facility Services
- Psychiatric Nursing Facility Services

Case Management services solely serve the purpose of coordinating placement of the beneficiary on discharge from the psychiatric inpatient hospital, psychiatric health facility or psychiatric nursing facility and may be provided during the 30 calendar days or less per continuous stay in the facility.

Staffing:

Case Management services may be provided by:

- Physicians
- Psychologists or related waivered/registered professionals
- Licensed/Registered Clinical Social Worker
- Licensed/Registered Marriage Family Therapist
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Staff with a bachelor's degree in a mental health related field

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SECTION 5: THERAPEUTIC BEHAVIORAL SERVICES

This section provides a detailed description of Therapeutic Behavioral Services (TBS) in Fresno County and intended for use by organizational providers contracted with the FCMHP to provide TBS only. Organizational providers contracted with FCMHP to provide other specialty mental health services may use the information outlined in this section in understanding TBS and its eligibility requirements.

5.0 General Program Description

The Department of Behavioral Health currently provides a wide range of mental health services to the youth population of Fresno County through county operated programs and contracts with individual, group, or organizational providers. These services include individual, family and group therapy, individual and group rehabilitation, rehabilitative and intensive day treatment, mental health assessment, hospitalization, medication support, and case management services.

In August of 1999, all counties in the state were instructed by the California Department of Mental Health (now known as the Department of Health Care Services) to prepare and implement a plan to provide a new supplemental specialty mental health service known as Therapeutic Behavioral Services (TBS) for full-scope Medi-Cal beneficiaries under the age of 21. This service consists of one to one intensive behavioral intervention, provided up to 24 hours per day, 7 days a week.

TBS is a part of the beneficiary's existing Plan of Care. When a youth (beneficiary) in need of TBS has been identified and has agreed to the service, a TBS team is formed. The TBS team consists of TBS service provider, (called the Coach), the youth's assigned therapist (Mental Health Clinician), the youth's parents, foster parents or the group home staff (Caretakers) and the county oversight staff (Advisor). The Plan of Care is reviewed and appropriate inventions and goals for TBS are identified. The service is initiated and continued until the targeted behaviors are reduced or eliminated.

5.1 Managed Care's Responsibilities

Notifying Providers of Responsibilities

Managed Care is responsible for notifying TBS providers of their responsibilities through the following mechanisms:

- DHCS letters and other written communications regarding TBS.
- Individual consultation on a regular basis.
- Procedures for TBS referral and provision of service as outlined in this Procedure Manual will be distributed to all organizational contract providers.

Organizational Provider Contract

The FCMHP has an established contractual agreement with an organizational provider who will provide all TBS services.

TBS Coordinator

Managed Care assigns Mental Health Clinicians with extensive experience on behavioral interventions with very seriously disturbed youth. The Coordinator's responsibilities include reviewing all applications for Coach certification, developing and disseminating all TBS guidelines, forms, and procedures. If request for TBS is denied after a mental health assessment, the TBS Coordinator is responsible for ensuring that the NOABD Denial Notice is given to the beneficiary, and that they understand how to appeal that decision.

5.2 Organizational Contract Provider's Responsibilities

Administrative Responsibilities

The TBS organizational provider is responsible for all aspects of TBS, just as it is for individual therapy, family counseling or other types of service. The organizational provider hires Coaches, supervises them, documents and bills the service(s), and reports the costs associated with the service(s) to the FCMHP for reimbursement. The provider is expected to follow all policies and procedures that apply to treatment services. In most aspects, TBS should be handled like any other Medi-Cal funded service.

Since TBS is an intensive and expensive service designed for the most seriously disturbed beneficiary, the FCMHP provides support and oversight beyond other Medi-Cal Services. The FCMHP responsibilities do not substitute for organizational provider's obligations but

supplement them. The following are examples of those providers' obligations:

- Staff education about TBS and engaging their cooperation.
- Identifying potential sources of Coaches, selecting and orienting the Coaches.
- Reviewing and coordinating the above activities with the TBS Coordinator.
- Ensuring that Coaches attend required consultation and planning meetings. Coaches meet with their Advisor weekly. Other residential staff involved with a TBS beneficiary may also need to join some team meetings to ensure coordination of services.
- Tracking costs for TBS.
- Tracking hours worked against progress notes.

Clinical Responsibilities

The organizational provider is responsible for the supervision of the TBS Coach. This must be a licensed mental health clinician. The FCMHP TBS Coordinator will also be available to Coaches to provide regular specialized consultation about their TBS duties.

Hiring Coaches

Minimum Requirements: The minimum requirements for a Coaching position are the same as for a group home counselor. The large majority of Coaches have experience well beyond this minimum. There is no upper limit with respect to education and experience for a Coach.

The TBS Coordinator approves or denies potential Coaches. A Coach Application Form must be filled out by each Coach and submitted to the TBS Coordinator for review and filing. Decision to approve or deny a Coach application depends on Coach's experience and education, and prior work history. (Refer to end of this section for a copy of this form.)

Some Group Home agencies may have reassigned current staff to new responsibilities as Coaches. This works best if the Coach works in a cottage or hall different from their prior assignment as children often become very jealous if current staff seems to be devoting all of their time to just one child. These assignments have been part and full time,

temporary and continuing. The advantages to this model are that the staff are familiar with the program and procedures, that it can be a way of recognizing top staff and/or providing a model for other staff. The disadvantage is the possible jealousy noted above and the possibility that negative staff attitudes about the TBS beneficiary may be difficult to abandon.

Some group homes have hired new staff to work as Coaches. As the Coaching job is often not full time, and is most often needed in the afternoons, this is an attractive job for graduate students and for experienced childcare workers with night or morning shifts. For those who are hired full time, duties other than TBS must be guaranteed for those times when TBS is not needed. Hiring this type of Coach is more difficult and time consuming but the possible prejudices of staff are avoided and there is more flexibility in assignments. However, the lack of knowledge of the program and identification with staff may lead to more serious "splitting" between the Coach and residential staff if there is no careful and ongoing coordination of treatment.

A fingerprint check request must be initiated and training in confidentiality and child abuse reporting must be completed before a Coach can begin providing TBS. When the Coach is already a current employee of a local facility licensed by Social Services that requires a fingerprint check, a letter from that facility saying that the Coach is currently an employee in good standing can substitute for a new fingerprint check. The following must be in the organizational provider's personnel file and available to the TBS Coordinator upon request.

- Completed and approved Coach application
- Supporting documents regarding education or experience
- Fingerprint check request
- Signed statement regarding training on confidentiality
- Signed statement regarding training on child abuse reporting

5.3 Process for Determining TBS Eligibility

A beneficiary, parent, legal guardian or staff may request an assessment for TBS services. The process is initiated by calling 1-800-654-3937 or completing the TBS Screening and Referral form and then forwarded to the TBS Coordinator.

The TBS Coordinator reviews the application for the following items:

1. Beneficiary is under age 21

2. Beneficiary has full-scope Medi-Cal.

3. Beneficiary meets one of the class requirements:

    a. Has been admitted to a psychiatric hospital during the past 24 months.

    b. Is currently residing in a Level 12 – 14 Group Home

    c. Is in danger of being placed in a Level 12 – 14 Group Home

    d. Has received TBS within the past 12 months

4. Beneficiary is currently receiving Specialty Mental Health services and thus

    i. Meets medical necessity criteria

    ii. Has had a complete assessment or is currently being assessed

5. Beneficiary is exhibiting behaviors that are

    i. Jeopardizing placement or blocking transition to a lower level of care.

    ii. These behaviors are amenable to interventions by a TBS provider and not due solely to an ongoing chronic condition such as developmental delay, autism or other conditions.

    iii. Not the reason for placement in the current facility.

6. Treatments less restrictive than TBS have been attempted.

The TBS Coordinator contacts the person initiating the referral with one of the following decisions:

a. The beneficiary is a member of the class who may benefit from TBS. The TBS request is approved, and a TBS team will be formed.

b. Additional information is requested. TBS request is pended.

c. A recommendation for alternative service may be made. This occurs when less restrictive interventions have not been attempted. The TBS Coordinator identifies possible interventions and assists the referring party to secure those interventions within the FCMHP. The beneficiary is then placed on the "Inactive List." The request for TBS is reactivated if the recommended alternative interventions are not successful in addressing the problem behaviors.

TBS Notice of Adverse Benefits Decision

If the referring provider does not agree with the recommendation for alternative service, an NOABD Denial Notice will need to be provided. The NOABD process for TBS is the same as for any other Specialty Mental Health Service except that a copy of the NOABD is sent to DHCS.

5.4 Service Delivery

TBS is a Medi-Cal Specialty Mental Health Service (SMHS), thus all of the regulations and procedures that apply to individual, group and other forms of SMHS apply to TBS. The procedures and responsibilities outlined below are additional guidelines.

Parameters of Service

The amount of time scheduled per week varies per beneficiary. Some beneficiaries have required more than eight hours per day or more than 40 hours per week and thus more than one Coach. This is acceptable if justified clinically.

Initial Authorization Request

The initial TBS authorization will not exceed 30 days or 60 hours, whichever is less. The initial authorization covers the initial TBS assessment, development of the initial TBS plan, and initial delivery of direct one-to-one TBS. The initial TBS assessment must identify at least one symptom or behavior that TBS will address, and the initial TBS plan must identify at least one TBS intervention. The FCMHP will make an authorization decision within 14 calendar days of receipt of the TBS request.

Reauthorization Request

TBS reauthorizations will not exceed 30 days or 60 hours, whichever is less. The FCMHP will not approve the provider's reauthorization request unless the request includes a TBS Plan of Care that meets the requirements as listed on 58. In addition, reauthorization requests will be based upon clear documentation in the client's medical record of the following:

- The beneficiary's progress towards the specific goals and timeframes of the TBS plan. A strategy to decrease the intensity of services and/or initiate the transition plan and/or terminate services. When TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness.

- If applicable, the beneficiary's lack of progress towards the specific goals and timeframes of the TBS plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not

making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the alternatives will be effective.

- The review and updating of the TBS Plan as necessary to address any significant changes in the beneficiary's environment (e.g., change in residence).

- The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

Expedited Authorization Request

In cases when the provider or the FCMHP determines that following the 14 calendar day timeframe could jeopardize the beneficiary's life or health, or ability to attain, maintain, or regain maximum function, the FCMHP will process the request within 3 working days of receipt of the request. The provider will mark the "Expedite Referral" box at the bottom of the TBS Screening and Referral form and include the clinical justification for the expedited request.

The FCMHP will use the following standards to determine whether TBS authorization should be expedited:

- Without TBS, the beneficiary is likely to be placed in a higher level of care or require acute psychiatric hospitalization within the next 14 days.

- The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.

- The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap of services, and the request is being made before the end of the previously authorized service period.

Planning Meeting

After the TBS request has been screened for TBS eligibility, a planning meeting is usually held that includes the beneficiary, the caretakers, the therapist, the Coach and the TBS Supervisor. The TBS Supervisor arranges for this meeting. This group is called the TBS team. The purpose of the meeting is to identify target behaviors, possible interventions and expected outcomes. If the critical times for these behaviors can be identified, the coaching schedule is set at these times

(for example, before dinner, at bedtime, Sunday evening, etc.) Other logistical arrangements are made, and all necessary signatures, permissions and releases completed. A tentative length of service in weeks is also discussed. The TBS Plan of Care is completed as an addendum to the Plan of Care, and a progress note detailing all of the items discussed. In almost all cases, this meeting will take place before TBS is started. In emergency cases, TBS may be started if the meeting takes place during the first week of the service.

Coach Responsibilities

The Coach is responsible for meeting with the beneficiary at the agreed upon times and following the intervention plan. Sample interventions successfully used by Coaches are used in the methodologies section. The Coach completes a progress note for every day of service using the TBS Progress Notes form. The note is reviewed and countersigned by the supervising Clinician. The Coach also notes the hours spent in TBS in progress notes, timecard or some other record.

The Coach is also responsible for attending a group consultation meeting with the TBS Supervisor where the interventions are reviewed and fine-tuned. The Coach completes a progress note describing these discussions and also records the beneficiary's Serious Incident Reports (SIR) for the week. A coordination meeting with the therapist occurs at least monthly. This can be conducted individually or as part of the organization's treatment team meeting. The TBS Supervisor joins these meetings as needed. The Coach also prepares a progress note on these meetings. Consistency in meeting these obligations is necessary to continue coaching.

Therapist Responsibilities

The Mental Health Therapist may be a contract provider or Department of Behavioral Health staff. The role of the therapist is critical to the success of TBS. Ideally, the TBS intervention plan is an extension of the Plan of Care and the Coach and therapist work as a team. Regular and extensive communication between the Coach and therapist is the best way of accomplishing this, thus a weekly or biweekly meeting is essential to the plan.

As the therapist is ultimately responsible for the coordination of the Plan of Care, the therapist oversees the provision of TBS and works with the Coach to develop the goals, interventions and desired outcomes for the service. The therapist is responsible for meeting with the Coach on a regular basis and for attending those planning and consultation meetings as agreed upon with the TBS provider.

Termination

It is the responsibility of the TBS team to plan for termination from the beginning of service. The interventions should always be planned so that they can be generalized to situations where the Coach is not present. A major part of the TBS plan must also be to incorporate others – parents, residential staff – into the interventions with the beneficiary. If this is done consistently, termination can be a natural rather than painful process.

5.5 Clinical Process and Methodology

Role of the Coach

The primary duty of the Coach is to implement the TBS Plan of Care that was developed by the beneficiary, parent or caretaker, therapist, Advisor and Coach. This can take many forms and depends on the needs and strengths of the beneficiary as well as the creativity and expertise of the TBS team. However, across all beneficiaries, three types of interventions usually have been successful:

1. Identification of the early signs of distress. These beneficiaries are often described by caretakers as "unpredictable," "exploding/running away for no reason," and when asked, often do not know what triggered a particular incident. The Coach role is uniquely suited to be able to observe the beneficiary minutely and identify the external signs of agitation, and often, the probable precipitant. This information is continuously shared with the beneficiary until the beneficiary is able to make these observations themselves.

2. Development of self-soothing and self-controlling behaviors. Simultaneously, the Coach is working with the beneficiary to identify behaviors to use instead of "blowing up", "running away" or to reduce the level of agitation once it is identified.

3. Positive reinforcement. Success on the above tasks is supported initially with both verbal and concrete positive reinforcement. Over time, the concrete becomes less important, as does any type of external reinforcement. The Coach then begins to support the beneficiary's self-rewarding observations and statements.

These interventions are often accompanied by activities designed to enhance the self-esteem of the beneficiary and may take place where the beneficiary lives in the community.

Some of the topics that have most often been the focus of the intervention are explosive outbursts, AWOL behaviors, medication compliance and social interactions. Coaches in different settings have been very creative in the development of activities that support the principles above. Group activities, outings and special events that require maximum planning and responsibility by the beneficiaries have been very successful.

Selection of Coaches

Good Coaches can come from a wide range of backgrounds. The ability to connect with kids, being non-threatening to caregivers, and ability to think positively are more critical than degrees or background.

Assignments

Less than full time, 20 hours of TBS a week works in many cases. The extreme lower limit appears to be 10 hours per week. For most cases, afternoons and early evenings are the critical times, occasionally weekends or very early in the morning.

It has been found that in group homes, the Coach should be someone who works in that agency, perhaps from a different cottage or section from where the beneficiary is located. Problems can arise if the Coach is from another agency or is very unfamiliar with the residential program.

Only one beneficiary must be assigned to a Coach at a time. If two beneficiaries in the same residential program are assigned to the same Coach, intense "sibling rivalry" is evoked, precipitating crises rather than resolving them, even if the Coach is assigned to the two beneficiaries at different times of the day or week. With the rare exception, more than one case at a time is also too much for a Coach.

Use of Coaches in Schools, Community Events and Hospitals

The use of a Coach in a public school is a common practice. TBS in school may be approved on a case-by-case basis.

Coaches have been widely used to allow a beneficiary to participate in events in the community that they otherwise would be unable to attend. This has been successful to date, with no incidents occurring in these outings.

Hospitalization constitutes a lock-out (i.e. a period for which TBS cannot be billed to Medi-Cal.) When clinically appropriate, the Coach can visit the beneficiary in the hospital several times before discharge. The Coach is paid but Medi-Cal cannot be billed for the visits.

Role of Therapist

The close collaboration of the Coach and Therapist is critical for success. A common format is for the therapist to work with the beneficiary on critical concepts in the session and for the Coach to help the beneficiary identify specific instances of those ideas in the "real world" and to apply the agreed upon intervention. Conflict resolution is the most common topic in therapy. Coaches often use rehearsal, reflection, self-control techniques and positive rewards to support the beneficiary's steps towards conflict resolution in the "real world."

To many therapists, TBS appears as a non-traditional approach to treatment. In its focus on strengths, it may also present a different philosophy than that of the therapist. It is not uncommon for the perception to arise that the Coach is supplanting rather than supplementing the work of the therapist. It is very critical that, from the start, the therapist and Coach work as a team and that the therapist sees the Coach's work as an extension of the therapist's work. This will occur naturally if TBS is based on the Plan of Care and if the Coach and therapist meet regularly.

Role of Caretaker

A critical role in TBS service delivery is that of the Caretaker(s), such as the parents, foster parents, or group home staff, who are responsible for the daily care of the beneficiary. Success of TBS requires active involvement of the Caretakers in planning and implementation. The Caretaker makes a major contribution in identifying the target behaviors and the critical times for TBS. In both family and group home settings, the Coach is usually in daily contact with Caretakers. At the very least, the interventions of the Coach foster a more positive relationship between the Beneficiary and Caretaker because of the reduction of conflict. In most cases, the impact is considerably greater as the Caretakers learn new ways of interacting and intervening from the Coach. This learning takes place through both modeling and direct instruction. The Caretakers are also keys to determining whether the gains the beneficiary has made are generalizing – i.e. do the behaviors seen while the Coach is present still occur when the coach leaves. If not, further refinement of the plan is needed.

Caretakers can be very jealous of the Coach's relationship with the beneficiary. A tension that arises at the initiation of service in a home or facility is the perception of supplanting, as noted above in the section on therapists.

The most difficult aspect of the Coach's role is to remain unconditionally aligned with the beneficiary while also working positively and co-

operatively with caretakers. As the majority of these beneficiaries are referred because they have failed to progress in their placement, the level of conflict around them and their treatment is often high.

Although the caretaker may be absent for part of the time the Coach is present, it has generally been a requirement that caretaker be present in the home for the majority of the time the Coach is working with the beneficiary. This not only avoids possible liabilities, but also allows a broader interpretation of the Coach's role – i.e. that of a model and assistant to the caretaker as well as to the beneficiary.

Role of Residential Staff

An equally critical role in the success of TBS is that of the residential staff. Residential staff should agree that the Coach is needed and at a minimum, be aware of the goals for TBS. Programs where the Coach, therapist, Advisor and residential staff all meet together weekly regarding TBS goals are more successful than when staff are peripheral to the process. TBS interventions have a greater impact when they can be at least partially continued by residential staff in the Coach's absence and where they have been developed in consultation with the staff.

Supervision of Process

Oversight by someone in addition to the therapist is critical to a successful outcome. This supervision can be within the Coach's organization, from the county or from an outside consultant, and provides a degree of perspective that may be missing in the TBS team for these beneficiaries.

A major task of the supervisor is to get everyone on board at the beginning – anyone who is left out tends to obstruct the process at worst or delay it at best. Regular consultation or supervision resolves problems inherent in the process before they become disruptive.

Group supervision is a good format for learning. In some settings these meetings have become the forum for the discussion of intervention tactics and philosophy and are attended by other program staff.

The most demanding task of the supervisor is to address the problems of "splitting" which is common in residential settings and is often manifested in a split between the Coach and the caretakers. This can be effectively handled in supervision by using the analogy of children splitting parents. Focus on how it is necessary for the child to learn to deal with different views from different people is helpful. This empowers the Coach and the beneficiary without automatically condemning the residential staff or

"rescuing" the beneficiary from "them," both of which are tempting positions for Coaches to take.

The development of a clinical perspective in staff is the most powerful, unanticipated impact of TBS. The assignment of a Coach seems to re-evoke the observational and clinical skills of the staff member who has not had an opportunity to use them previously in their tasks as group manager. In some cases, staff who were previously confrontational with beneficiaries may have changed their style as a result of functioning as a Coach.

Generalization

The greatest clinical challenge is to have the process started by the Coach continue into the period when the coach is not there. This is true whether the Coach is simply leaving for the day or week, or whether the service is ending. The interventions noted below have been found to be helpful in promoting generalization and eventually termination.

- Reward system developed in conjunction with caretakers and used by them when the Coach is absent.

- If the beneficiary is capable of verbalization, generalization is easier. Explicit support self-talk is a very useful tactic.

- If the beneficiary cannot internalize, establishing very predictable external routines with the caretakers will be very helpful.

- Reiteration of what constitutes a good day and how the beneficiary achieved that helps to solidify the gains made that day and makes it more likely that the positive behaviors will remain.

- Praise, support and active efforts towards the expansion of outside activities and relationships are crucial. The beneficiary not only benefits from these directly but the Coach's active encouragement in this helps to allay the beneficiary's fears that the Coach will be jealous of other relationships.

Termination

Often, the beneficiary will say, "I've really learned something, I can do something, I can handle this problem, etc." The beneficiary may even say, "You know, I'm not always going to need you." The most definitive sign that the beneficiary is ready for termination is the regular and automatic generalization of the behavior with the Coach to other people and times. For those beneficiaries who do not verbalize as much, the scores on the

BAF will often reflect progress before caretakers or therapists remark on it.

The staff around a beneficiary may be reluctant to have a Coach leave, even when they see the progress that has been made. Staff concerns that the beneficiary's old behaviors will re-surface may be confirmed when the beneficiary's conduct temporarily deteriorates when the topic of termination is broached. These "termination blues" on the part of the beneficiary and those around the beneficiary are not any different than what occurs at the end of any type of therapeutic service and needs to be handled in the same way.

Development Phases

There are clearly several phases to starting a TBS program. The first set of tasks involves locating the potential beneficiaries and Coaches and education of the participating agencies. During this period discussion of many potential problems abound. Initial concerns can be minimized by discussion, accommodation to individual needs and persistence. A focus on TBS as not something rare and unusual but as an extension of the treatment plan is an effective argument for many staff. At some point, however, an executive decision to proceed may be necessary as all fears cannot be addressed before the service mode is started. In fact, few of these anticipated problems actually materialize.

The second phase of program implementation, service delivery, is a period of excitement, but also widespread confusion. Procedures previously developed have to be modified to meet the demands of reality and new ones created to handle unanticipated issues. Staff and agencies are seeing the benefits of the program, however and concerns about possible disasters recede.

The third phase of the program is program solidification. The major task here is to decide which procedures and processes to keep and which to abandon, which support effective service delivery and intervention, and which do not. The litmus test of effectiveness is seeing if the behaviors learned from the Coach generalize to other settings and times, and, eventually, if the beneficiary can be "weaned" from TBS. The beneficiary, staff and parents are understandably reluctant to have the Coach depart but to be considered successful, this must occur. The successful termination of service is the final test of the program. This aspect may well be the most difficult phase to date.

TBS is not so different from other forms of therapeutic intervention such as individual, family, group, etc. therapy. The same phases, phenomena and problems occur but the processes occur much more rapidly with TBS.

There is likely a direct correlation between the number of service hours per week and how quickly problems are resolved. Fortunately, the principles learned in other forms of therapy apply to TBS as well and solutions to problems work whether applied to family therapy or TBS.

5.6 WHAT A TBS COACH IS NOT

A Taxi Service

Although the Coach may transport the beneficiary to an activity, with the permission of the caretaker and supervisor, the Coach should not be expected to provide regular transportation for activities such as school, therapy, doctor appointments, etc. unless this is an agreed upon part of the treatment intervention.

A Spy

Although the Coach is a Mandated Reporter with respect to Child Abuse Reporting, the coach is not "the eyes and ears of the court," parent or social worker. The Coach can be considered an extension of the therapist and as such respects the confidentiality of the beneficiary.

A Security Guard

Although a Coach will work to help the beneficiary avoid behaving in threatening or self-abusive ways, the Coach cannot restrain a beneficiary, participate in a "take down," block a beneficiary's attempt to go AWOL, press charges against the beneficiary or protect the beneficiary from other aggressive beneficiaries except to the degree that any concerned adult would.

A Chaperone

Although the Coach will counsel the beneficiary against self-defeating behaviors, the Coach may not always be able to prevent *covert* smoking, drinking, drug use and sexual activity.

A Babysitter

Although the Coach will spend a substantial amount of time with the beneficiary, a parent or a caretaker must be onsite or easily available a majority of the time while the beneficiary is receiving TBS. The Coach may take the beneficiary on an in-county activity but is not allowed to travel out of county or accompany the family or the beneficiary on an overnight trip.

A Messenger

Although the Coach should actively and regularly communicate with the therapist and others, the Coach should not be the conduit for passing information between the beneficiary, family and treatment team members.

A Gopher

Although a Coach is willing and able to help families or group home staff with projects involving the beneficiary, the Coach should not be expected to run errands, monitor parental visits, fill in for absent staff or parents, make telephone calls for case management or participate in activities that draw the Coach from the beneficiary and the therapeutic goals.

A Date

Although the Coach often becomes "like a member of the family," they are nonetheless performing a therapeutic function and follow the usual expectations for professional behavior. Coaches are not allowed to date beneficiaries, ex-beneficiaries, family members, or close friends of the beneficiary.

5.7 Ethical Standards for TBS Coaches

Treatment Goals

TBS Coaches negotiate with the beneficiary's Treatment Team regarding the purpose, goals, and nature of the helping relationship prior to the onset of TBS. This includes discussing the limitations of the relationship and the expectations of the beneficiary and/or caretakers. It is the TBS Coach's responsibility to remain focused on agreed treatment goals and to ensure ongoing Treatment Team meetings. The TBS Coach should not make decisions, nor act on decisions concerning treatment goals without consulting with their Supervisor and/or the Treatment Team.

General Attitude

The TBS Coach respects the integrity and welfare of the beneficiary and the beneficiary's caretakers at all times. Each beneficiary and caretaker is to be treated with respect, acceptance and dignity. Personal issues with beneficiaries and/or caretakers should be addressed in supervision with TBS Advisor before being acted upon with the beneficiary/caretaker.

Confidentiality

The TBS Coach protects the beneficiary and caretaker's right to privacy and confidentiality except in those cases in which harm to the beneficiary or others has taken place or is determined eminent, or when agency guidelines state otherwise (this can be discussed with the TBS Supervisor). During initial meetings with beneficiary and/or caretakers, the limits of confidentiality should be discussed thoroughly. These limits include duty to report child abuse, elder abuse, dependent adult abuse, and any situation in which the beneficiary poses a serious danger of violence to self or another. Should details of the TBS work with the beneficiary need to be discussed with a Treatment Team member not employed by the county or a county contract agency (i.e. a private therapist), an informed consent form must be signed by the caretakers and/or beneficiary.

The TBS Coach is also responsible for ensuring the integrity, safety, and security of beneficiary records while in the Coach's possession. The assigned TBS Supervisor should review all written beneficiary information. Once co-signed by the Coach's supervisor, written material should then be securely filed at the treatment facility or agency responsible for the case. Should the TBS Coach wish to retain copies of

any such notes, the Coach is responsible for securing such documents in a manner that prevents loss or breach of confidentiality.

Dual Relationship

The TBS Coach is in a therapeutically unique relationship with their beneficiary and the beneficiary's caretakers. Services often require working with a family in their home, and/or spending several hours daily with a beneficiary. This can develop into a very intimate and intense relationship. The TBS Coach therefore must recognize that dual or multiple relationships with their beneficiaries may increase the risk of harm to, or exploitation of the beneficiary. This would include developing a friendship outside of the therapeutic relationship, entering into romantic relationships, entering business related relationships, etc.

Such relationships could impair professional judgment and cause great harm. Should any relationship outside of the therapeutic one be suggested by the beneficiary/caretaker, this should be discussed openly with the TBS Supervisor immediately. As a rule, TBS Coaches must support the trust implicit in the relationship by avoiding dual relationships that could impair professional judgment, increase the risk of harm to the beneficiary, or that could lead to exploitation of any kind.

Refusal of Services

Therapeutic Behavioral Services are offered to the beneficiary on an "at will" basis. The beneficiary's right to self-determination is recognized and respected within this relationship. While some beneficiaries can be resistant at times and need some coaxing to engage in treatment, the TBS Coach must recognize the beneficiary's right to refuse services. If the beneficiary presents a strong refusal of services, the TBS Coach should immediately consult with their TBS Supervisor.

Focus of Treatment

The TBS Coach recognizes, draws out and builds upon the beneficiary's strengths. The focus of treatment is to develop a relationship with a beneficiary such that new, more productive behaviors can be explored and developed which are in service to the beneficiary's overall mental health and stability. The Coach works in tandem with the treatment team and/or caretakers to ensure that the beneficiary develops the skills necessary to lead a more functional and fulfilling life. The TBS Coach does not work alone, nor are they solely responsible for the mental health and stability of the beneficiary. Close supervision and

teamwork ensure that the TBS Coach is supported and that proper focus is maintained.

Multicultural Issues

The TBS Coach should be knowledgeable about the cultures and communities in which they work and be sensitive to and aware of multicultural issues. TBS Coaches should respect individuals and groups, their cultures and their belief systems. Coaches should also have an awareness of their own cultural background, beliefs and values and should continuously recognize the potential for such to have an impact on their beneficiaries, co-workers and Treatment Team members. Issues of a cultural nature can and should be discussed with the TBS Supervisor openly.

5.8 Documentation

The TBS documentation follows all of the rules established for any SMHS. The items noted below are additional local requirements or interpretations of Medi-Cal regulations as they apply to TBS. The TBS documents should be segregated into a separate section of the beneficiary's medical record.

TBS Screening and Referral Form

The TBS Screening and Referral form must be completed by the referring clinician. It must be accompanied by a signed copy of the current clinical assessment and copy of the signed treatment plan indicating TBS as an authorized intervention. The potential TBS beneficiary's Medi-Cal eligibility must be verified before approval of the application, as TBS requires the beneficiary to have full-scope Medi-Cal. A copy of this form is provided at the end of this section.

TBS Assessment

Assessment activities are both initial and on-going components of all specialty mental health treatment. Initial and on-going assessments of the need for TBS may be accomplished as a part of the overall assessment of a child or youth's mental health needs or through a separate assessment specifically targeted to determine whether TBS is needed.

Consistent with DMH Letter No. 99-03, Section III, "Criteria for Medi-Cal Reimbursement for Therapeutic Behavioral Service", an assessment for specialty mental health services, focused either on TBS or with TBS consideration as a component, must be comprehensive enough to identify the following:

a. That the child or youth meets medical necessity criteria

b. Is a full-scope Medi-Cal beneficiary under 21 years of age

c. Is a member of the certified class

d. That there is a need for specialty mental health services in addition to TBS

e. That the child or youth has specific behaviors and/or symptoms that require TBS

In addition, TBS Assessments must:

a. Identify the child or youth's specific behaviors and/or symptoms that jeopardize continuation of the current residential placement or the specific behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.

b. Describe the critical nature of the situation, the severity of the child or youth's behaviors and/or symptoms, what other less intensive services have been tried and /or considered, and why less intensive services are not or would not be appropriate.

c. Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition to a lower level of residential placement and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care.

d. Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated.

e. Identify skills and adaptive behaviors that the child or youth is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

   Concrete identification of behaviors and interventions in the assessment process is the key component necessary to developing an effective TBS Plan of Care.

Original Plan of Care

TBS must be listed as an added intervention on the original Plan of Care. The therapist is responsible for amending the original Plan of Care.

TBS Plan of Care

The TBS Plan of Care is an Addendum to the original Plan of Care. The TBS Plan of Care is developed and completed by the TBS team at the planning meeting. It is connected to the original plan and ensures that the TBS goals and interventions are addressed. It is intended to provide clinical direction for one or a series of short-term interventions to address very specific behaviors or symptoms of the child/youth as identified during the assessment process. The therapist, in coordination with the TBS team writes the TBS Plan of Care. The original copy of the TBS Plan of Care is kept in the beneficiary's medical record. If the Plan of Care is to be used for an IEP, the TBS Plan of Care should **not** be included as part of the IEP.

The TBS Plan of Care must include:

a. Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

b. A specific plan of intervention for each of the targeted behaviors or symptoms identified in the TBS assessment and the TBS Plan of Care.

c. A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a timeframe for these changes.

d. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

e. A transition plan that describes in measurable terms how and when TBS will be reduced and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the client progresses towards achieving Plan of Care goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgement of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

f. As necessary, a plan for transition to adult services when the client turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

g. If the client is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

A clear and specific TBS client plan is a key component in ensuring effective delivery of TBS.

TBS Plan of Care Addendum

A Plan of Care addendum should be used to document the following situations:

a. There have been significant changes in the child or youth's environment since the initial development of the TBS Plan of Care.

b. The TBS provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the provider indicating that they have considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective.

Parental Consent

This is to be completed and signed by the beneficiary's legal guardian, if applicable.

DHCS Notification

A copy of the notification to the California Department of Health Care Services that TBS has been initiated or renewed is kept at the Managed Care office.

TBS Progress Note

A single note covering all of the interventions and responses during a day is required for every day of service using the TBS Progress Notes form. If the Coach is unlicensed or un-waivered, this note must be countersigned by a licensed professional.

Progress notes should clearly and specifically document the following:

a. Occurrence of the specific behaviors and/or symptoms that threaten the stability of the residential placement or prevent transition to a lower level of residential placement.

b. Delivery of the significant interventions identified in the TBS Plan of Care.

c. Progress being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors.

Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The time of service may be noted by contact/shift.

Non-Billable Services

A note to chart must be completed but not billed, whenever a beneficiary has a break in TBS. This might occur when the beneficiary is hospitalized, a lockout for all SMHS, including TBS. It might also occur when a beneficiary goes out of town, goes to camp or some other overnight activity that the Coach cannot attend. A break due to extended illness of the beneficiary should also be noted in the chart.

Termination Documentation

When TBS ends, this should be noted in the progress note on the last day of service, with the reason for and beneficiary's response to the termination noted.

5.9 TBS Staff Training

All staff involved in the TBS service delivery must have completed training on Confidentiality, Child Abuse Reporting and non-violent crisis intervention. In addition, TBS staff must have training in behavioral analysis with emphasis on positive behavioral interventions.

5.10 FCMHP Monitoring

a. Licensed Clinical Staff Credentialing

The TBS Supervising Clinician and Alternate Supervising Clinician must be credentialed by the FCMHP before employment with the organization begins.

b. TBS Coach Application Checklist

The TBS organizational provider must complete the Coach Application Checklist for each TBS Coach and submit to Managed Care for approval. No TBS Coach can provide TBS until the application form is approved by Managed Care. Refer to end of this section for copy of TBS Coach Application Checklist form.

Section 5:

Therapeutic Behavioral Services

Forms and Attachments

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FRESNO COUNTY MENTAL HEALTH PLAN

(TBS) Therapeutic Behavioral Services REFERRAL Form

***TBS MUST be added to current Treatment Plan *Referral MUST include most current full assessment**

***Please complete all items and include current assessment, CANS, and client plan with TBS authorized.**

Child's Name: _____ Preferred Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Preferred Gender: _____

Primary Caregiver: _____ Phone: _____

Relationship: ☐ Bio ☐ Foster ☐ Guardian ☐ Adoptive Presumptive Transfer YES ☐ NO ☐

Accurate Address: _____ City: _____ Zip: _____

Ethnicity: _____ Caregiver's Preferred Language: _____ Preferred TBS service time: _____

School: Grade: IEP ☐ Yes ☐ No ☐ Enrolled ☐ Suspended/Expelled

To have initial 30 days of TBS, must be a "yes" for both #1 and #2 below:

1. Does child have Full Scope Medi-Cal? ☐ Yes ☐ No County Code: _____ Aid Code: _____

2. Is child currently receiving EPSDT services (**E**arly **P**eriodic **S**creening, **D**iagnosis & **T**reatment services)? ☐ Yes ☐ No

☐ Therapy ☐ Medication ☐ Other: _____ ICD-10/DSM 5 Dx: _____

THERAPIST	COUNTY SOCIALWORKER	PROBATION OFFICER
Name:	Name:	Name:
Phone:	Phone:	Phone:
Email:	Email:	Email:

3. Please list current medications and name of MD/psychiatrist:

To meet class for additional TBS beyond the initial 30 days, must meet criteria for at least one of the following:

4. Is it highly likely that child will be unable to transition to lower level of care? ☐ Yes ☐ No

5. Is child currently placed in or being considered for an STRTP? STRTP Facility: ☐ Yes ☐ No

6. Was the child hospitalized or considered for hospitalization in a psychiatric facility during the past 24 months? ☐ Yes ☐ No

Name of hospital and date: _____

7. Without TBS is it highly likely that the child will require higher level of care? ☐ Yes ☐ No

8. Has the child previously received TBS? ☐ Yes ☐ No

CURRENT PROBLEM BEHAVIORS that are jeopardizing placement or transition based on medical necessity.

☐ Self injurious behavior
☐ Threat to others
☐ Withdrawal, isolates self
☐ Disregard for rules
☐ Property damage
☐ Verbal aggression
☐ Physical aggression
☐ Other
☐ Has made allegations of abuse in past
Explain:

POSSIBLE AREAS of FOCUS

☐ Increasing coping strategies
☐ Increasing social skills
☐ Increasing daily living skills
☐ Increasing school functioning
☐ Sexual behaviors Explain:
☐ Decreasing opposition/defiance
☐ Decreasing self-injurious behaviors
☐ Decreasing property damage
☐ Decreasing verbal/physical aggression
☐ Community integration
☐ Other:

Print Name Title; Agency	**Fax Number:**

☐ **Expedite Referral**	**Rational:**

***Incomplete TBS referral packets cannot be processed.** Please fax or email all items together (TBS Referral form, signed copy of clinical assessment, CANS, signed copy of treatment plan that includes the intervention of TBS) to Managed Care at Fax: (559)455-4633 or Email: DBHAuthorizations@fresnocountyca.gov.*

Therapist's Signature _____ **Date** _____

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FRESNO COUNTY MENTAL HEALTH PLAN
THERAPEUTIC BEHAVIORAL SERVICES
Coach Application Checklist

Name: _____ DOB: _____ SSN: _____

Gender: _____ Ethnicity: _____ NPI: _____

Languages Spoken other than English: _____

State of Birth: _____ Country of Birth: _____

Criteria	Yes	No	Description / Date
MINIMUM EDUCATION AND EXPERIENCE (REQUIRED)			
• **Bachelors Degree** in a non MH related field, but with at least **one year of full-time experience** working with children/youth, or			
• Completed **12 semester units** from an accredited college or university from any of the following disciplines- Social Work, Psychology, Rehab Counseling, Education Counseling or Marriage and Family Counseling, or			
• Completed **6 semester units** from an accredited college or university from any of the following disciplines- Social Work, Psychology, Rehab Counseling, Education Counseling or Marriage and Family Counseling, and with **one year of full-time experience** working with clients in human service settings.			
BACKGROUND CHECK (REQUIRED)			
• Licensed, Certified, registered, or waivered by a State Professional Board			
• Currently or recently employed in a position requiring a background check (law enforcement, child care, health care, teaching, residential care, CPS).			
TRAINING (REQUIRED)			
• Confidentiality			
• Child Abuse Reporting			
• Non-violent crisis intervention training (MAB, Pro-Act)			
• CPR			
• Fresno County General Compliance, includes Doc/Billing			
• TBS Video from state			
Others (Optional)			
• Classes taken on Child Development			
• Classes taken on Behavior Modification			
• Previous TBS experience			

Organizational Provider: _____

Organizational Provider Supervising Staff: _____

Office Address: _____

Phone Number: _____ Fax: _____ E-mail: _____

(For Managed Care staff only)

Comments on Coaches Profile: Approve ( ) Deny ( ) Staff Signature _____

Applicant Signature, please print name and sign Date

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COUNTY MENTAL HEALTH PLAN

PROGRESS NOTES

FRESNO COUNTY

CHILD'S NAME: SSN/CLIENT#: COACH:

Date of Service:_____Start Time: _____ End Time:_____Doc Time:_____Travel Time:_____Total Minutes:_____

Start Time:_____End Time:_____

(Actual Time Billed to County for Documentation and Travel: Documentation Time:_____ Travel Time:_____ Billed Minutes:_____)

TULARE COUNTY ONLY: Location of Services: Location of Services DSM 5/ICD 10:

PLAN OF CARE TARGET BEHAVIORS

Authorization Date for Plan of Care

Services available in preferred language:

☐ **YES** ☐ **NO**

INTERVENTIONS WITH CHILD AND CHILD'S RESPONSE

Intervention 1

Intervention 2

Intervention 3

Intervention 4

Intervention 5

Intervention 6

COUNTY MENTAL HEALTH PLAN

PROGRESS NOTES

REPLACEMENT AND COPING SKILLS UTILIZED

Skills Observed 1	Skills Observed 2	Skills Observed 3	Skills Observed 4

INTERVENTIONS WITH CAREGIVER & CAREGIVER'S RESPONSE

Caregiver Intervention 1	Caregiver Intervention 2	Caregiver Intervention 3	Caregiver Intervention 4

PLAN FOR CONTINUATION OF SERVICES (Describe Plan for Subsequent Visits)

SERVICES CONTINUE TO BE JUSTIFIED DUE TO:

Justification 1	Justification 2	Justification 3	Justification 4

Coach's Signature _____ **Date:** _____

Print Coach Name & Credentials: _____

Licensed Staff Signature _____ **Date:** _____

Print Supervisor Name: Jana D. Todd, LCSW #16669

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

Preferred language of Caregiver: _____ **DOB:** _____

Language of Client: _____ **SSN:** _____

Services provided in preferred language: YES ☐ NO ☐

PLACEMENT Verification

Current Caregiver Name: _____ Phone: _____

Caregiver Address: Cell:

_____ _____

Type of current placement ☐ Bio Family ☐ Foster Family ☐ Level 12-14 ☐ Other _____

Length of time in current placement:

_____

Why was child moved from former placement?

_____

Other placement information:

_____

OTHER SERVICES THAT ARE BEING PROVIDED

☐ MH Treatment ☐ Supportive Services ☐ Educational Services

Services	Provider	How frequently/When

MEDICATION SERVICES: Drug Allergies:

Medication	Dosage	Prescribing MD/Phone

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

Child's Name:_____ **Date:** _____ **Duration:**_____

ADDITIONAL COMMENTS: include mental health diagnosis, drug exposure, substance use, contact with law enforcement, allegations made against caregivers, if known, physical disorders.

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

Behaviors that put placement at risk or prevent transition to lower level of care. Include severity & frequency of behavior.

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

CURRENT FUNCTIONING: Include Caregiver and Client strengths, skills and adaptive behavior used.

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

☐ Caregiver understands the intensive nature and necessary commitment of time to services.

Services will be provided at: ☐ Home ☐ School ☐ Other:_____

1	Behavior Frequency		Behavioral Goal
2	Behavior Frequency		Behavioral Goal
3	Behavior Frequency		Behavioral Goal

Replacement behaviors to be taught:

Interventions addressing target behaviors:

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

Specific measures used to gauge effectiveness of interventions:	
☐ BAF ☐ BX Chart ☑ Caregiver Report ☐ Other:	

Strategies to involve caregiver in preparation for discontinuing services:

AUTHORIZED SERVICES

Services will be provided for _____ hours per week. **(Excludes Documentation and Travel Time)**

Start date End date

TRANSITION PLAN

When behavioral goals are met, hours will be decreased from _____ to _____

When discharged from services, Child will continue with:

_____

Caregiver will continue to implement:

_____

Please describe the Transition Plan from the inception of services to decrease or discontinue when these services are no longer needed or when the need to continue appears to have reached a plateau in benefit effectiveness:

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

1. _____ ⇨ _____
   Client Print Name — Client Signature
2. _____ ⇨ _____
   Caregiver Print Name — Caregiver Signature
3. _____ ⇨ _____
   TBS Coach Print Name — TBS Coach Signature
4. _____ ⇨ _____
   TBS Coach Print Name — TBS Coach Signature
5. _____ ⇨ _____
   Print Name/Role — Signature
6. _____ ⇨ _____
   Print Name/Role — Signature
7. _____ ⇨ _____
   Print Name/Role — Signature
8. _____ ⇨ _____
   Print Name/Role — Signature

Clinician Signature/Credential _____ Date _____

Print Name/Credential

Clinician Signature/Credential _____ Date _____

Please Select Licensed Clinician

Assessment & Plan of Care

Child's Name:_____ Date: _____ Duration:_____

Supplemental Page for Additional Information

SECTION A

SECTION B

SECTION C

SECTION D

SECTION 6: ELIGIBILITY AND CLAIMS

6.0 Eligibility

A beneficiary means any person certified as eligible under the Medi-Cal Program according to Title 22, California Code of Regulations, Section 51000.2. However, due to the complexity of the Medi-Cal program and its eligibility requirements, beneficiaries who have Medi-Cal eligbility in one given month may not have eligibility in another. It is thus imperative for all Fresno County Mental Health Plan (FCMHP) providers to check eligibility of their clients on a regular basis.

6.0.1 Initial Eligibility Determination

The FCMHP will determine beneficiary's Medi-Cal eligibility before referring their to a provider for specialty mental health services. Providers who receive direct referrals from other agencies such as Child Protective Services or Foster Care agencies must check Medi-Cal eligibility prior to provision of services. Providers may call the FCMHP for assistance in determining eligibility. A list of Medi-Cal aid codes acceptable for billing of Specialty Mental Health Services (SMHS) is provided at the end of this section.

6.0.2 Subsequent Eligibility Determination

The provider is responsible for determining the beneficiary's subsequent Medi-Cal eligibility. While the beneficiary may be eligible at the time of their referral and initial treatment, their continued eligibility is not guaranteed.

6.0.2.1 Determination of Eligibility

At the beginning of each month, or, if clients are seen on a regular basis, during their clinical visits, the provider must verify and determine the eligibility of beneficiaries who will continue to receive services. This may be accomplished by various methods:

- **Automated Eligibility Verification System (AEVS).** Providers must have a Medi-Cal Provider Identification Number (PIN).

- **Internet.** Providers may also access the Medi-Cal Website using the PIN and provider number supplied by Managed Care. Providers needing a copy of this

information can contact their assigned PRS, or email Managed Care through the Managed Care mailbox (mcare@fresnocountyca.gov). Information about how to access the Medi-Cal eligbility website is included at the end of this section.

The FCMHP will assist providers who have temporary difficulties verifying eligibility. Please call us at (559) 600-4645 and ask to speak to a Provider Relations Specialist.

6.1 Claims

6.1.1 Claim Submission

- Claims for payment must be submitted on a calendar month basis for all services provided to a beneficiary during that month. **The FCMHP may deny payment for invoices submitted beyond thirty (30) days of the billing month**. An exception applies to claims billed to third party payers, which are "balanced-billed" to the FCMHP for Medi-Cal reimbursement. (See 6.2.1, Third Party Insurers.)

- Each claim for payment will be for one member only and must include the name of the beneficiary as recognized by Medi-Cal, ICD-10 diagnosis, type of service provided indicated by the FCMHP Service Code, and the date and duration of service (in minutes.) **The FCMHP Service Codes must be used in lieu of HCPCS/CPT codes**.

    - **Individual and Group Providers,** refer to the FCMHP Fee Schedule provided at the end of this section.
    - **Organizational Providers,** refer to your Agreement with the FCMHP to review your contracted rates.

- Each claim submitted for payment must have a Medi-Cal billable ICD-10 mental health diagnosis code. Claims submitted for payment with non-billable diagnosis codes will not be paid, with the exception of an assessment. A list of all Medi-Cal billable, ICD-10 mental health diagnosis codes is provided at the end of this section.

- **Individual and Group Providers** must use the CMS-1500 Health Insurance Claim Form to submit all claims for services provided. Please see example of a completed CMS-1500 form at the end of this section indicating all required information. Completion instructions are also included. **Organizational Providers** may have other means,

including electronic claim submission, available to them. Refer to your Agreement with the FCMHP to determine what options your organization has for claim submission.

- Remit all claims to:

  Fresno County Mental Health Plan
  Attn: Claims
  P.O. Box 45003
  Fresno, CA 93718-9886

- **Individual and Group Providers** may drop off claims in-person at the Managed Care office, located at 1925 E. Dakota Ave, Suite G, Fresno, CA 93726. Please check in with reception on the first floor. A Managed Care Division staff member will come down to the first floor to receive the claims in person. Claims must always be handed off to a Managed Care Division staff member and cannot be left unattended.

6.1.2 Claims / Billing Audit

Each claim/billing is subject to auditing for compliance with federal and state regulations.

6.1.3 Disapproved Claims

In the event that a claim is disapproved by the FCMHP, Fresno County may withhold compensation or, if already paid, set off from future payments due, the amount of the disapproved claims.

Providers May <u>NOT:</u>

- Bill in his/her name for treatment provided by another practitioner or an assistant (for example, when a progress note is signed by a practitioner different than the practitioner claiming the service.)
- Bill the beneficiary for amounts over the contracted rate.

6.2 Beneficiaries with Share of Cost or Third Party Insurers

6.2.1 Share of Cost

Depending on a beneficiary's monthly income, Medi-Cal may determine that he/she must meet a share of cost (SOC) before Medi-Cal will pay for medical expenses. Therefore, the beneficiary may not be eligible for Medi-Cal covered benefits until the SOC is met.

The provider is responsible for collecting the SOC amount from the beneficiary and for clearing this amount from the beneficiary's account. Providers must bill the FCMHP only for the difference between the SOC collected and the FCMHP contract rate. **Individual and Group Providers,** please refer to the CMS-1500 example at the end of this section on how to report SOC amounts.

6.2.2 Third Party Insurers

Medi-Cal is the payer of "last resort", meaning that providers must bill the beneficiary for their authorized SOC and any third party insurers before requesting payment from the FCMHP. The FCMHP will only reimburse the difference between the FCMHP service rates and the payment amount by the primary payer, minus the SOC. The total reimbursement will not exceed the FCMHP's service rate schedule.

Medi-Cal Beneficiaries with Medicare A & B or B Only Coverage

Providers treating Medi-Cal beneficiaries that also have Medicare A & B or B only coverage must submit claims directly to Medicare.

To submit a Medi-Cal claim for a beneficiary with a third party payer, the provider must:

- Submit a claim to the FCMHP along with a copy of the third party payer denial letter or Explanation of Benefits (EOB) **within 30 days** of the date of the denial or EOB.

However, if provider does not receive an EOB or denial from the third party payer within two (2) months from the month of service, the provider must:

- Contact the third-party payer and inquire as to the status of the claim.

- Submit the Medi-Cal claim **and** a copy of the claim that was submitted to the primary insurance, to the FCMHP within two (2) months from the month of service.

6.3 Payment Policies

Payment will be authorized for valid claims for specialty mental health services if:

- Services were delivered by a contract provider, and were within the range of pre-selected service codes allowed by scope of practice and contract agreements;
- The beneficiary receiving services had Medi-Cal eligibility at the time services were provided; it is the provider's responsibility to ensure that services are provided to eligible beneficiaries. Services provided to beneficiaries who were not eligible at the time of service will be denied.

Terms of payment are as follows:

- **For Individual and Group Providers,** payment will be based on the prevailing FCMHP fee schedule. A copy of the current Individual and Group Provider fee schedule is included at the end of this section.

- For **Organizational Providers,** payment be determined by the terms of their agreement with the FCMHP. Prevailing reimbursement rates shall be considered payment in full, subject to third party liability and beneficiary share of cost for the specialty mental health services.

- The FCMHP pays **Individual and Group Providers** in arrears, within 45 days after receipt *and* verification of provider's claims by the FCMHP. **Organizational Providers** will be paid per the terms of their Agreement with the FCMHP.

- The FCMHP will **not** pay for sessions for which a beneficiary fails to show.

6.4 Claims Certification

In compliance with Title 42, Code of Federal Regulations, Section 438.608, FCMHP Program Integrity has been developed as a safeguard against fraud and abuse. The FCMHP requires its providers to ensure all claims submitted to the FCMHP for payment meet the following criteria:

- An assessment of the beneficiary was conducted

- Beneficiary is eligible to receive Medi-Cal services at the time the service was provided.

- Services claimed were actually provided.

- Medical necessity was established.

- A plan of care was developed and maintained.
- Authorization requirements were met for Day Treatment Intensive and Rehabilitative services, and EPSDT supplemental services.

Please refer to the end of this section for a copy of the FCMHP Claims Certification form.

Claims/Billing inquiries may be made by calling the FCMHP at (559) 600-4645, and asking to speak to a Provider Relations Specialist.

6.5 Cost Report

The Fresno County Mental Health Plan (FCMHP) requires organizational providers (but **not** Individual and Group providers) to submit a complete and accurate Cost Report for each fiscal year (July 1 through June 30.) The Cost Report must be submitted to the FCMHP within 90 calendar days following the end of each fiscal year or within 90 days after contract termination with the FCMHP.

Cost Reports must be submitted to the FCMHP as a hard copy with a signed cover letter, and electronic copy of the completed Cost Report form along with requested support documents. Remit the hard copies of the Cost Reports to the following address:

County of Fresno
P.O. Box 45003, Fresno CA 93718
ATTN: Cost Report Team

Remit the electronic copy or any inquiries to the DBH Cost Report Team e-mail box, DBHCostReportTeam@FresnoCountyCA.gov.

All Cost Reports must be prepared in accordance with General Accepted Accounting Principles (GAAP) and Welfare and Institutions Code §§ 5651(a) (4), 5664(a), 5705(b) (3) and 10 5718(c).

The FCMHP may immediately suspend or terminate a Provider's agreement, in whole or in part, if a substantially incorrect or incomplete report is submitted to the FCMHP.

6.6 Over/Underpayment

If the Cost Report indicates an amount due to the County of Fresno, the provider must submit payment within 45 days of notification by the FCMHP. If the Cost Report indicates an amount due to the provider by the

County of Fresno, the provider will be paid after the Department of Health Care Services (DHCS) Cost Report settlement process.

6.7 State Disallowance

If, during a State audit process, a disallowance is discovered due to the provider's deficiency, the provider will be held financially liable. The disallowance will be deducted from the provider's future payments.

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Section 6:

Eligibility and Claims

Forms and Attachments

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Fresno County Mental Health Plan
Individual and Group Provider Fee Schedule
Effective July 1, 2020

Service Description	Avatar Service Codes	Fresno County Rates (Rate/Minute)	
Psychiatrist			
MD Meds Eval Mngt Assessment (up to 120 min)	170	$4.65	
MD Reauthorization including plan development only (up to 60 min)	170	$4.65	
MD Med Eval Mngt Brief	172	$4.65	
MD Meds Eval Mngt Follow-Up	173	$4.65	
Individual Medical Psychotherapy	126	$1.32	
Hospital Care - Inpatient - New/Established (flat rate)	839	$110 (flat rate)	
Hospital Care - Subsequent - Bedside (flat rate)	840	$61 (flat rate)	
Inpatient Consultation - Initial - New/Established	822	$1.40	
Emergency Department	823	$1.29	
Nursing Facility Assessment	825	$1.56	
Subsequent Nursing Facility	828	$1.84	
Individual Assessment	103	$1.32	
Group Therapy	82	$1.91	
Individual or Family Psychotherapy	83	$1.91	
Family Therapy	156	$1.31	
Collateral	150	$1.31	
Case Management / Linkage & Consult	205	$0.84	
Psychologist (Licensed/Registered/Waivered)			
Individual Assessment	103	$1.25	
Individual or Family Psychotherapy	83	$1.91	
Group Therapy	82	$1.91	
Test Administration Including Pre-Interview	891	$1.09	
Collateral	150	$1.25	
Case Management / Linkage & Consult	205	$0.84	
Plan Development	159	$1.25	
Rehabilitation	158	$1.25	
LCSW/ASW, LMFT/AMFT, LPCC/APCC, RN - MS		***Licensed***	***Unlicensed***
Individual Assessment	103	$1.25	$1.07
Individual or Family Psychotherapy	83	$1.91	$1.71
Group Therapy	82	$1.91	$1.72
Collateral	150	$1.25	$1.07
Case Management / Linkage & Consult	205	$0.84	$0.75
Plan Development	159	$1.25	$1.07
Rehabilitation	158	$1.25	$1.07

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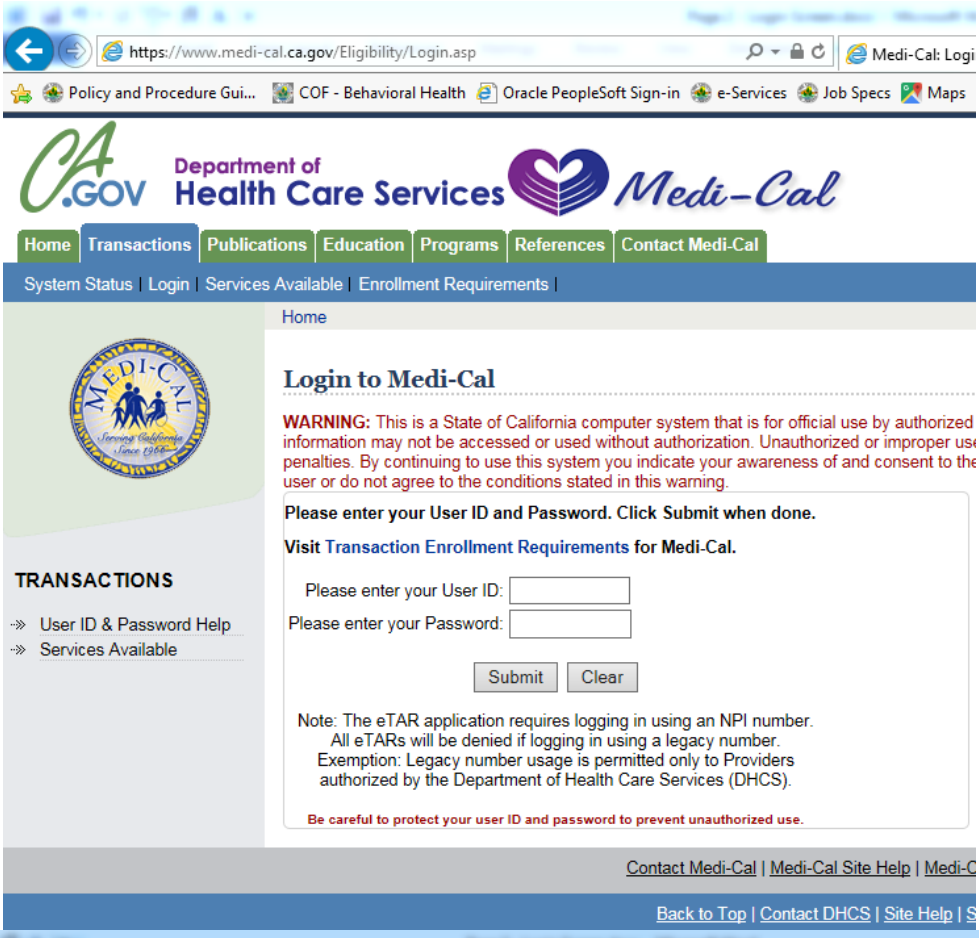
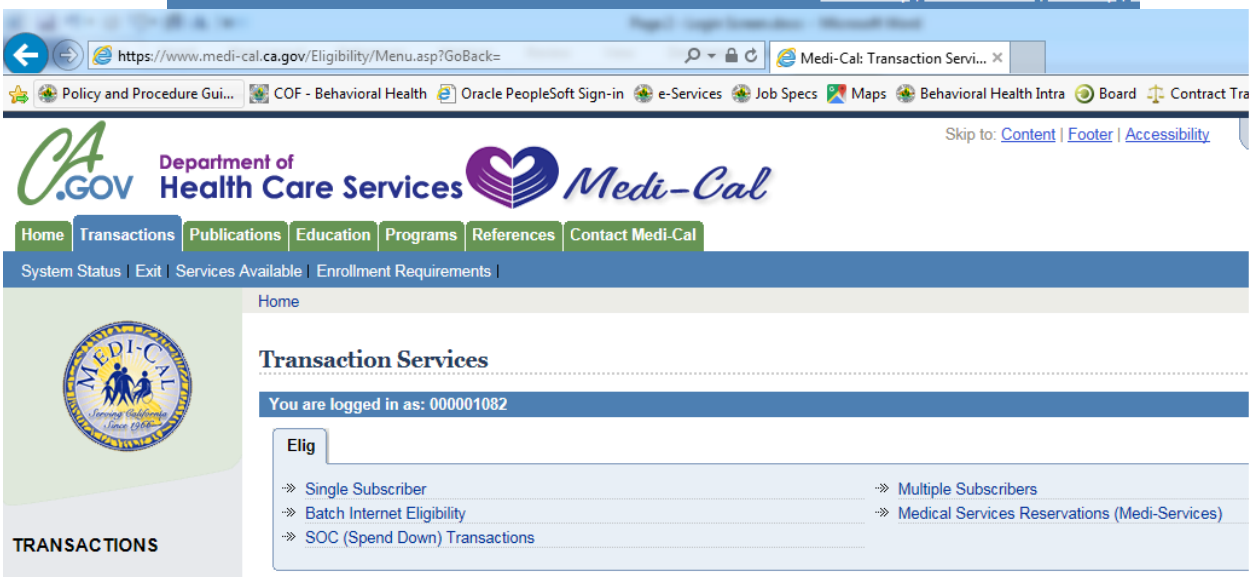
MEDI-CAL VERIFICATION WEBSITE EXAMPLES

1) Log-in Screen (Note: Transaction Services - "Single Subscriber")
2) Eligibility Verification page
3) Response pages
    a. No Medi-Cal Eligibility
    b. Fresno County Medi-Cal
    c. Non-Fresno County Medi-Cal (Out-of-County Medi-Cal)
    d. Medicare and Medi-Cal (Medi-Medi or "crossover" coverage)
    e. Share of Cost Medi-Cal
    f. Medi-Cal and Other Insurance

Medi-Cal eligibility can be checked on the Department of Health Care Services website: https://www.medi-cal.ca.gov/Eligibility/Login.asp





Usually, you will choose “Single Subscriber”

Swipe Card	Leave blank
Subscriber ID	SSN or Medi-Cal # on card (Usually a nine digit # starting with a 9 and ending with a letter)
Subscriber Birth Date	mmddyyyy (just the numbers, no dashes or //)
Issue Date	Today's date (mmddyyyy) the date on which you are doing the Medi-Cal check
Service Date	May be actual date service is provided or 1st day of the month service is provided. Again format is mmddyyyy

When you hit submit, a response page will appear. Attached are some examples of what you might see:

California Home

Thursda

Medi-Cal Home
Login
Publications
Related Sites
Dept. of Health Services
Site Map
Site Help
System Status
Web Tool Box

▸Eligibility
▸Share of Cost
▸Medi-Services
▸Provider Services
▸Batch Eligibility
▸Login
▸Exit

Eligibility Response

My CA

Eligibility transaction performed by provider: 000001067
on Thursday, May 30, 2002 at 9:11:51 AM)

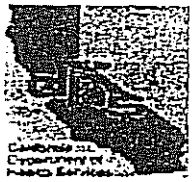
Recipient ID: 999999999		
Date of Service: 05/30/2002	Date of Birth:	Date of Issue: 05/30/2002
Primary Aid Code:	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Recipient County:	HIC Number:	
Primary Care Physician Phone #:	Scope of Coverage:	
Eligibility Verification Confirmation (EVC) Number:		
Eligibility Message: NO RECORDED ELIGIBILITY FOR 05/02.		

Server:www.medi-cal.ca.gov |File:/Eligibility/EligResp.asp |Last Modified:5/15/2002 11:00:26 PM

No Medi-Cal Eligibility

Medi-Cal Home
Login
Publications
Related Sites
Dept. of Health Services
Site Mao
Site Help
System Status
Web Tool Box

➤ Eligibility
➤ Share of Cost
➤ Medi-Services
➤ Provider Services
➤ Batch Eligibility
➤ Login
➤ Exit



Eligibility Response

My CA

Eligibility transaction performed by provider: 000001067
on Thursday, May 30, 2002 at 9:10:53 AM)

Name: [redacted]		
Recipient ID: [redacted]		
Date of Service: 05/30/2002	Date of Birth: [redacted]	Date of Issue: 05/30/2002
Primary Aid Code: 30	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Recipient County: 10 - Fresno	HIC Number:	
Eligibility Verification Confirmation (EVC) Number: 244L6LVG55		
Eligibility Message: LAST NAME [redacted] EVC #: [redacted] CNTY CODE: 10. PRMY AID CODE: 30. MEDI-CAL ELIGIBLE W/ NO SOC. HEAL TH PLAN MEMBER: PHP-BLUE CROSS OF CALIFORNIA: MEDICAL CALL (800)407-4627.		

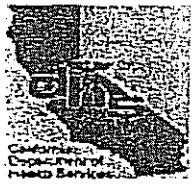
Server:www.medi-cal.ca.gov |File:/Eligibility/EligResp.asp |Last Modified:5/15/2002 11:00:26 PM

Fresno County Medi-Cal

California Home Thursda

Medi-Cal Home
Login
Publications
Related Sites
Dept. of Health Services
Site Map
Site Help
System Status
Web Tool Box

▸ Eligibility
▸ Share of Cost
▸ Medi-Services
▸ Provider Services
▸ Batch Eligibility
▸ Login
▸ Exit



Eligibility Response

My CA

Eligibility transaction performed by provider: 000001067
on Thursday, May 30, 2002 at 9:38:42 AM)

Name:		
Recipient ID:		
Date of Service: 05/30/2002	Date of Birth:	Date of Issue: 05/30/2002
Primary Aid Code: 60	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Recipient County: 42 - Santa Barbara	HIC Number:	
Eligibility Verification Confirmation (EVC) Number: 004NG3T6PW		
Eligibility Message: LAST NAME: [redacted] EVC #: 004NG3T6PW. CNTY CODE: 42. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC.		

Server:www.medi-cal.ca.gov |File:/Eligibility/EligResp.asp |Last Modified:5/15/2002 11:00:26 PM

Non-Fresno County Medi-Cal

Eligibility Response

MyCA

Eligibility transaction performed by provider: 000001067
on Thursday, May 30, 2002 at 10:40:38 AM)

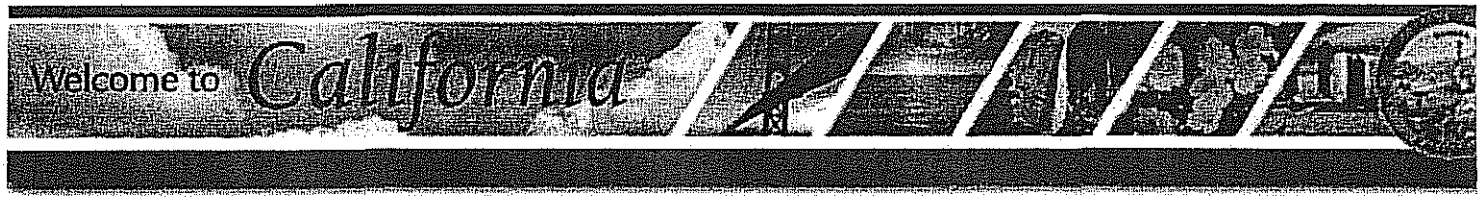
Name: [redacted]		
Recipient ID:		
Date of Service: 05/30/2002	Date of Birth:	Date of Issue: 05/30/2002
Primary Aid Code: 60	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Recipient County: 10 - Fresno	HIC Number:	
Primary Care Physician Phone #:	Scope of Coverage:	
Eligibility Verification Confirmation (EVC) Number: 544910T8JQ		
Eligibility Message: LAST NAME: [redacted] . CNTY CODE: 10. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC. PART A, B MEDICARE COVERAGE W/HIC # . BILL MEDICARE COVERED SVCS TO MEDICARE BEFORE MEDI-CAL.		

Server:www.medi-cal.ca.gov |File:/Eligibility/EligResp.asp |Last Modified:5/15/2002 11:00:26 PM

Medicare and Medi-Cal
(also referred to as "Medi-Medi" or "crossover" coverage)

California Home

Monday, December 13



Medi-Cal Home
Transaction Login
Contact Us
Publications
Provider Relations
Dept. of Health Services
Site Map
Site Help
System Status
POS System Status
Web Tool Box

- Eligibility
  - Single Subscriber
  - Multiple Subscribers
- SOC (Spend Down)
- Medical Services Reservation
- Provider Services
- Login
- Exit

Eligibility Response

My CA

Eligibility transaction performed by provider: 000001067
on Monday, December 13, 2004 at 1:46:55 PM

Name:		
Subscriber ID:		
Service Date: **12/13/2004**	Subscriber Birth Date:	Issue Date: **12/13/2004**
Primary Aid Code:	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County:	HIC Number:	
Spend Down Amount Obligation: **$632.00**	Remaining Spend Down Amount: **$632.00**	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: **SUBSCRIBER LAST NAME: . MEDI-CAL SUBSCRIBER HAS A $00632 SOC/SPEND DOWN. REMAINING SOC/SPEND DOWN $ 632.00.**		

Server:www.medi-cal.ca.gov |File:/Eligibility/EligResp.asp |Last Modified:2/17/2004 2:32:40 PM

Share of Cost Medi-Cal

Eligibility transaction performed by provider: 000001067 on Wednesday, May 01, 2002 at 4:26:17 PM

Name:		
Recipient ID:		
Date of Service: 03/15/2002	Date of Birth:	Date of Issue: 05/01/2002
Primary Aid Code: 3N	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Recipient County: 10 - Fresno	HIC Number:	
Primary Care Physician Phone #:	Scope of Coverage: OIM PDV	
Eligibility Verification Confirmation (EVC) Number: 2743LZ6GM4		
Eligibility Message: LAST NAME: [redacted] EVC #: 2743LZ6GM4. CNTY CODE: 10. PRMY AID CODE: 3N. MEDI-CAL ELIGIBLE W/NO SOC. OTHER HEALTH INSURANCE COVERAGE UNDER CODE P - PHP/HMO. CARRIER NAME: HEALTH NET HMO. ID: . COV: OIM PDV.		

Medi-Cal & Other Insurance

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SPECIALTY MENTAL HEALTH INPATIENT SERVICES **Enclosure 1**
ICD-10 COVERED DIAGNOSES TABLE
EFFECTIVE OCTOBER 1, 2019 THROUGH SEPTEMBER 30, 2020

Diagnosis Code	Diagnosis Description
F01.51	Vascular Dementia With Behavioral Disturbance
F10.14	Alcohol Abuse With Alcohol-Induced Mood Disorder
F10.150	Alcohol Abuse With Alcohol-Induced Psychotic Disorder With Delusions
F10.151	Alcohol Abuse With Alcohol-Induced Psychotic Disorder With Hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol Abuse With Alcohol-Induced Anxiety Disorder
F10.24	Alcohol Dependence With Alcohol-Induced Mood Disorder
F10.250	Alcohol Dependence With Alcohol-Induced Psychotic Disorder With Delusions
F10.251	Alcohol Dependence With Alcohol-Induced Psychotic Disorder With Hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.280	Alcohol Dependence With Alcohol-Induced Anxiety Disorder
F10.94	Alcohol Use, Unspecified, With Alcohol-Induced Mood Disorder
F10.950	Alcohol Use, Unspecified, With Alcohol-Induced Psychotic Disorder With Delusions
F10.951	Alcohol Use, Unspecified, With Alcohol-Induced Psychotic Disorder With Hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F11.14	Opioid Abuse With Opioid-Induced Mood Disorder
F11.150	Opioid Abuse With Opioid-Induced Psychotic Disorder With Delusions
F11.151	Opioid Abuse With Opioid-Induced Psychotic Disorder With Hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11.24	Opioid Dependence With Opioid-Induced Mood Disorder
F11.250	Opioid Dependence With Opioid-Induced Psychotic Disorder With Delusions
F11.251	Opioid Dependence With Opioid-Induced Psychotic Disorder With Hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.94	Opioid Use, Unspecified, With Opioid-Induced Mood Disorder
F11.950	Opioid Use, Unspecified, With Opioid-Induced Psychotic Disorder With Delusions
F11.951	Opioid Use, Unspecified, With Opioid-Induced Psychotic Disorder With Hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.988	Opioid-Induced Anxiety Disorder Without Opioid Use Disorder
F12.150	Cannabis Abuse With Psychotic Disorder With Delusions
F12.151	Cannabis Abuse With Cannabis-Induced Psychotic Disorder With Hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis Abuse With Cannabis-Induced Anxiety Disorder
F12.250	Cannabis Dependence With Psychotic Disorder With Delusions
F12.251	Cannabis Dependence With Cannabis-Induced Psychotic Disorder With Hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis Dependence With Cannabis-Induced Anxiety Disorder
F12.950	Cannabis Use, Unspecified, With Psychotic Disorder With Delusions
F12.951	Cannabis Use, Unspecified, With Cannabis-Induced Psychotic Disorder With Hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F12.980	Cannabis Use, Unspecified, With Cannabis-Induced Anxiety Disorder

Diagnosis Code	Diagnosis Description
F13.14	Sedative, Hypnotic or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.150	Sedative, Hypnotic, or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Delusions
F13.151	Sedative, Hypnotic, or Anxiolytic Abuse With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Hallucinations
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, Hypnotic or Anxiolytic Abuse With Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F13.24	Sedative, Hypnotic or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.250	Sedative, Hypnotic, or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Delusions
F13.251	Sedative, Hypnotic, or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.280	Sedative, Hypnotic or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F13.94	Sedative, Hypnotic or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.950	Sedative, Hypnotic, or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Delusions
F13.951	Sedative, Hypnotic, or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Hallucinations
F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.980	Sedative, Hypnotic or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F14.14	Cocaine Abuse With Cocaine-Induced Mood Disorder
F14.150	Cocaine Abuse With Cocaine-Induced Psychotic Disorder With Delusions
F14.151	Cocaine Abuse With Cocaine-Induced Psychotic Disorder With Hallucinations
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine Abuse With Cocaine-Induced Anxiety Disorder
F14.24	Cocaine Dependence With Cocaine-Induced Mood Disorder
F14.250	Cocaine Dependence With Cocaine-Induced Psychotic Disorder With Delusions
F14.251	Cocaine Dependence With Cocaine-Induced Psychotic Disorder With Hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine Dependence With Cocaine-Induced Anxiety Disorder
F14.94	Cocaine Use, Unspecified, With Cocaine-Induced Mood Disorder
F14.950	Cocaine Use, Unspecified, With Cocaine-Induced Psychotic Disorder With Delusions
F14.951	Cocaine Use, Unspecified, With Cocaine-Induced Psychotic Disorder With Hallucinations
F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980	Cocaine Use, Unspecified, With Cocaine-Induced Anxiety Disorder
F15.14	Other Stimulant Abuse With Stimulant-Induced Mood Disorder

Diagnosis Code	Diagnosis Description
F15.150	Other Stimulant Abuse With Stimulant-Induced Psychotic Disorder With Delusions
F15.151	Other Stimulant Abuse With Stimulant-Induced Psychotic Disorder With Hallucinations
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other Stimulant Abuse With Stimulant-Induced Anxiety Disorder
F15.24	Other Stimulant Dependence With Stimulant-Induced Mood Disorder
F15.250	Other Stimulant Dependence With Stimulant-Induced Psychotic Disorder With Delusions
F15.251	Other Stimulant Dependence With Stimulant-Induced Psychotic Disorder With Hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other Stimulant Dependence With Stimulant-Induced Anxiety Disorder
F15.94	Other Stimulant Use, Unspecified, With Stimulant-Induced Mood Disorder
F15.950	Other Stimulant Use, Unspecified, With Stimulant-Induced Psychotic Disorder With Delusions
F15.951	Other Stimulant Use, Unspecified, With Stimulant-Induced Psychotic Disorder With Hallucinations
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15.980	Other Stimulant Use, Unspecified, With Stimulant-Induced Anxiety Disorder
F16.14	Hallucinogen Abuse With Hallucinogen-Induced Mood Disorder
F16.150	Hallucinogen Abuse With Hallucinogen-Induced Psychotic Disorder With Delusions
F16.151	Hallucinogen Abuse With Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen Abuse With Hallucinogen-Induced Anxiety Disorder
F16.183	Hallucinogen Abuse With Hallucinogen Persisting Perception Disorder (Flashbacks)
F16.24	Hallucinogen Dependence With Hallucinogen-Induced Mood Disorder
F16.250	Hallucinogen Dependence With Hallucinogen-Induced Psychotic Disorder With Delusions
F16.251	Hallucinogen Dependence With Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen Dependence With Hallucinogen-Induced Anxiety Disorder
F16.283	Hallucinogen Dependence With Hallucinogen Persisting Perception Disorder (Flashbacks)
F16.94	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Mood Disorder
F16.950	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Psychotic Disorder With Delusions
F16.951	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16.980	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Anxiety Disorder

Diagnosis Code	Diagnosis Description
F16.983	Hallucinogen Use, Unspecified, With Hallucinogen Persisting Perception Disorder (Flashbacks)
F18.14	Inhalant Abuse With Inhalant-Induced Mood Disorder
F18.150	Inhalant Abuse With Inhalant-Induced Psychotic Disorder With Delusions
F18.151	Inhalant Abuse With Inhalant-Induced Psychotic Disorder With Hallucinations
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.180	Inhalant Abuse With Inhalant-Induced Anxiety Disorder
F18.24	Inhalant Dependence With Inhalant-Induced Mood Disorder
F18.250	Inhalant Dependence With Inhalant-Induced Psychotic Disorder With Delusions
F18.251	Inhalant Dependence With Inhalant-Induced Psychotic Disorder With Hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.280	Inhalant Dependence With Inhalant-Induced Anxiety Disorder
F18.94	Inhalant Use, Unspecified, With Inhalant-Induced Mood Disorder
F18.950	Inhalant Use, Unspecified, With Inhalant-Induced Psychotic Disorder With Delusions
F18.951	Inhalant Use, Unspecified, With Inhalant-Induced Psychotic Disorder With Hallucinations
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.980	Inhalant Use, Unspecified, With Inhalant-Induced Anxiety Disorder
F19.14	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Mood Disorder
F19.150	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.151	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.180	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Anxiety Disorder
F19.24	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Mood Disorder
F19.250	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.251	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.280	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Anxiety Disorder
F19.94	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Mood Disorder
F19.950	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.951	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified

Diagnosis Code	Diagnosis Description
F19.980	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Anxiety Disorder
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorders
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
F30.11	Manic Episode Without Psychotic Symptoms, Mild
F30.12	Manic Episode Without Psychotic Symptoms, Moderate
F30.13	Manic Episode, Severe, Without Psychotic Symptoms
F30.2	Manic Episode, Severe, With Psychotic Symptoms
F30.3	Manic Episode in Partial Remission
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.10	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Unspecified
F31.11	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Mild
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, Without Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
F31.61	Bipolar Disorder, Current Episode Mixed, Mild
F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features

Diagnosis Code	Diagnosis Description
F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.01	Agoraphobia With Panic Disorder
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.210	Arachnophobia
F40.218	Other Animal Type Phobia
F40.220	Fear of Thunderstorms
F40.228	Other Natural Environment Type Phobia
F40.230	Fear of Blood
F40.231	Fear of Injections and Transfusions
F40.232	Fear of Other Medical Care
F40.233	Fear of Injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of Bridges
F40.243	Fear of Flying
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.291	Gynophobia

Diagnosis Code	Diagnosis Description
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety]
F41.1	Generalized Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder With Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder with Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.20	Hypochondriacal Disorder, Unspecified
F45.21	Hypochondriasis
F45.22	Body Dysmorphic Disorder
F45.29	Other Hypochondriacal Disorders
F45.41	Pain Disorder Exclusively Related to Psychological Factors
F45.42	Pain Disorder With Related Psychological Factors
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified

Diagnosis Code	Diagnosis Description
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.2	Antisocial Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.1	Pyromania
F63.81	Intermittent Explosive Disorder
F63.89	Impulse Disorder, Unspecified
F84.0	Autistic Disorder (Autism spectrum disorder)
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome
F84.8	Other Pervasive Developmental Disorder
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactivity Disorder, Other Type
F90.9	Attention-Deficit/Hyperactivity Disorder, Unspecified Type
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Conduct Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Attachment Disorder of Childhood
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder

SPECIALTY MENTAL HEALTH INPATIENT SERVICES
ICD-10 COVERED DIAGNOSES TABLE
EFFECTIVE OCTOBER 1, 2019 THROUGH SEPTEMBER 30, 2020

Diagnosis Code	Diagnosis Description
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Early Childhood
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
G21.0	Malignant neuroleptic syndrome
G21.11	Neuroleptic induced parkinsonism
R15.0	Incomplete Defecation
R15.9	Full Incontinence of Feces
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out

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SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
ICD-10 COVERED DIAGNOSES TABLE
EFFECTIVE OCTOBER 1, 2019 THROUGH SEPTEMBER 30, 2020

Enclosure 2

Diagnosis Code	Diagnosis Description
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorder
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
F30.11	Manic Episode Without Psychotic Symptoms, Mild
F30.12	Manic Episode Without Psychotic Symptoms, Moderate
F30.13	Manic Episode, Severe, Without Psychotic Symptoms
F30.2	Manic Episode, Severe, With Psychotic Symptoms
F30.3	Manic Episode in Partial Remission
F30.4	Manic Episode in Full Remission
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.10	Bipolar Disorder, Current Episode Manic, Without Psychotic features, Unspecified
F31.11	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Mild
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, Without Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
F31.61	Bipolar Disorder, Current Episode Mixed, Mild
F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features
F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
F31.70	Bipolar Disorder, Currently in Remission, Most Recent Episode Unspecified
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.72	Bipolar Disorder, in Full Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.74	Bipolar Disorder, in Full Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.76	Bipolar Disorder, in Full Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.78	Bipolar Disorder, in Full Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder

Diagnosis Code	Diagnosis Description
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.5	Major Depressive Disorder, Single Episode, in Full Remission
F32.81	Premenstrual dysphoric disorder
F32.89	Other Specified Depressive Episodes
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.40	Major Depressive Disorder, Recurrent, in Remission, Unspecified
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.42	Major Depressive Disorder, Recurrent, in Full Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.01	Agoraphobia With Panic Disorder
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.210	Arachnophobia
F40.218	Other Animal Type Phobia
F40.220	Fear of Thunderstorms
F40.228	Other Natural Environment Type Phobia
F40.230	Fear of Blood
F40.231	Fear of Injections and Transfusions
F40.232	Fear of Other Medical Care
F40.233	Fear of Injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of Bridges
F40.243	Fear of Flying
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.291	Gynophobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F40.9	Phobic Anxiety Disorder, Unspecified
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety Disorder]
F41.1	Generalized Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts

Diagnosis Code	Diagnosis Description
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder with Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder With Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.20	Hypochondriacal Disorder, Unspecified
F45.21	Hypochondriasis
F45.22	Body Dysmorphic Disorder
F45.29	Other Hypochondriacal Disorders
F45.41	Pain Disorder Exclusively Related to Psychological Factors
F45.42	Pain Disorder With Related Psychological Factors
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.8	Other Eating Disorders
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive-Compulsive Personality Disorder

Diagnosis Code	Diagnosis Description
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.0	Pathological Gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent Explosive Disorder
F63.89	Other Impulse Disorders
F63.9	Impulse Disorder, Unspecified
F64.0	Transsexualism
F64.2	Gender Identity Disorder of Childhood
F64.8	Other Gender Identity Disorders
F64.9	Gender Identity Disorder, Unspecified
F65.0	Fetishism
F65.1	Transvestic Fetishism
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.50	Sadomasochism, Unspecified
F65.51	Sexual Masochism
F65.52	Sexual Sadism
F65.81	Frotteurism
F65.89	Other Paraphilias
F65.9	Paraphilia, Unspecified
F68.10	Factitious Disorder Imposed on Self, Unspecified
F68.11	Factitious Disorder Imposed on Self, With Predominantly Psychological Signs and Symptoms
F68.12	Factitious Disorder Imposed on Self, With Predominantly Physical Signs and Symptoms
F68.13	Factitious Disorder Imposed on Self, With Combined Psychological and Physical Signs and Symptoms
F68.A	Factitious Disorder Imposed on Another
F80.82	Social (Pragmatic) Communication Disorder
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.0	Autistic disorder (Autism spectrum disorder)
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome
F84.8	Other Pervasive Developmental Disorders
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive Type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactive Disorder, Other Type
F90.9	Attention Deficit/Hyperactivity Disorder, Unspecified Type
F91.0	Conduct Disorder Confined to Family Context
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Conduct Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders

Diagnosis Code	Diagnosis Description
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Social Engagement Disorder
F94.8	Other Childhood Disorders of Social Functioning
F94.9	Childhood Disorder of Social Functioning, Unspecified
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Early Childhood
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
F98.8	Other Specified Behavioral and Emotional Disorders With Onset Usually Occurring in Childhood and Adolescence
F98.9	Unspecified Behavioral and Emotional Disorders With Onset Usually Occurring in Childhood and Adolescence
G21.0	Malignant neuroleptic syndrome
G21.11	Neuroleptic-Induced Parkinsonism
G24.4	Idiopathic Orofacial Dystonia
G25.1	Drug-Induced Tremor
G25.70	Drug-Induced Movement Disorder, Unspecified
G25.71	Medication-Induced Acute Akathisia
G25.9	Extrapyramidal and Movement Disorder, Unspecified
R15.0	Incomplete Defecation
R15.9	Full incontinence of feces
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out

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AEVS: General Instructions

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows you the ability—through a touch-tone telephone—to access beneficiary eligibility, clear Share of Cost (SOC) liability and/or reserve a Medi-Service.

Beneficiary eligibility verification information is available for Medi-Cal, County Medical Services Program (CMSP) and Family PACT. Beneficiary eligibility for the Child Health and Disability Prevention (CHDP) program, the California Children Services (CCS) program or the Genetically Handicapped Persons Program (GHPP) is not available.

There is no enrollment requirement to participate in AEVS. Providers must use a valid Provider Identification Number (PIN) to access AEVS. The PIN is issued when providers enroll with Medi-Cal. If the PIN is unknown, providers should complete and return the *Provider Identification Number (PIN) Reissue Request* form at the end of the *Provider Telecommunications Network (PTN)* section in this manual.

For questions about:	**Call:**
Operation of AEVS	POS Help Desk: 1-800-427-1295
Medi-Cal Policy	Telephone Support Center (TSC): 1-800-541-5555
Family PACT	Health Access Programs (HAP): 1-800-257-6900

GENERAL INFORMATION

Edit Conditions

Use of AEVS does not guarantee that the claim will be paid. All existing edit conditions – such as service restrictions, SOC certification, provider eligibility or prior authorization requirements – must still be satisfied.

Transactions Available

AEVS verifies a beneficiary's eligibility for the current and/or prior 12 months; provides information on SOC, Other Health Coverage and Prepaid Health Plan (PHP) status; identifies beneficiaries in fee-for-service pending enrollment into a Medi-Cal managed care plan, a Denti-Cal managed care plan, or both; identifies any service restrictions placed on that beneficiary; clears SOC liability; and allows podiatrists and certain allied health providers to reserve Medi-Services.

BIC Card

When a beneficiary presents a plastic Medi-Cal Benefits Identification Card (BIC), beneficiary eligibility must be verified. BICs are not a guarantee of Medi-Cal, CMSP or Family PACT eligibility because they are a permanent form of identification and beneficiaries retain the cards even if they are not eligible for Medi-Cal, CMSP or Family PACT during the current month.

HAP Card

A Health Access Programs (HAP) card is issued and activated by the provider after the client has completed and signed a *Health Access Programs State-Only Family Planning Program Client Eligibility Certification* form. HAP cards are not a guarantee of Family PACT eligibility because they are a permanent form of identification and clients retain the cards even if they are not eligible for Family PACT during the current month.

Eligibility Verification Confirmation (EVC) Number

AEVS accesses the most current beneficiary information for a specific month of eligibility. AEVS returns a 10-character EVC number, after eligibility is confirmed. It is recommended to enter in the EVC number in the remarks area of the claim. However, the EVC number is not required information for claim processing.

Note: An Eligibility Verification Confirmation (EVC) number is only valid for the provider who submitted the inquiry.

Unmet Share of Cost

If the beneficiary has an unmet SOC, no EVC number is given unless the beneficiary is dually eligible (eligible for services under more than one aid code). For a dually eligible beneficiary, who is eligible for certain services with no SOC and the remaining services with a SOC, the aid code and corresponding eligibility message and an EVC number are given in the eligibility response for the non-SOC aid code only. An SOC message is then given for the SOC aid code.

Important: To avoid having a claim deny for beneficiary eligibility, the claim must be submitted with the same provider number, beneficiary ID and date of service used for the AEVS inquiry.

ACCESSING TELEPHONE AEVS

Introduction

Before you access telephone AEVS, you should have the required information ready to enter using your touch-tone telephone when prompted by AEVS.

Time Limit

Telephone AEVS allows you a specified amount of time following each prompt to enter information using your touch-tone telephone. If you fail to respond to a prompt within five seconds, AEVS will remind you up to three times. If you have not entered any information after the third reminder, you will "time out" and AEVS will terminate the call with the following message:

> *"We're sorry, we are unable to complete your call. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

Error Limits

When entering required information using your touch-tone telephone, AEVS will allow you three opportunities to correctly enter the information. Upon your first and second error, AEVS will prompt you to re-enter the information correctly. After the third error, AEVS will terminate your call with the following message:

> *"We are unable to locate the Provider Identification Number. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the Technical Help Desk at 1-800-541-5555. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

Documenting Eligibility Information

Following receipt of AEVS eligibility information, note the information for future reference when completing your claim forms. Be prepared to write down the eligibility information for each inquiry as it is given to you over the telephone. AEVS will give an Eligibility Verification Confirmation (EVC) number for each inquiry that receives an eligible response.

Providers verifying eligibility information for Medi-Cal beneficiaries may want to use the *AEVS Response Log* to track AEVS transactions. This form is located at the end of the *AEVS: Transactions* section in this manual.

The EVC number should be noted in your patient's records for future reference. AEVS will provide you with the option to repeat eligibility information and the verification code as needed to ensure that you record the information accurately.

Hours of Operation

Telephone AEVS is available by using a touch-tone telephone between 2 a.m. and midnight, seven days a week. If you attempt to access telephone AEVS during non-operational hours, you will receive the following message:

> *"The Medi-Cal Automated Eligibility Verification System is* available between 2 a.m. and midnight. Please call back during these hours of operation. Thank you for calling the Automated Eligibility Verification System. Good-bye."

In the unlikely event that telephone AEVS is unavailable during normal hours of operation, you will receive the following message when you attempt to verify eligibility for Medi-Cal or County Medical Services Program (CMSP) beneficiaries:

> "The Medi-Cal Automated Eligibility Verification System is currently unavailable. Please call back later. Good-bye."

If AEVS is not available when you attempt to access Family PACT transactions, you will receive the following message:

> *"The State-Only Family Planning system is currently unavailable.* Please report your problem to the POS Help Desk at 1-800-541-5555."

ENTERING ALPHABETIC DATA

Introduction

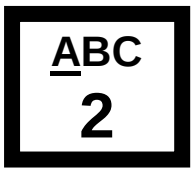
To enter alphabetic data (letters A, B, C, etc.), press the star key (*) followed by a two-digit code representing the letter. This function issued when entering some Medi-Cal identification numbers or procedure codes with alphabetic characters.

Two-Digit Code

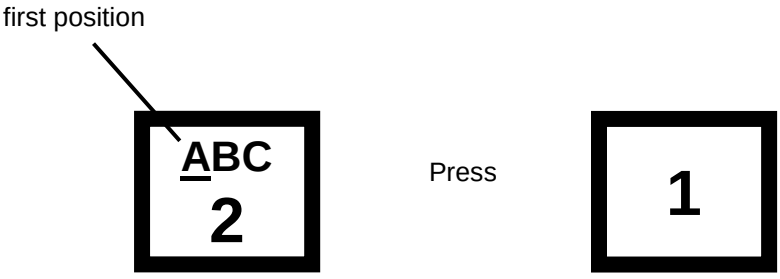
The first digit of the code for all letters is the keycap on which the letters appear. The second digit of the code identifies the letter's corresponding position on the appropriate keycap.

To enter the first digit of the code, press the keycap on which the letter appears. To enter the second digit of the code for the letter, find the position of the letter on the keycap (first, second or third position) and press the corresponding keycap representing the position (**[1]**, **[2], [3] or [4]**).

For example, to enter the two-digit code for the letter "A," first press the star key (*), then press **[2]** keycap to identify "A":



Then press the **[1]** keycap to identify the first position:



Therefore, the two-digit code for the letter "A" is *** 21**.

14-digit Medi-Cal ID

To enter the 14-digit Medi-Cal Identification Number "443C5213910234" you would identify the letter "C" by entering the following two-digit code (including the required star):

C = ***** 23

Therefore, the touch-tone entry for "443C5213910234" would be "443*235213910234."

Nine-digit ID Number

To enter the nine-digit ID Number "444-55-611P" you would identify the letter "P" by entering the following two-digit code (including the required star):

P = * 71

Therefore, the touch-tone entry for "444-55-611P" would be "44455611*71."

HCPCS Codes

To enter the HCPCS code "Z2345" you would identify the letter "Z" by entering the following two-digit code (including the required star):

Z = * 94

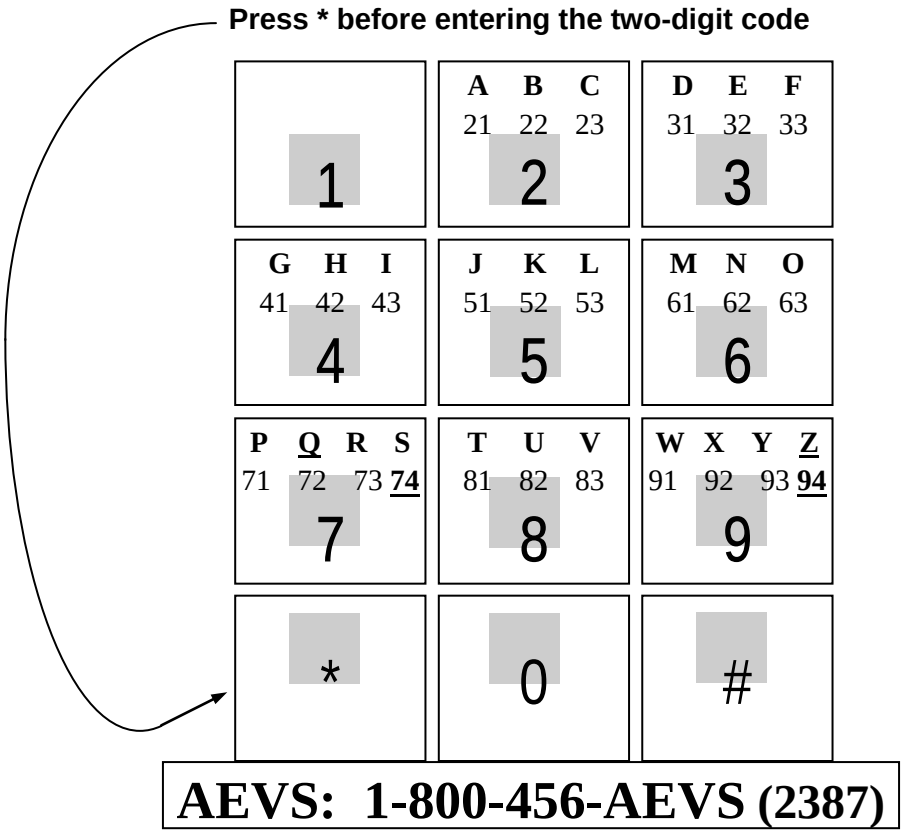
Therefore, the touch-tone entry for "Z2345" would be "*942345."

List of Alphabetic Codes

The alphabetic code listing for AEVS is as follows:

LETTER	2-DIGIT CODE	LETTER	2-DIGIT CODE
A	* 21	N	* 62
B	* 22	O	* 63
C	* 23	P	* 71
D	* 31	Q	* 72
E	* 32	R	* 73
F	* 33	S	* 74
G	* 41	T	* 81
H	* 42	U	* 82
I	* 43	V	* 83
J	* 51	W	* 91
K	* 52	X	* 92
L	* 53	Y	* 93
M	* 61	Z	* 94

Alphabetic Code Listing



AEVS: Transactions

This section describes how to access the Medi-Cal Automated Eligibility Verification System (AEVS) and complete eligibility verifications.

Also included at the end of this section is the *AEVS Response Log.* This is designed to be photocopied for use in tracking AEVS transactions. The log was created as a convenient means of maintaining provider records only. It does not serve as valid proof of eligibility for claim submissions or appeals. It is recommended that you have this form available when you access AEVS.

GENERAL INFORMATION

Provider Identification Number (PIN)

Using a touch-tone telephone, dial 1-800-456-AEVS (2387) or 1-800-541-5555. AEVS will respond with the following message:

> *"Welcome to Medi-Cal. Please listen carefully as our menu has changed. For English press or say 1. Para Español marque dos.*
>
> *If you are a provider please press or say 1.*
> *If you are a beneficiary please press or say 2.*
>
> *For the Automated Eligibility Verification System please press or say 1.*
>
> *If you have a PIN please press or say 1.*
> *If you have a temporary PIN please press or say 2.*
>
> *Please enter your PIN followed by a pound sign (#)."*

Enter your Provider Identification Number (PIN).

When the entered PIN is associated with both NPI and Legacy ID, the NPI will be given as the first option to select. In this case AEVS will respond with the following message:

> *"If your Provider Number is (NPI), press 1.*
> *If your Provider Number is (Legacy ID), press 2.*
> *Or press 3 to re-enter your PIN."*

The second option will be unavailable if only Legacy ID or NPI is associated with the entered PIN.

If the PIN cannot be found on the Provider Master File, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the third try, the call will be terminated with the following message:

> *"We are unable to locate the Provider Identification Number. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual.*

If you have any questions concerning AEVS, please contact the Technical Help Desk at 1-800-541-5555. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."

Transaction Menu

If the PIN can be verified by AEVS, you will receive the following prompt by provider type:

For Podiatrist, Acupuncturist, Chiropractor, OT, Psychologist, Speech Pathologist, Audiologist

"For Eligibility Verification, press or say 1. For Share of Cost, press or say 2. To perform a Medi-Service transaction, press or say 3. For general information please visit us on the Web at www.medi-cal.ca.gov."

For all others

"For Eligibility Verification, press or say 1. For Share of Cost, press or say 2. For Family PACT transactions, press or say 3. For general information please visit us on the Web at www.medi-cal.ca.gov."

Beneficiary ID Number

Press 1 to verify eligibility. You will then hear the following message:

"If you know the beneficiary ID press or say 1.
If not, press or say 2."

If you chose 1, you will hear the following message:

"The beneficiary identification number can be found on the face of the Benefits Identification Card. If the beneficiary identification number includes a letter, and you need instructions on how to enter them, press or say 1."

If you press or say 1, you will hear the following:

"To enter a letter, you must press three keys. First, press star (*), then press the key which has the letter you want, finally press one, two, three or four to indicate the position of the letter on that key. You enter numbers normally. For example, for A-2-3-Z, press star-two-one, two, three, star-nine-four. If you need to hear this message again, press or say 1.

If you are ready to enter the beneficiary number, press or say 2. If it is all numeric or you know to enter letters, press or say 2."

If you chose 2, you will hear the following message:

"Please enter the beneficiary's identification number followed by the pound sign.
You entered xxxxxxxxx.

If this is correct, press or say 1.
If not, press or say 2."

Enter the beneficiary's Medi-Cal identification number followed by the pound sign key (#). If there are any alpha characters in the number, press the star key (*) and number keys that correspond with the letter.

Beneficiary Birth Date

If the beneficiary ID number you enter is invalid, AEVS will prompt you to re-enter the number. If the beneficiary identifier is entered correctly, you will receive the following message:

"*Please enter the two-digit month and four-digit year of the beneficiary's birth. For example, June 1972, would be entered as 0-6-1-9-7-2.*

You entered <xxxxxx>.
If this is correct, press or say 1.
If not, press or say 2."

Verifying Newborn Infant Eligibility

If you are verifying eligibility for a newborn infant billing on the mother's ID number, enter the mother's date of birth.

Date of Service

Please enter the date of service using the two-digit month, two-digit day and four-digit year. To enter today's date press star:

"*You entered <xxxxxxxx>.*
If this is correct, press or say 1.
If not, press or say 2."

If you press or say an invalid date you will hear the following message:

"*That date is not valid. You must enter an eight-digit number only. Please enter the date of service. <MMDDYYYY>"*

If you enter an invalid beneficiary date of birth you will hear the following message:

"*The birth date you entered does not match our records. The date you entered is invalid. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. Denti-Cal providers should call 1-800-541-5555. Thank you for calling the Automated Eligibility Verification System. Good-bye "*

When a valid date is entered, AEVS will attempt to access the requested beneficiary's eligibility information. At this point, you should be prepared to record the information provided by AEVS.

If the beneficiary's eligibility cannot be verified, you will receive the following message:

> *"No recorded eligibility for (month) (year) for beneficiary (ID number) with a birth date of (month) (year)."*

If the beneficiary has a Share of Cost (SOC), you will hear the following message:

> *"This Medi-Cal beneficiary has a Share of Cost of (dollar amount) dollars. To hear this information again, press or say 1. Otherwise, press or say 2."*

If you press or say 2 you will hear the following message:

> *"This Medi-Cal beneficiary has a Share Cost of (dollar amount) dollars. To hear this information again, press or say 1. Otherwise press or say 2."*

If AEVS successfully retrieves the beneficiary's eligibility information for the month that you requested and you pressed or said 2, you will receive the following message that will verify the beneficiary's eligibility by giving you the first six letters of the last name and the first initial:

> *"Thank you.*
> *The first six letters of the beneficiary's name are _ _ _ _ _ _.*
> *The beneficiary's first initial is _.*
> *The county code is _ _.*
> *The primary aide code is _ _.*
> *The first special aide code is _ _.*
> *Please call the health care plan for PCP information.*
> *The Eligibility Verification Confirmation number is (number)."*

After this message is spoken, please be prepared to record the beneficiary's eligibility information on the *AEVS Response Log*.

Eligibility Message Types

The following are examples of messages you may receive when AEVS provides you with the beneficiary eligibility information that you requested. A beneficiary may have more than one eligibility message spoken for each transaction. Be prepared to record the following information:

> *"Beneficiary Medi-Cal eligible.*
>
> *Beneficiary is Medi-Cal eligible for dialysis and related services only, with _ _ percent obligation.*
>
> *Beneficiary is restricted to medical services related to pregnancy and family planning.*
>
> *The beneficiary has other health insurance coverage under code (OHC code) – (OHC name) – (carrier code). Scope of coverage is: (scope of coverage [COV] code[s]).*"

If a Medi-Cal fee-for-service beneficiary will be enrolled in a health care plan (HCP) in the next month of enrollment (MOE), then you will receive the following message with that pending three-digit HCP number and HCP phone number:

> *For information only pending health care plan enrollment into: (HCP) XXX, (HCP phone number) 1-800-XXX-XXXX.*

You may contact the HCP for information regarding the pending HCP enrollment only.

If available, you also may hear up to 10 occurrences of the carrier code and policy number. For a list of AEVS carrier codes, refer to AEVS: Carrier Codes for Other Health Coverage on the Medi-Cal website at *www.medi-cal.ca.gov* (click the "Publications" link, followed by the "Provider Manuals" link and scroll to "Other Sections").

Note: Providers may view and download the online *AEVS: Carrier Codes for Other Health Coverage* section in Microsoft Word format.

The Eligibility Verification Confirmation number is <xxxxxxx>.

After all eligibility messages and eligibility verification confirmation (EVC) numbers are spoken for this transaction, you will receive the following message:

"To hear this information again, press 1. Otherwise, press 2."

If you press 2, you will return to the main menu and hear the following message:

"For Eligibility Verification, press or say 1. For Share of Cost, press or say 2. To perform a Medi-Service transaction, press or say 3. For general information, please visit us on the Web at www.medi-cal.ca.gov."

SHARE OF COST CLEARANCE OR REVERSAL

Introduction

The following process is used to access the Medi-Cal eligibility verification system to complete a Share of Cost (SOC) clearance or reversal transaction.

Provider Identification Number (PIN)

Using a touch-tone telephone, dial 1-800-456-AEVS (2387) or 1-800-541-5555. AEVS will respond with the following message:

"Welcome to Medi-Cal. Please listen carefully as our menu has changed. For English press or say 1. Para Español marque dos.

If you are a provider, please press or say 1.
If you are a beneficiary, please press or say 2.

For the Automated Eligibility Verification System, please press or say 1.

If you have a PIN, please press or say 1.
If you have a temporary PIN, please press or say 2.

Please enter your PIN followed by a pound sign (#)."

Enter your Provider Identification Number (PIN).

When the entered PIN is associated with both an NPI and Legacy ID number, the NPI will be given as the first option to select. In this case AEVS will respond with the following message:

"If your Provider Number is (NPI), press 1.
If your Provider Number is (Legacy ID), press 2.
Or press 3 to re-enter your PIN."

The second option will be unavailable if only the Legacy ID or NPI is associated with the entered PIN.

If the PIN cannot be found on the Provider Master File, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the third try, the call will be terminated with the following message:

"We are unable to locate the Provider Identification Number. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. Denti-Cal providers should call1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."

Transaction Menu

If the PIN can be verified by AEVS, you will receive the following prompt by provider type:

For Podiatrist, Acupuncturist, Chiropractor, OT, Psychologist, Speech Pathologist, Audiologist

"For Eligibility Verification, press or say 1. For Share of Cost, press or say 2. To perform a Medi-Service transaction, press or say 3. For general information please visit us on the Web at www.medi-cal.ca.gov."

For all others

"For Eligibility Verification, press or say 1. For Share of Cost, press or say 2. For Family PACT transactions, press or say 3. For general information please visit us on the Web at www.medi-cal.ca.gov."

Press 2 to clear an SOC liability or reverse a previous clearance. You will then hear the following message:

"To perform an update, press or say 1.
To perform a reversal, press or say 2."

Beneficiary ID Number

To perform an update, press 1. To perform a reversal, press 2. After you press 1 or 2, you will receive the following message:

> *"The beneficiary identification number can be found on the face of the Benefits Identification Card.*
>
> *If the beneficiary identification number includes letters, and you need instructions on how to enter them, press or say 1."*

If you press or say 1 you will hear the following:

> *"To enter a letter, you must press three keys. First, press star (*), then press the key which has the letter you want. Finally press one, two, three or four to indicate the position of the letter on that key. You enter numbers normally. For example, for A-2-3-Z, press star-two-one, two, three, star-nine-four. If you need to hear this message again, press or say 1.*
>
> *If you are ready to enter the beneficiary number, press or say 2.*
>
> *If it is all numeric or you know how to enter letters, press or say 2."*

If you chose 2, you will hear the following message:

> *"Please enter the beneficiary's identification number.*
> *You entered <xxxxxxxxx>.*
>
> *If this is correct, press or say 1.*
> *If not, press or say 2."*

Beneficiary Birth Date

If the beneficiary ID number you enter is invalid, AEVS will prompt you to re-enter the number. If the beneficiary identifier is entered correctly, you will receive the following message:

> *"Please enter the two-digit month and four-digit year of the beneficiary's birth. For example, June, 1972, would be entered as 0-6-1-9-7-2."*

Verifying Newborn Infant SOC

If you are performing this transaction for services rendered to a newborn infant billing on the mother's ID number, enter the mother's date of birth.

Date of Service

Please enter the date of service using two-digit day and four-digit year. To enter today's date press star.

> *"You entered <xxxxxx>.*
>
> *If this is correct, press or say 1.*
> *If not, press or say 2."*

If you press or say an invalid date you will hear the following message:

> *"That date is not valid. You must enter an eight-digit number only. Please enter the date of service <MMDDYYYY>."*

If the date of service that you entered is invalid, AEVS will prompt you to re-enter the date.

Note: If you have to re-enter the date of service, this is considered to be an additional inquiry and will count against the 10 inquiries you are allowed per call.

Procedure Code

If the date is entered correctly, you will receive the following message:

> *"If the procedure code includes letters and you need help entering letters, press or say 1.*
>
> *If it is all numeric or you know how to enter letters, press or say 2."*

If you chose option 1, you will hear the following message:

> *"If the procedure code includes letters and you need help entering letters, press or say 1.*
>
> *If it is all numeric or you know how to enter letters, press or say 2."*

If you chose option 2 you will hear the following message:

"Please enter a procedure code followed by the pound sign (#).

You entered <xxxxxxxx>.
If this is correct, press or say 1.
To re-enter, press or say 2."

Total Billed Amount

If you press 1, you will hear the following message:

"Please enter the total claim charged amount including dollars and cents followed by a pound sign (#). For example, for twenty dollars and fifty cents would be, entered 2-0-5-0#".

If the amount you entered is invalid, AEVS will prompt you to re-enter the amount. If the amount is entered correctly, you will receive the following message:

"You entered <xxxxxxxx>.
If this is correct, press or say 1.
To re-enter, press or say 2."

Case Number

If you press 1, you will hear the following message:

"If the case number includes letters, press or say 1.
If it is all numeric, press or say 2.
Or press pound to bypass the case number."

If you chose option 1 you will hear the following message:

"To enter a letter, you must press three keys. First, press star (*),then press the key which has the letter you want, finally press one, two, three or four to indicate the position of the letter on that key. You enter numbers normally. For example, for A-2-3-Z, press star-two-one, two, three, star-nine-four. If you need to hear this message again, press or say 1.

If you are ready to make your entry, press or say 2."

If you chose option 2 you will hear the following message:

"Please enter the case number followed by the pound sign."

If the beneficiary has multiple cases, see "Multiple SOC Cases" on the following page.

Clearance With SOC Liability Remaining

After you press the pound sign (#) for a beneficiary without multiple cases, you will hear the following message if the beneficiary has additional liability:

"The amount deducted was <000.00>.
The amount of Share of Cost remaining is <000.00>.

To enter a different procedure code, press or say 1.
To enter a different case number, press or say 2.
To return to the main menu, press or say 9."

Clearance With No SOC Liability Remaining

After you press the pound sign (#) for a beneficiary without multiple cases, you will hear the following message if the beneficiary's Share of Cost is certified (no Share of Cost liability remaining):

"The first six letters of the beneficiary's name are _ _ _ _ _ _.
The beneficiary's first initial is _.
The county code is _ _.
The primary aid code is _ _.
The first special aid code is _ _.
The amount deducted was (amount). Share of Cost certified.
The Eligibility Verification Confirmation number is (number)."

Multiple SOC Cases

A beneficiary may have multiple cases for SOC clearance. You will hear the following messages based on the beneficiary case number status:

"This beneficiary is in multiple cases. Their case numbers are:
<xxxxxxxxxx>
<xxxxxxxxxx>
<xxxxxxxxxx>
<xxxxxxxxxx>."

If the beneficiary has more than four case numbers you will hear:

"This beneficiary is in multiple cases. Their case numbers are:
<xxxxxxxxxx>
<xxxxxxxxxx>
<xxxxxxxxxx>
<xxxxxxxxxx>.
The beneficiary also has additional Share of Cost case numbers not mentioned in this transaction."

You will then hear the following:

"If the case number includes letters, and you need instructions on how to enter them, press or say 1. If it is all numeric or you know how to enter letters, press or say 2".

If you chose option 1 you will hear:

"To enter a letter, you must press three keys. First, press star (*), then press the key which has the letter you want, finally press one, two, three or four to indicate the position of the letter on that key.

You enter numbers normally. For example, for A-2-3-Z, press star-two-one, two, three, star-nine-four.

If you need to hear this message again, press or say 1.

If you are ready to enter the beneficiary number, press or say 2."

If you chose option 2 you will hear the following message:

"Please enter the case number, followed by the pound sign.

You entered <xxxxxxxx>.
If this is correct, press or say 1.
To re-enter, press or say 2."

You will then hear the messages telling you what kind of eligibility and/or restrictions the beneficiary has. For example:

"Beneficiary Medi-Cal eligible.

Beneficiary is Medi-Cal eligible for dialysis and related services only, with _ _ percent obligation.

Beneficiary is restricted to medical services related to mental health care."

Entering Applied Amount for Case Numbers

If you press 1, you will hear the following message:

"Please enter the applied amount for the case number as dollars and cents. For example, for twenty dollars and fifty cents, would be entered 2-*0-5-0#.*

You entered <xxxxxxxx>.
If this is correct, press or say 1.
To re-enter, press or say 2."

If you chose option 1 you will hear:

"Amount added was <xxx.xx>.
Share of Cost remaining is <xxx.xx>.

To repeat this information, press or say 1.
To enter a different case number, press or say 2.
To return to the main menu, press or say 9."

SOC Reversal

If you press 2, you will hear the following message <u>if you requested a reversal</u>:

You will hear the following message:

"The beneficiary identification number can be found on the face of the Benefits Identification Card.

If the beneficiary identification number includes letters, and you need instructions on how to enter them, press or say 1."

If you press or say 1, you will hear the following message:

> *"To enter a letter, you must press three keys. First, press star (*), then press the key which has the letter you want, finally press one, two, three or four to indicate the position of the letter on that key. You enter numbers normally. For example, for A-2-3-Z, press star two-one, two, three, star-nine-four. If you need to hear this message again, press or say 1.*
>
> *If you are ready to enter the beneficiary number, press or say 2.*
>
> *If it is all numeric or you know how to enter letters, press or say 2."*

If you chose 2, you will hear the following message:

> *"Please enter the beneficiary's identification number.*
> *You entered <xxxxxxxxx>.*
>
> *If this is correct, press or say 1.*
> *If not, press or say 2."*

Beneficiary Birth Date

If the beneficiary ID number you enter is invalid, AEVS will prompt you to re-enter the number. If the beneficiary identifier is entered correctly, you will receive the following message:

> *"Please enter the two-digit month and four-digit year of the beneficiary's birth. For example, June, 1972, would be entered as 0-6-1-9-7-2."*

Verifying Newborn Infant SOC

If you are performing this transaction for services rendered to a newborn infant billing on the mother's ID number, enter the mother's date of birth.

Date of Service

Please enter the date of service using two-digit day and four-digit year. To enter today's date press star.

"You entered <xxxxxx>.
If this is correct, press or say 1.
If not, press or say 2."

If you press or say an invalid date you will hear the following message:

"That date is not valid. You must enter an eight-digit number only. Please enter the date of service <MMDDYYYY>."

If the date of service that you entered is invalid, AEVS will prompt you to re-enter the date.

Note: If you have to re-enter the date of service, this is considered to be an additional inquiry and will count against the 10 inquiries you are allowed per call.

Procedure Code

If the date is entered correctly, you will receive the following message:

"If the procedure code includes letters and you need help entering the letters, press or say 1.

If it is all numeric or you know how to enter the letters, press or say 2."

If you chose option 1, you will hear the following message:

"If the procedure code includes letters and you need help entering letters, press or say 1.

If it is all numeric or you know how to enter letters, press or say 2."

If you chose option 2 you will hear the following message:

"Please enter a procedure code followed by the pound sign.

You entered <xxxxxxxx>.
If this is correct, press or say 1.
To re-enter, press or say 2."

Total Billed Amount

If you press 1, you will hear the following message:

> *"Please enter the total claim charged amount including dollars and cents followed by a pound sign (#). For example, twenty dollars and fifty cents would be entered 2-0-5-0#".*

If the amount you entered is invalid, AEVS will prompt you to re-enter the amount. If the amount is entered correctly, you will receive the following message:

> *"You entered <xxxxxxxx>.*
> *If this is correct, press or say 1.*
> *To re-enter, press or say 2."*

Requesting Reversal SOC Non-Phased-In Counties not

If you request a SOC clearance for a beneficiary whose county has phased to plastic Benefits Identification Cards (BICs), you will hear the following message:

> *"The Share of Cost clearance system is not operative in the beneficiary's county for the month requested. Use the MC 177 form for Share of Cost clearance."*

MEDI-SERVICE RESERVATION OR REVERSAL

Introduction

The following process is used to access the Medi-Cal eligibility verification system to complete a Medi-Service reservation or reversal transaction. This inquiry can be performed only by the following providers:

- Podiatrists
- Acupuncturists
- Chiropractors
- Occupational Therapists
- Psychologists
- Speech Pathologists
- Audiologists

Provider Identification Number (PIN)

Using a touch-tone telephone, dial 1-800-456-AEVS (2387). AEVS will respond with the following message:

> *"Welcome to Medi-Cal. For English press or say 1. Para Español marque dos.*
>
> *Please enter your PIN followed by the pound sign."*

Enter your Provider Identification Number (PIN).

When the entered PIN is associated with both NPI and Legacy ID, the NPI will be given as the first option to select. In this case AEVS will respond with the following message:

> *"If your Provider Number is (NPI), press 1.*
> *If your Provider Number is (Legacy ID), press 2.*
> *Or press 3 to re-enter your PIN."*

The second option will be unavailable if only Legacy ID or NPI is associated with the entered PIN.

For Medi-Service Reversal Transaction providers are requested to select the Provider Number that was submitted in the original Medi-Service Reservation transaction.

If the PIN cannot be found on the Provider Master File, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the third try, the call will be terminated with the following message:

"We are unable to locate the Provider Identification Number. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."

Transaction Menu

If the PIN can be verified by AEVS, you will receive the following prompt:

"For Eligibility Verification, press or say 1. For Share of Cost, press or say 2. To perform a Medi-Service transaction, press or say 3. For general information please visit us on the Web at www.medi-cal.ca.gov."

Press 3 to reserve a Medi-Service or to reverse a previous reservation. You will then hear the following message:

"To perform an update, press 1. To perform a reversal, press 2."

Beneficiary ID Number

Press 1 to verify eligibility. You will then hear the following message:

"If you know the beneficiary ID press or say 1.
If not, press or say 2."

If you chose 1, you will hear the following message:

"The beneficiary identification number can be found on the face of the Benefits Identification Card. If the beneficiary identification number includes letter, and you need instructions on how to enter them, press or say 1."

If you press or say 1, you will hear the following:

"To enter a letter, you must press three keys. First, press star (*), then press the key which has the letter you want, finally press one, two, three or four to indicate the position of the letters on that key. You enter numbers normally. For example, for A-2-3-Z, press star-two-one, two, three, star-nine-four. If you need to hear this message again, press or say 1."

If you are ready to enter the beneficiary number, press or say 2.

If it is all numeric or you know to enter letters, press or say 2."

If you chose 2, you will hear the following message:

> *"Please enter the beneficiary's identification number. You entered <xxxxxxxxx>.*
>
> *If this is correct, press or say 1.*
> *If not, press or say 2."*

Enter the beneficiary's Medi-Cal identification number followed by the pound sign key (#). If there are any alpha characters in the number, press the star key (*) and number keys that correspond with the letter.

Beneficiary Birth Date

If the beneficiary ID number you enter is invalid, AEVS will prompt you to re-enter the number. If the beneficiary identifier is entered correctly, you will receive the following message:

> "*Please enter the two-digit month and four-digit year of the beneficiary's birth. For example, June, 1972, would be entered as 0-6-1-9-7-2.*
>
> *You entered <xxxxxx>.*
> *If this is correct, press or say 1.*
> *If not, press or say 2."*

If you enter an invalid beneficiary date of birth you will hear the following message:

> "*The birth date you entered does not match our records. The date you entered is invalid. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. Denti-Cal providers should call 1-800-541-5555. Thank you for calling the Automated Eligibility Verification System. Good-bye "*

Verifying Newborn Infant Eligibility

If you are verifying eligibility for a newborn infant billing on the mother's ID number, enter the mother's date of birth.

Date of Service

Please enter the date of service using the two-digit month, two-digit day and four-digit year. To enter today's date press star:

"*You entered <xxxxxxxx>.*
If this is correct, press or say 1.
If not, press or say 2."

If you press or say an invalid date you will hear the following message:

"*That date is not valid. You must enter an eight-digit number only. Please enter the date of service. <MMDDYYYY>"*

If the date of service that you entered is invalid, AEVS will prompt you to re-enter the date.

Note: If you have to re-enter the date of service, this is considered to be an additional inquiry and will count against the 10 inquiries you are allowed per call.

Procedure Code

If the date is entered correctly, you will receive the following message:

"If the procedure code includes letters and you need help entering the letters, press or say 1.

If it is all numeric or you know how to enter the letters, press or say 2."

If you chose option 1, you will hear the following message:

"If the procedure code includes letters and you need help entering letters, press or say 1.

If it is all numeric or you know how to enter the letters, press or say 2."

If you chose option 2 you will hear the following message:

"Please enter a procedure code followed by the pound sign (#).

You entered <xxxxxxxx>.
If this is correct, press or say 1.
To re-enter, press or say 2."

Reservation Available

If you press 1, you will hear the following message if you requested a Medi-Service reservation and the beneficiary has remaining reservations:

"The Medi-Service reservation was applied.

For additional Medi-Service reservations for this beneficiary, press or say 1.

To return to the main menu, press or say 9."

Reservation Declined

If the Medi-Service reservation is not required you will hear the following:

"No Medi-Service is required for this procedure.
The Medi-Service was rejected.
For additional Medi-Service reservations for this beneficiary, press or say 1.

To return to the main menu, press or say 9."

Reservation Not Available

If the beneficiary has no more available Medi-Service reservations you will hear the following:

"The beneficiary has no more Medi-Services available for <month><year>.
The Medi-Service reservation was rejected.
For additional Medi-Service reservations for this beneficiary, press or say 1.
To return to the main menu, press or say 9."

Reserving Additional Medi-Service Reservations

If you press 1, you will hear the preceding response again. If you press 2, you will hear the following message:

"For additional Medi-Service reservations for this beneficiary, press 1. Otherwise, press or say 9 to return to the Main Menu."

Note: If the first Medi-Service reservation was rejected or there are no more Medi-Service reservations available, press or say 9 to return to the main menu.

Reservation Unavailable	If you press 1, you will hear the following message if you requested a Medi-Service reservation and the beneficiary has no more reservations: *"The beneficiary has no more Medi-Services available for (month) (year). The Medi-Service reservation was rejected."*
Service Does Not Require Medi-Service Reservation	If you press 1, you will hear the following message if you requested a Medi-Service reservation and the procedure is not a Medi-Service procedure: *"No Medi-Service reservation is required for this procedure. The Medi-Service reservation was rejected."*
Medi-Service Reversal: No Claim Paid in History	If you press 1, you will hear the following message if you requested a Medi-Service reversal and you have not yet been paid for the procedure on the date of service: *"The Medi-Service Reversal was applied."*
Medi-Service Reversal: Claim Paid in History	If you press 1, you will hear the following message if you requested a Medi-Service reversal and you have already been paid for the procedure on the date of service: *"The Medi-Service has already been used on a claim paid by Medi-Cal."* **Note:** You will receive this message if the Medi-Cal eligibility system has marked the claim as paid, even if you have not yet received the warrant in the mail.
Requesting Medi-Services For Non-Phased-In Counties	If you request a Medi-Service reservation for a beneficiary whose county has not phased to plastic Benefits Identification Cards (BICs), you will hear the following message: *"The Medi-Service system is not operative in the beneficiary's county for the month requested."* If you receive this message, submit your claim with a MEDI label from the beneficiary's paper card.

STATE-ONLY FAMILY PLANNING – See *AEVS User Guide for AEVS Transactions - SOFP*

CMS 1500 – Completion Instructions

REQUIRED INFORMATION

Box #1a Insured's correct Medi-Cal Identification Number/Social Security Number.

Box #2 Consumer's Full Name as recognized by Medi-Cal or as indicated on their Benefit Identification Card (BIC), last name, first name and initial (if applicable).

Box #3 Correct Date of Birth and Gender (male or female).

Box #5 Complete home address and telephone number.

Box #11 Enter the Eligibility Verification Confirmation (EVC) Number, Month/Year and any Share of Cost (SOC) amount.

Box #11d Is there another Health Benefit Plan? If so, Provider is to bill the carrier and then submit a Medi-Cal claim with a copy of the Denial letter or Explanation of Benefits (EOB) **within 30 days** of the date of the denial or EOB.

Box #12/13 Patient's signature or noted that signature is "On File".

Box #21 Diagnosis "A" **must** be an included diagnosis code or a "rule-out" diagnosis for assessments.

Box #24

a) Date of Service must match date in chart notes.
b) Place of Service.
d) FCMHP Service Codes must be those on the Provider Fee Schedule.
e) Diagnosis must equal item "A" in Box 21.
f) Charges should not be less than reimbursable rate.
g) Units must be correct.

Box #25 Federal Tax ID Number is required as indicated in Provider Contract.

Box #28 Total of all charges.

Box #29 Indicate the SOC amount (whether collected or not collected).

Box #30 Balance Due = Total charge less SOC.

Box #31 Original signature required of Provider or authorized biller for the Provider, along with Provider's credentials. Do not pre-date this box. The date the claim is signed must not be prior to the services provided, as shown in Box #24.

Box #32 Name and Address of Facility where services were rendered is required for Inpatient Claims or outpatient services as appropriate.

Box #33 Provider or Group Name and complete address with telephone number.

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CMS 1500 Field Location	Required Field?	Description and Requirements
24B	**Required**	Place of Service - Enter one code indicating where the service was rendered. 01 - Pharmacy 03 - School 04 - Homeless Shelter 05 - Indian Health Service Free-Standing Facility 06 - Indian Health Service Provider-Based Facility 07 - Tribal 638 Free-Standing Facility 08 - Tribal 638 Provider Based-Facility 11 - Office Visit 12 - Home 13 - Assisted Living 14 - Group Home 15 - Mobile Unit 20 - Urgent Care Facility 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room 24 - Ambulatory Surgical Center 25 - Birthing Center 26 - Military Treatment Facility 31 - Skilled Nursing Facility 32 - Nursing Facility 33 - Custodial Care Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance - Air or Water 50 - Federally Qualified Health Center 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 54 - Intermediate Care Facility 55 - Residential Substance Abuse Treatment Facility 56 - Psychiatric Residential Treatment Center 60 - Mass Immunization Center 61 - Comprehensive Inpatient Rehab Facility 62 - Comprehensive Outpatient Rehab Facility 65 - End Stage Renal Disease Treatment Facility 71 - State or Local Public Health Clinic 72 - Rural Health Clinic 81 - Independent Laboratory 99 - Other Unlisted Facility
24C	***If Applicable***	Emergency Indicator - Check box and attach required documentation.

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Medi-Cal Aid Codes Appropriate for Mental Health Services (FFP Medi-Cal Funding)

Code	MHS
01	Yes
02	Yes
03	Yes
04	Yes
06	Yes
07	Yes
08	Yes
10	Yes
13	Yes
14	Yes
16	Yes
17	Yes
18	No
20	Yes
23	Yes
24	Yes
26	Yes
27	Yes
28	Yes
30	Yes
32	Yes
33	Yes
34	Yes
35	Yes
36	Yes
37	Yes
38	Yes
39	Yes
40	Yes
42	Yes
43	Yes
44	Yes
45	Yes
46	Yes
47	Yes
48	Yes
49	Yes
53	No
54	Yes

Code	MHS
55	Yes
58	Yes
59	Yes
60	Yes
63	Yes
64	Yes
65	No
66	Yes
67	Yes
68	Yes
69	Yes
72	Yes
74	Yes
76	Yes
80	Yes
81	No
82	Yes
83	Yes
86	Yes
87	Yes
0A	Yes
0M	Yes
0N	Yes
0P	Yes
0R	No
0T	No
0U	Yes
0V	Yes
0W	Yes
1E	Yes
1H	Yes
1U	Yes
1X	Yes
1Y	Yes
2A	Yes
2E	Yes
2H	Yes
3A	Yes
3C	Yes

Code	MHS
3D	Yes
3E	Yes
3F	Yes
3G	Yes
3H	Yes
3L	Yes
3M	Yes
3N	Yes
3P	Yes
3R	Yes
3T	Yes
3U	Yes
3V	Yes
3W	Yes
4A	Yes
4E	Yes
4F	Yes
4G	Yes
4H	Yes
4K	Yes
4L	Yes
4M	Yes
4N	Yes
4P	No
4R	No
4S	Yes
4T	Yes
4W	Yes
5C	Yes
5D	Yes
5E	Yes
5F	Yes
5J	Yes
5K	Yes
5R	Yes
5T	Yes
5W	Yes
6A	Yes
6C	Yes

Code	MHS
6E	Yes
6G	Yes
6H	Yes
6J	Yes
6N	Yes
6P	Yes
6R	Yes
6U	Yes
6V	Yes
6W	Yes
6X	Yes
6Y	Yes
7A	Yes
7C	Yes
7J	Yes
7K	Yes
7M	Yes
7N	No
7P	No
7S	Yes
7U	Yes
7W	Yes
7X	Yes
8E	Yes
8G	Yes
8N	Yes
8P	Yes
8R	Yes
8T	Yes
8U	Yes
8V	Yes
8W	Yes
8X	Yes
8Y	No
9H	Yes
9R	Yes
C1	Yes
C2	Yes
C3	Yes

Code	MHS
C4	Yes
C5	Yes
C6	Yes
C7	Yes
C8	Yes
C9	Yes
D1	Yes
D2	Yes
D3	Yes
D4	Yes
D5	Yes
D6	Yes
D7	Yes
D8	Yes
D9	Yes
E1	Yes
E2	Yes
E4	Yes
E5	Yes
E6	Yes
E7	Yes
G0	Yes
G1	Yes
G2	Yes
G5	Yes
G6	Yes
G7	Yes
G8	Yes
G9	Yes
H0	Yes
H1	Yes
H2	Yes
H3	Yes
H4	Yes
H5	Yes
H6	Yes
H7	Yes
H8	Yes
H9	Yes

Code	MHS
J1	Yes
J2	Yes
J3	Yes
J4	Yes
J5	Yes
J6	Yes
J7	Yes
J8	Yes
K1	Yes
L1	Yes
L2	Yes
L3	Yes
L4	Yes
L5	Yes
M0	Yes
M1	Yes
M2	Yes
M3	Yes
M4	Yes
M5	Yes
M6	Yes
M7	Yes
M8	Yes
M9	Yes
N0	Yes
N5	Yes
N6	Yes
N7	Yes
N8	Yes
N9	Yes
P0	Yes
P1	Yes
P2	Yes
P3	Yes
P4	Yes
P5	Yes
P6	Yes
P7	Yes
P8	Yes

Code	MHS
P9	Yes
R1	No
T0	Yes
T1	Yes
T2	Yes
T3	Yes
T4	Yes
T5	Yes
T6	Yes
T7	Yes
T8	Yes
T9	Yes

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SECTION 7: QUALITY MANAGEMENT

7.0 Quality Management Overview

The Fresno County Mental Health Plan (FCMHP) is responsible in assuring that high quality services are provided to mental health beneficiaries in a cost-effective and efficient manner. It is broad in scope, reflecting a range of clinical care, service and organizational issues that are relevant to beneficiaries and providers. More importantly, it is designed to provide the framework within which the FCMHP monitors and improves the quality of care, service, and organizational performance.

The FCMHP staff reviews services and programs of all providers to ensure:

- Accessibility of services
- Services are meaningful and beneficial to the beneficiary
- Services are culturally and linguistically competent; and
- Services that produce highly desirable results through the efficient use of resources.

7.1 Provider Training

The FCMHP provides one-to-one training to providers regarding medical necessity criteria, patient's rights issues, billing and claims, documentation requirements, and other relevant topics. Provider training is available after credentialing with the FCMHP, following annual chart reviews to address areas of compliance in which the provider may need assistance, and upon the provider's request.

For Individual and Group Providers, training may be arranged by contacting a Provider Relations Specialist (PRS) at the Managed Care office. The PRS will work with providers to schedule a training date and time. If the requested training is regarding completion and/or payment of claims, then the PRS will conduct the training. If the requested training is clinical in nature (medical necessity, documentation, etc.), the Managed Care Clinical Supervisor will assign clinical staff as needed to conduct the training.

Organizational providers may request training through their assigned contract analyst. If the requested training is regarding the provider's specific contract, as it pertains to billing, scope of work, contractual requirements, etc., the assigned contract analyst will work with the provider. If the requested training is clinical in nature (medical necessity, documentation, etc.), the Managed Care Clinical Supervisor will assign clinical staff as needed to conduct the training.

7.2 Provider Credentialing

The FCMHP requires its providers to comply and maintain professional competencies in their fields of expertise. To ensure competency, a provider credentialing process is followed for all new and current providers. Credentialing Application packets can be found online at: http://www.co.fresno.ca.us/departments /behavioral-health/managed-care/become-a-contract-provider

7.2.1 Credentialing Committee

The Committee is a confidential, multi-disciplinary body appointed by the Director of Behavioral Health, Behavioral Health Medical Director, and the Managed Care Division Manager. The function of the Committee is to ensure that all providers are highly qualified to provide mental health services to Fresno County beneficiaries.

7.2.2 Credentialing Standards

- All FCMHP providers will have a verified and approved credentialing packet on file.
- The Credentialing Committee has the authority to grant probationary or provisional status.
- The FCMHP will query the following sources:
    - Licensing Boards (all current and previous licenses will be reviewed)
    - Medi-Cal Suspended and Ineligible Provider List
    - Office of Inspector General List of Excluded Individual/Entities
    - National Practitioner Data Bank
    - System for Award Management (SAM)
- Provider Relations Specialists from Managed Care will verify all information concerning licensure, certificates, malpractice coverage, letters of reference, and education for applicants.
- Each application for credentialing will be reviewed by the FCMHP Credentialing Committee. The committee is comprised of appointed, licensed staff that review, approve, and vote on credentialing applications. If, during the review, the committee discovers information concerning competency,

malpractice, limitation of privileges, on-going ethical investigations, or other factors presenting potential risk to the FCMHP, the application may be denied.

- Applications received for providers that were previously denied within the past 7 years will be denied.

- Providers who are denied will receive written notice within fifteen (15) days of the decision.

- Any provider not satisfied with the decision rendered by the Credentialing Committee may appeal by requesting a formal meeting with the Credentialing Committee to discuss the decision. The request must be in writing and must be received in the Managed Care office within 30 days of the denial notice being served.

- All licenses, certificates, and insurance coverage must remain current at all times.

- All providers will be re-credentialed at least every three years.

- At time of recredentialing, audit results, history of compliance and beneficiary grievances will be reviewed.

7.3 Contract Requirements

A provider must first enter into a contractual agreement with the FCMHP before rendering specialty mental health services to a Fresno County Medi-Cal beneficiary. The Agreement is effective upon execution by the FCMHP and the provider and remains effective until terminated by action of the provider or the FCMHP.

The FCMHP may immediately suspend or terminate the agreement when the FCMHP determines any of the following:

- Illegal or improper use of funds
- Failure to comply with any term of the agreement
- Improperly performed service
- A substantially incorrect or incomplete report is submitted to the FCMHP.

Other terms and conditions related to termination of the agreement are described in the contract. Upon termination of the agreement for any reason, the provider will cooperate with the FCMHP in ensuring an orderly

transition of care for beneficiaries under treatment, including, but not limited to, the transfer of all beneficiaries' medical records to the FCMHP. Refer to Section 1.8 – Provider Transition Plan, for more details.

7.4 Potential Tort, Casualty, or Worker's Compensation Awards

Providers must notify the FCMHP immediately for any potential tort, casualty insurance, or Worker's Compensation awards that may reimburse the provider for any covered SMHS rendered by the provider to a beneficiary. (Please see the Tort, Casualty, or Worker's Compensation form, at the end of this section, which providers must complete and submit to the FCMHP in case of potential awards.)

7.5 License and Insurance Coverage Requirements

Providers must maintain current and active professional license(s) while contracted with Fresno County. Physicians must submit a current copy of their DEA certificate. Failure to meet these requirements will result in withholding of payments for current and future claims and/or contract termination.

Providers must notify the FCMHP immediately for any changes in his/her license status, imposed by the California Board of Behavioral Sciences or other licensing agencies.

Providers must submit a copy of the annual renewal of required insurance coverage certificates. Failure to provide evidence of current and adequate insurance coverage will result in withholding of payments for claims and/or contract termination.

7.6 Quality Improvement Plan

The California Department of Health Care Services requires that each FCMHP submit an annual Quality Improvement Work Plan. Likewise, the FCMHP requires its organizational providers to develop and implement an annual Quality Improvement Work plan. Individual and Group providers are **not** subject to this requirement.

In the plan, the provider identifies the areas which should be monitored or where improvement is sought. The Quality Improvement Division is available to assist in identifying outcome indicators to monitor and track. There is a wide range of items that can be monitored-examples include access to mental health services, beneficiary satisfaction, documentation review, staff training, or beneficiary education.

Improvement can be measured by comparing outcome with information from the previous year. The beneficiary satisfaction survey may be included as part of the Quality Improvement Work Plan if it is used to monitor an outcome indicator.

Each organizational provider is expected to report their progress on their outcome indicators at the Quality Improvement Council meeting at the beginning of each calendar year.

7.7 Satisfaction Surveys

The overall objective of the monitoring and evaluation process is to assure that beneficiaries receive appropriate care from competent providers at a fair and manageable cost. The Quality Improvement Division will monitor beneficiaries' satisfaction with services they receive from providers through beneficiary satisfaction survey.

The FCMHP will also monitor providers' satisfaction with the FCMHP through provider satisfaction surveys.

7.8 Outcome Studies

Each organizational provider contracted with the FCMHP (with the exception of organizational providers offering Therapeutic Behavioral Services only) is required to implement the outcome measure system for children, youth, and adults.

Organizational providers shall utilize the outcome measure results in their quality improvement programs. Completed outcome measure instruments must be submitted to the FCMHP as scheduled.

Provider Responsibilities

Satisfaction Questionnaires for adult, children and youth outcome measure instruments must not be administered by the staff delivering direct service to the beneficiary.

An interpreter or bilingual staff must be available to administer the outcome measure instruments to non-English speaking beneficiaries. Interpreter or bilingual staff must give beneficiary a copy of the translated instrument to follow along as he/she reads the instrument. If interpreter or bilingual staff is unavailable or beneficiary refuses assistance, beneficiary will be asked to write the number to responses directly on the translated instrument after the question.

The FCMHP will provide regular trainings to keep providers abreast of current outcome requirements.

Confidentiality

Organizational provider must maintain beneficiary confidentiality during administration of the instrument. Organizational provider must keep the original copies of the outcome measure instruments in a safe, locked cabinet or beneficiary's medical record. The outcome printouts must be kept in the beneficiary's medical record.

7.9 Consent for Treatment Form

The FCMHP requires its providers to obtain beneficiary's consent before the beginning of treatment, and annually thereafter. FCMHP staff will review this form during the annual medical record review. A provider's credentialing status may be affected if provider does not consistently obtain the beneficiary's consent prior to beginning of treatment. This form must be available in the beneficiary's primary language if beneficiary is monolingual. Refer to end of this section for sample of the Consent for Treatment form.

7.10 Medication Consent Form

The FCMHP requires contracted psychiatrists to obtain Medication Consent when medications are prescribed. The beneficiary, or legal guardian, must sign the Medication Consent form when starting a new medication, and whenever a change in medication class or addition of new class of psychotropics occurs (e.g., addition of antidepressant to medication regime, change from antidepressant to anti-psychotic medication). This form must be available in the beneficiary's primary language if beneficiary is monolingual. The consent must be kept in the medical record at all times.

FCMHP will staff review this form during the annual medical record review. A provider's credentialing status may be affected if provider does not consistently obtain beneficiary's consent. Refer to end of this section for sample of the Medication Consent form.

7.11 Abnormal Involuntary Movement Scale (AIMS) Form

An AIMS survey must be completed once a year by prescribing psychiatrist for all beneficiaries who are on antipsychotic medications.

FCMHP staff will review this form during the annual medical record review. A provider's credentialing status may be affected if provider does not consistently complete an AIMS survey/form. Refer to end of this section for sample of the AIMS form.

7.12 Advance Directives

Federal Medicaid Managed Care Regulations require the FCMHP to provide adult beneficiaries with written information about Advance Directives when the beneficiary first receives a specialty mental health service (usually when the Plan of Care is being developed) from the FCMHP or one of its contracting providers.

An Advance Directive only goes into effect when the beneficiary's physician/clinician decides that the beneficiary no longer has the **capacity** to make their own health care decisions. Capacity refers to the ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and make and communicate a decision. An Advance Directive is no longer in effect as soon as the person regains the capacity to make their own health care decisions.

The FCMHP requires all contracted providers to ask adult Medi-Cal beneficiaries if they want to execute or have executed an Advance Directive. The beneficiary's response shall be documented on the Plan of Care. If the beneficiary has executed an Advance Directive, the provider must ask the beneficiary for a copy of the Advance Directive and must file it under the "Legal" tab in the mental health record; if no Advance Directive has been executed, the provider will give beneficiary the FCMHP's Advance Directive brochure.

Providers must ensure that the beneficiary's Advance Directive is valid. A valid Advance Directive must have signatures of two witnesses, as well as the signature of the beneficiary or their mark and an appropriate witness signature. If the beneficiary is incapacitated and unable to receive the information at the time of admission to mental health services, then the information about Advance Directives may be given to family members or others involved in their care. Once the beneficiary has capacity, the Advance Directive information shall be offered to them. The FCMHP provides the Advance Directive brochure online (in English, Spanish, and

Hmong) at: http://www.co.fresno.ca.us/departments/behavioral-health/managed-care/consumer-and-provider-downloads

In the event that a beneficiary feels that a contract provider is not honoring their advance directive(s), they should address their complaint to:

California Department of Public Health
Licensing and Certification
P.O. Box 997377, MS 3000
Sacramento, CA 95899-7377
Telephone: (800) 236-9747 (Toll-Free)

7.13 HIPAA and security of Protected Health Information

The FCMHP requires all contract providers to adhere to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA). The FCMHP and its Providers each consider and represent themselves as covered entities as defined by HIPAA. The FCMHP and Provider(s) agree to use and disclose Protected Health Information (PHI) as required by law. The exchange of PHI shall be limited for purposes of treatment, payment, and health care operations. Per this understanding, the FCMHP and its providers intend to protect beneficiary privacy and provide for the security of PHI of all beneficiaries.

7.13.1 What is considered Protected Health Information?

Protected health information is any individually identifiable health information. Examples include, but are not limited to: Phone numbers, Social Security numbers, Home/mailing addresses, dates of birth, and insurance or other ID numbers. Any information that could potentially be used to identify a beneficiary should be considered PHI.

7.13.2 Guidelines for securing Protected Health Information

- Medical records containing PHI must be stored in one central location, secure and inaccessible (preferably locked) to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration, or destruction of the records.

- Medical records and other documents containing PHI must only be accessible for authorized staff within the provider's office, FCMHP Staff with proper identification that require access for

purposes of quality and utilization review, or to persons authorized through a legal instrument (i.e., subpoena).

- Confidential beneficiary information being transmitted electronically must be encrypted according to Advanced Encryption Standards (AES) of 128-bit or higher. Additionally, a password or pass phrase must be utilized.

- When confidential beneficiary information is being transmitted via Facsimile (Fax), always be sure to confirm that the information is being transmitted to the correct fax number. Additionally, always contact someone on the receiving end who can receive the fax as it arrives to prevent unauthorized access.

7.13.3 What to do if PHI is compromised or potentially compromised

Providers are responsible to notify the FCMHP, as soon as possible, of any violations, breaches, or potential breaches of security related to the FCMHP's confidential information, confidential data maintained in computer files, processing systems that handle confidential data, and data processing equipment which stores or processes confidential data internally or externally.

Some examples of a breach or potential breach of PHI include, but are not limited to:

- Accidentally transmitting a Fax containing PHI to an incorrect fax number.

- Accidentally sending an E-mail containing PHI to an incorrect e-mail address.

- Accidentally mailing documents containing PHI to an incorrect address.

- Failing to secure medical records or other documents containing PHI, leaving them unattended in patient waiting rooms, reception areas, examination rooms, etc., potentially exposing them to unauthorized disclosure and review.

- Leaving a computer workstation unlocked and unattended that contains or has access to PHI or other confidential information, potentially exposing the information to unauthorized disclosure and review.

- An office break-in, where areas containing records or documents with PHI appear to have been broken in to, or where records containing PHI were left out unsecured, potentially exposing them to unauthorized disclosure and review.

In the event of a breach of PHI or other confidential information, providers are responsible to issue any notification to affected individuals as required by law or deemed necessary by the FCMHP in its sole discretion.

The FCMHP requires all providers who are covered entities under HIPAA to comply with all HIPAA regulations whenever Fresno County Medi-Cal beneficiaries may be affected or impacted.

7.14 FCMHP Compliance Program

Federal Medicaid Managed Care regulations require that FCMHP's have administrative and management arrangements or procedures, including a mandatory compliance program, designed to guard against fraud and abuse (Title 42, Code of Federal Regulations, Chapter 4, Section 438.608: Program Integrity Requirements). The Compliance Program has general and specific requirements that affect all providers of mental health services. The FCMHP Compliance Program requires all of its contracted providers to understand the contents of the Compliance Program and abide by all of its requirements.

The Fresno County Mental Health Compliance Program has adopted policies and procedures regarding the prevention and detection of fraud, waste and abuse in Federal health care programs as required by the **Federal Deficit Reduction Act** (DRA) signed into law in February 2007. (Refer to the Fresno County Mental Health Plan Compliance Program Policy and Procedure Guide entitled, "Prevention, Detection, and Correction of Fraud, Waste and Abuse" at the end of this section) This County policy is applicable to County contractors providing health services for which Medi-Cal monies are received. A copy of this policy, which cites information from the Federal False Claims Act and California False Claims Act, must be provided to all employees and subcontractors and remain readily accessible to employees and subcontractors at all times.

7.14.1 Contractor Code of Conduct and Ethics

Fresno County is firmly committed to full compliance with all applicable laws, regulations, rules and guidelines that apply to the provision and payment of mental health services.

Mental health contractors and the manner in which they conduct themselves are a vital part of this commitment.

Fresno County has established this Contractor Code of Conduct and Ethics with which contractor and its employees and subcontractors shall comply. Contractor shall require its employees and subcontractors to attend a compliance training that will be provided by Fresno County. After completion of this training, each contractor, contractor's employee and subcontractor must sign the Contractor Acknowledgment and Agreement form and return this form to the Compliance Officer or designee.

Contractor and its employees and subcontractors shall:

1. Comply with all applicable laws, regulations, rules or guidelines when providing and billing for mental health services.
2. Conduct themselves honestly, fairly, courteously and with a high degree of integrity in their professional dealings related to their contract with the County and avoid any conduct that could reasonably be expected to reflect adversely upon the integrity of the County.
3. Treat County employees, beneficiaries and other mental health contractors fairly and with respect.
4. NOT engage in any activity in violation of the County's Compliance Program, nor engage in any other conduct that violates any applicable law, regulation, rule or guideline.
5. Take precautions to ensure that claims are prepared and submitted accurately, timely and are consistent with all applicable laws, regulations, rules or guidelines.
6. Ensure that no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind are submitted.
7. Bill only for eligible services actually rendered and fully documented. Use billing codes that accurately describe the services provided.
8. Act promptly to investigate and correct problems if errors in claims or billings are discovered.
9. Promptly report to the Compliance Officer any suspected violation(s) of this Code of Conduct and

Ethics by County employees or other mental health contractors, or report any activity that they believe may violate the standards of the Compliance Program, or any other applicable law, regulation, rule or guideline. Fresno County prohibits retaliation against any person making a report. Any person engaging in any form of retaliation will be subject to disciplinary or other appropriate action by the County. Contractor may report anonymously.

10. Consult with the Compliance Officer if you have any questions or are uncertain of any Compliance Program standard or any other applicable law, regulation, rule or guideline.
11. Immediately notify the Compliance Officer if they become or may become an Ineligible Person and therefore excluded from participation in the Federal health care programs.

7.14.2 Training and Education

The FCMHP will provide initial and annual General Compliance training to all contract providers. Documentation and billing training will be provided within 30 days of contract implementation and when requested by the contractor.

7.14.3 Communication

Effective lines of communication between the Compliance Officer and contract providers are critical for the adherence to and effectiveness of the Compliance Program. Communication may consist of or be in the form of formal trainings, e-mail, internet or other appropriate means.

7.14.4 Reporting Violations or Suspected Non-compliance

Contract providers are expected to report any activity that may violate the Compliance Program's mission, standards, and any applicable law, regulation, rule or guideline. The FCMHP prohibits retaliation against any person making a report. Any FCMHP employee engaging in any form of retaliation will be subject to disciplinary action.

The goal of all reporting methods is to provide opportunities for the identification, investigation, correction and prevention of

inappropriate activities. Providers may report anonymously by the methods described below.

- **TELEPHONE**: The compliance Hotline (1-888-262-4174) is available Monday through Friday, 8 a.m. to 5 p.m. The Compliance Officer may also be reached directly at (559) 600-6728. All calls will remain confidential and private and every caller has the option to remain anonymous (the phone number will not be identified or traced.) If the caller wishes to remain anonymous, he/she will be given a log number. Using this log number, the caller will be urged to call back within 20 days to find out the status of their report. This is also an opportunity for the caller to provide more information if needed by the investigation staff.
- **FAX**: (559) 453-4554
- **MAIL**: Addressed to: FCMHP Compliance Officer, 1925 E. Dakota Ave, Fresno, CA 93726.
- **INTERNET**: Using the FCMHP website, click the anonymous Reporting Form link located on the County website at: http://www.co.fresno.ca.us/departments /behavioral-health/mental-health-compliance/report-a-violation-or-suspected-non-compliance/fresno-county-department-of-behavioral-health-re

7.14.5 Clarification

With ongoing changes in federal and state regulations, it is expected that providers may be uncertain of or have questions about practice and procedures. It is also expected that providers will need clarification on compliance standards and procedures. Questions should be directed to the Compliance Officer by telephone (1-888-262-4174) or e-mail (*evasquez@FresnoCountyCA.gov*). These requests will be documented and presented for review to the Compliance Committee to determine if there are specific departments, areas or programs that should be reviewed for possible non-compliance.

7.14.6 Enforcement and Discipline

A Contract provider's non-adherence to the FCMHP Compliance Program may result in termination of the Agreement between the County of Fresno and the provider.

7.14.7 Monitoring and Auditing Procedures

The FCMHP conducts periodic medical record reviews of all its contracted providers to ensure compliance with established standards. Refer to Section 10, Site Certification/Medical Record Review, for details.

7.14.8 Corrective Action

Overpayments to contract providers by the FCMHP, discovered through any means, must be adjusted and refunded to the appropriate payer source within 60 days of the discovery. Organizational providers must immediately report the overpayment to the provider's contract analyst. Individual and Group providers must immediately report the overpayment to the Managed Care office. Failure to report or repay an overpayment within a reasonable amount of time could be interpreted as an intentional attempt to conceal it. Examples of overpayments include, but are not limited to:

- Paid twice for the same service, either by the same payer or a combination of payers;
- Paid for services that were planned but not actually provided;
- Paid for services that were not a covered benefit;
- Paid for services that are lockouts or were included in the per diem rate.
- Paid for services that were not adequately documented.

The FCMHP Compliance Officer will promptly investigate every report or discovery of suspected non-compliance. The investigation may include interviews of employees or other person(s) as needed, review of relevant records or documents, research of regulations, contracts or other information as appropriate, and access to other relevant documentation or assistance of any person(s) inside or outside of the organization.

7.15 Compliance to Regulations

The FCMHP expects providers to adhere to Title XIX of the Social Security Act and conform to all applicable laws, rules, regulations and guidelines.

Section 7:

Quality Management

Forms and Attachments

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Section: **Administration**

Effective Date: **12/22/2006** **Revised Date: 07/31/2019**

Policy Title: **Prevention, Detection, and Correction of Fraud, Waste and Abuse**

Approved by: Betty Brown (Division Manager - Managed Care), Dawan Utecht (Director of Behavioral Health), Elizabeth Vasquez (Compliance Officer)

POLICY: Fresno County will maintain a comprehensive Compliance Program that includes auditing, monitoring, and reporting methods to prevent, detect, and correct fraud, waste and abuse. All Fresno County employees, contractors (including contractor's employees and subcontractors), volunteers and students (hereinafter referred to as "Covered Persons") have a duty to participate in efforts to prevent fraud, waste and abuse and ensure that public resources are used ethically, prudently and for legally designated purposes.

PURPOSE: To communicate to all Covered Persons the procedures and methods for preventing, detecting and correcting fraud, waste and abuse.

REFERENCE: Fresno County Compliance Program; Fresno County Board of Supervisors Code of Ethics; California Government Code § 12650-12656; United States Code Title 18-Federal Criminal False Claims; United States Code Title 31-Federal Civil False Claims; Deficit Reduction Act of 2005

DEFINITIONS: Audit: to methodically review and examine records or accounts to check the accuracy of the information.

Monitoring: for the purposes of this policy means to systematically test processes on an ongoing basis to document compliance with policies, procedures, laws or regulations.

Fraud: intentional deception or misrepresentation that an individual knows or should know, to be false that could result in some unauthorized benefit to you or another.

Waste: extravagant, careless or needless expenditure of funds or consumption of resources that results from deficient practices, poor

systems controls or bad decisions. Waste may or may not provide any personal gain.

Abuse: intentional, wrongful, or improper use of resources or misuse of rank, position, or authority that causes the loss or misuse of resources, such as tools, vehicles, computers, copy machines, etc.

PROCEDURE:

I. Compliance Officer Responsibilities

A. The County's Compliance Officer shall:

1. Provide information to all Covered Persons of the duty to report and available protections for reporting compliance issues.
2. Maintain an auditing and monitoring plan that is reviewed annually and updated as needed. This plan includes but is not limited to training/education, policy and procedure development and/or reviews, audits of program and contractor activities, claims review and other auditing and monitoring activities to detect, deter and correct fraud, waste and abuse.
3. Coordinate and/or oversee the prompt investigation, resolution, and documentation of any report of alleged fraud, waste or abuse. Refer to the Compliance Program Policy: Process for Investigating Non-Compliance.
4. Ensure that corrective actions are completed timely and properly documented.
5. Refer to appropriate personnel, reports of employee fraud, waste or abuse, as well as retaliation against an employee's lawful, good faith reporting of compliance issues for investigation and appropriate action.
6. Provide a copy of this policy, or the information therein, to all current or new Covered Persons during the annual compliance training or at the initial general compliance training.
7. Ensure that a copy of this policy is always readily available to any Covered Person.
8. Notifying the proper authorities once a crime has been detected.

II. Management/Supervisor Responsibilities

A. Covered Persons serving in management or supervisory positions shall:

1. Create an environment of honesty and ethics within each

manager/supervisor's span of control.

a) Provide employees with clear direction about work expectations and internal controls.

b) Actively discourage manipulation of clients, vendors or others for advantage.

2. Reduce opportunities for fraud, waste, and abuse by implementing strong internal controls that detect and deter dishonest behavior and when such behavior is detected, take appropriate action against the perpetrator.
3. Ensure that all staff are informed of the options available for reporting fraud, waste and abuse and other compliance issues.
4. Establish an environment free from intimidation and retaliation to encourage open communication.

a) Ensure that any person who reports issues is not subject to any form of retaliation for reporting issues in good faith.

b) Immediately address any and all forms of retaliation by co-workers.

c) Actively discourage conduct that could be perceived as retaliatory.

III. Covered Persons' Responsibilities

A. All Covered Persons shall:

1. Adhere to the County's Code of Ethics (pertaining to Fresno County employees), and the Code of Conduct (pertaining to all Covered Persons). Refer to the Compliance Program Policy: Code of Conduct.
2. Perform duties in a way that promotes the public trust and ensures proper expenditures and use of County assets and property.
3. All Covered Persons have a duty to report actual or suspected violations of law, regulations or policy including fraud, waste and abuse to appropriate authorities. Additional information is included in the Communications chapter of the Compliance Program, as well as state and federal false claims statutes.
4. Cooperate with investigations of compliance issues. Refer to the Compliance Program Policy: Process for Investigating Non-Compliance.

IV. Contractor Responsibilities

A. Contractor shall:

1. Review this policy during the mandatory initial and annual general compliance

trainings.

2. Ensure that a copy of this policy is always readily available to its employees and subcontractors.

Tort, Casualty, or Worker's Compensation Form

Name of Patient: _____ Account Balance: _____
Patient ID No: _____ Referral Date: _____
Admission Date: _____ Discharge Date: _____
Phone Number of Patient: _____ Social Security Number: _____
Address of Patient: _____
_____
Date of Injury: _____ Date of Birth: _____

Name of Employer: _____ Employer's Phone Number: _____
Address of Employer: _____
_____

How did the injury occur:

_____
_____
_____
_____

Where did the injury occur:

_____
_____

Number of Police Report: (if any) _____ Agency: _____
Names and Addresses of Witnesses to Injury:

_____
_____
_____
_____

Insurance Company and Policy Number of Patient: _____
Name of the Insured: _____

Insurance Company and Policy number for person causing injury to patient:

_____
_____

Insurance Claim Number and/or Policy Number: _____

PATIENT HEALTH INSURANCE INFORMATION:
Insurance Company:_____Medi-Cal/Medicare Number: _____
Deductible _____ Coverage _____ Stop Loss _____ Out of Pocket _____
Name of Interviewer _____

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CONSENT FOR TREATMENT

I consent to and authorize mental health services provided by the staff of the Fresno County Mental Health Plan (FCMHP). These services may include psychological testing, psychotherapy, counseling, crisis stabilization, crisis intervention, follow-up services, rehabilitation, medication, case management, laboratory tests, or diagnostic procedures, and other appropriate services which may now or during the course of my care be necessary for my welfare.

I understand that FCMHP programs provide clinical experiences for a variety of behavioral health trainees. I understand that these individuals, who are under the direction of the supervising clinical staff, may provide treatment to me (my dependent).

I understand that information from my treatment record that is important to my service delivery needs may be shared within this agency and within the Fresno County mental health system (directly-operated programs and contract agencies) or with my physical healthcare providers without obtaining my authorization. The Fresno County Notice of Privacy Practices further explains how my (my dependent's) confidential information and treatment records may be used or disclosed by the FCMHP.

I understand that I am financially responsible for mental health services which are not covered by third party payers. I also understand that I may apply to be charged according to a sliding scale based upon my ability to pay, if I am unable to pay the full cost of my care and meet the qualifications for sliding fee consideration.

I have been given an opportunity to read this form and ask questions about its contents and provisions. I freely give my consent for necessary treatment and understand that I can withdraw my consent and stop receiving services at any time.

X_____ _____

Printed Name and Signature of client/parent/conservator/legal representative* Date

If signed by someone other than the client, please state your legal relationship to the client:

_____

X_____ _____

Printed Name and Signature of witness/interpreter** Language Date

X_____ _____

Printed Name and Signature of witness*** Date

A copy of this Consent ☐ was given/offered ☐ was declined on _____ by _____

Date Staff name

This section must be completed by staff if there is no signature by client/parent/legal representative, or if signed by a minor:

☐ Client desires mental health services, but will not sign the form. Please indicate reason: _____

☐ I have completed the Checklist to Determine Minor's Ability to Consent to Treatment form for any client between the ages of 12-18 signing above without parent/guardian consent.

_____ _____

Signature of Staff Date

* A minor client receiving services under his/her own signature must have the signed Checklist to Determine Minor's Ability to Consent to Treatment form on file in the treatment record.

** Witness/interpreter is a person who either witnessed the signing of the form (may be staff or other person) or the person who, by signing the form, states that he/she has accurately and completely read the contents of the form to the client or legal representative in the client's/legal representative's primary language; and the client/legal representative understood all of the terms and conditions and acknowledged agreement by signing the consent.

*** If the adult client is unable to provide his or her full signature and does not have a legal representative, his or her own mark must be witnessed by two people.

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Fresno County Mental Health Services

MEDICATIONS CONSENT FOR PATIENTS

This is to acknowledge that I have had a discussion with my/the conservatee's/my child's physician, concerning his/her prescription of the following checked medication(s) some of which may not have U.S. FDA approval for the use(s) discussed.

I have been informed of the alternatives, risks, benefits and side effects, some of which are listed below, for different medications. Not all known or potential side effects are listed. This consent is effective until revoked by the patient/parent/legal guardian/conservator.
I understand that I/the conservatee/my child should avoid alcohol while taking any medications. Drug-drug interaction can occur with over the counter medications.

☐ Antipsychotic _____

Some possible side effects: nausea, vomiting, dizziness, weight gain, increased blood sugar/lipids, diabetes, sedation, restlessness, tremor, stiff muscles, Tardive Dyskinesia (involuntary movements of face, mouth or head, neck, arms, hands and feet; are potentially irreversible and may appear even after these medications have been discontinued), seizures, sexual problems, Neuroleptic malignant syndrome (rare medical emergency marked by high fever, rigidity, delirium, circulatory and respiratory collapse), increased risks of stroke or cardiovascular accidents. Additionally for Clozapine: seizures; lowered white blood cell count leading to infections; and, rarely, damage to heart. Black-Box warning for Dementia-related Psychosis and suicidality.

☐ Anti-Extrapyramidal (EPS) Medications _____

Some possible side effects: for Cogentin, Artane and Benadryl etc: Blurred vision, tiredness, mental dulling, dizziness, trouble urinating, dry mouth, constipation etc.

☐ Antidepressant _____

Some possible side effects: nausea, vomiting, appetite/weight changes, headaches, dizziness, sedation, sleep disturbances, dry mouth, sexual/erectile problems, seizures, abnormal internal bleeding, Persistent Pulmonary Hypertension of the Newborn, Mania.
Especially in youth: Suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outbursts, hostility, and violence.

☐ Antianxiety/Hypnotic _____

Some possible side effects: drowsiness, trouble concentrating, confusion, clumsiness, dizziness, weakness, decreased reflexes, difficulty driving, operating machinery and loss of inhibition.

☐ Mood Stabilizer _____

Some possible side effects: nausea, vomiting, skin rash, weight gain, dizziness, confusion, tiredness and birth defects. Additionally for Depakote: liver/pancreas problems, ovarian problems, Teratogenicity; for Carbamazepine: HLA-B* 1502 allele testing in Asians, lowered blood count leading to infections; for Trileptal: possible serious rash, potential life-threatening. For Lamictal: serious skin rash, Steven-Johnson Syndrome, potential life-threatening. Some of these are antipsychotic medications or antiepileptic drugs.

☐ Lithium _____

Some possible side effects: nausea, vomiting, diarrhea, tiredness, mental dulling, confusion, weight gain, thirst, increased urination, tremors, acne, thyroid disorder and birth defects.

☐ ADHD Medications _____

Some possible side effects: loss of appetite, decreased growth, trouble sleeping, restlessness, nausea, changes in blood pressure/heartbeat. Additionally for Strattera: rare liver injury with possible jaundice (yellow skin and eyes) abdominal pain, itchy skin, flu, dark urine.
Additionally for Adderall/Amphetamine salts: risk of sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities. Additionally for Concerta/methylphenidate: psychotic behavior including visual hallucinations, suicidal ideation, aggression or violent behavior.

☐ Others _____

I understand that I have the right to refuse this/these medication(s) and that it/they cannot be administered to me/the conservatee/my child until I have spoken with my/the conservatee's/my child's physician and have given my consent to treatment with this/these medications. I may seek further information at any time that I wish, and I may withdraw my consent to treatment with the above medication(s) at any time by stating my intention to my/the conservatee's/my child's physician.
I certify with my signature that I have legal authority to sign this medication consent and that the relationship listed is valid and legal.

Client/Parent/Guardian/Conservator Signature	Legal Relationship	Date

☐ *I withdraw this consent*

NAME: _____

DMH #: _____

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ABNORMAL INVOLUNTARY MOVEMENT SCALE

(AIMS)

INSTRUCTION:

Complete examination procedure before making ratings.

MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously

Code: 0 = None
1 = Minimal
2 = Mild
3 = Moderate
4 = Severe

FACIAL AND ORAL MOVEMENTS	1. Muscles of facial expression, e.g. movements of forehead, eyebrows, periorbital area, cheeks; including frowning, blinking, smiling, grimacing	1	(0)
	2. Lips and perioral area, e.g., puckering, pouting, smacking	2	(0)
	3. Jaw, e.g. biting, clenching, chewing, mouth opening, lateral movement	3	(0)
	4. Tongue, e.g., rate only increase in movement both in and out of mouth, not inability to sustain movement	4	(0)
EXTREMITY MOVEMENTS	5. Upper (arms, wrists, hands, fingers) include choreic movements, i.e., rapid objectively purposeless, irregular spontaneous, athetoid movements, i.e., slow, irregular, complex, serpentine. DO NOT include tremor, i.e., repetitive, regular, rhythmic	5	(0)
	6. Lower (legs, knees, ankles, toes) e.g., lateral knee movements, foot tapping, heel dropping, foot squirming, inversion, and eversion of foot	6	(0)
TRUNK MOVEMENTS	7. Neck, shoulders, hips, e.g., rocking, twisting, squirming, pelvic gyrations	7	(0)
GLOBAL MOVEMENTS	8. Severity of abnormal movements	8	(0)
	9. Incapacitation due to abnormal movements	9	(0)
	10. Patient's awareness of abnormal movements. Rate only patient's report: No awareness 0; Aware, no distress 1; Aware, mild distress 2; Aware, moderate distress 3; Aware, severe distress 4	10	(0)
DENTAL STATUS	11. Current problems with teeth and/or dentures	11	(0)
	12. Does patient usually wear dentures?	12	No

SIGNATURE | (Type/Print) NAME | TITLE | DATE

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Fresno County Mental Health Plan
Department of Behavioral Health

NAME: _____

Chart #: _____

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SECTION 8: PROBLEM RESOLUTION AND APPEAL PROCESS

8.0 Provider Problem Resolution and Appeal Process

The Fresno County Mental Health Plan (FCMHP) uses a simple, informal procedure in identifying and resolving provider concerns and problems regarding payment, other complaints, and concerns.

8.0.1 Informal Provider Problem Resolution Process

- The provider may first speak to a Provider Relations Specialist (PRS) regarding his or her complaint or concern.
- The PRS will attempt to settle the complaint or concern with the provider. If the attempt is unsuccessful and the provider chooses to forego the informal complaint process, the provider will be advised to file a written complaint to the FCMHP addressed to:

  Fresno County Mental Health Plan
  Attn.: Provider Appeals
  P.O Box 45003
  Fresno, CA 93718-9886

8.0.2 Formal Provider Appeal Process

The provider has the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun, when the complaint concerns the processing or payment of a provider's claim to the FCMHP.

8.0.2.1 Payment Issues

- The provider may appeal a dispute with the FCMHP regarding the processing or payment of a provider's claim to the FCMHP. The written appeal must be submitted to the FCMHP within 90 calendar days of the date of the receipt of the non-approval of payment.
- The FCMHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by

the provider, and any action required by the provider to implement the decision.

- If the Managed Care staff member reverses the appealed decision, the provider will be asked to submit a revised request for payment within 30 calendar days of receipt of the decision.

8.0.2.2 Other Complaints

If there are other issues or complaints, which are not related to payment authorization issues, providers are encouraged to send a letter of complaint to the FCMHP. The provider will receive a written response from the FCMHP within 60 calendar days of receipt of the complaint. The decision rendered by the FCMHP is final.

8.1 Beneficiary Problem Resolution System

The FCMHP maintains a Problem Resolution System that includes three processes:

1. Grievance Process
2. Appeal & expedited Appeal Process
3. State Fair Hearing Process.

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination.

Appeal: An expression of dissatisfaction about an adverse benefit determination.

Adverse Benefit Determination:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefits.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required timeframes for standard resolution of grievances and appeals.
- The denial of a person's served request to dispute financial liability.

Providers must make brochures related to the Beneficiary Problem Resolution

System, in all threshold languages, readily available at each service site without a beneficiary having to make a verbal or written request. Providers may contact Managed Care when additional self-address envelopes are needed.

Providers must post the Problem Resolution System poster, in all threshold languages, at each service site.

Provider must allow a beneficiary to authorize another person to act on their behalf. Providers may represent a beneficiary during the Grievance, Appeal, or State Fair Hearing process with the written consent of the beneficiary.

Provider must give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. Interpreter services and auxiliary aids are available for beneficiaries upon request. Beneficiaries may dial 711 to reach the California Relay Service (which supports TTY/TTD.)

Providers must not subject a beneficiary to discrimination or any other penalty for filing a grievance or appeal.

Providers must have procedures for the processes that maintain the confidentiality of beneficiaries.

Providers must email encrypted grievances, appeals, and expedited appeals to Managed Care at mcare@fresnocountyca.gov within one business day of the date of receipt.

Providers must log all complaints and the disposition of all complaints the disposition of all complaints from a beneficiary, then submit a monthly summary of the complaint log. Individual and group will submit their logs to DBH Managed Care Division. Contracted organizations must submit their log to the Contract Analyst.

Providers must work Managed Care to resolve each request as expeditiously as a beneficiary's health condition requires, not to exceed 90 calendar days for a grievance or 30 calendar days for an appeal.

8.1.1 State Fair Hearing Process

The FCMHP provides its beneficiaries with information on how to file for a State Fair Hearing when the beneficiary's appeal is not resolved entirely in favor of the beneficiary. The beneficiary must first exhaust the FCMHP's Appeal process before filing for a State Fair Hearing.

The Client Informing Materials provide information about the State Fair Hearing process. These materials are given to each client upon first accessing services and upon request. The reverse side of the Notice of Adverse Benefit Determination notice also contains information on how to file for a State Fair Hearing. Beneficiaries must request a State Fair Hearing no later than one hundred twenty (120) calendar days from the date of the FCMHP's notice of resolution. Providers may represent a beneficiary during the State Fair Hearing process with the written consent of the beneficiary.

Beneficiaries have the right to request an external medical review, at no cost to the beneficiary. This medical review must not extend the State Fair Hearing timeframe nor disrupt possible Aid Paid Pending. The review must not be required by the FCMHP and may not be required before or used as a deterrent to proceeding to a State Fair Hearing.

If the result of the State Fair Hearing **reverses** the FCMHP's decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, the FCMHP will authorize or provide the disputed services as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date the FCMHP receives notice of the State Fair Hearing decision.

8.1.1.1 Aid Paid Pending

A beneficiary who is currently receiving services must request a State Fair Hearing with ten (10) calendar days of receipt of an NOABD to be eligible for Aid Paid Pending. The FCMHP will provide Aid Paid Pending to a beneficiary who wants continued services and has filed a timely request (10 days from the date a NOABD was mailed or personally given to the beneficiary, or before the effective date of the change, whichever is later) for an appeal or State Fair Hearing. When these criteria are met, benefits will continue while an Appeal or State Fair Hearing is pending.

If the result of the State Fair Hearing **reverses** the FCMHP's decision to deny or limit services that **were** furnished while the State Fair Hearing or Appeal was pending, the FCMHP will pay for the costs of the services provided paid pending the State Fair Hearing or Appeal.

If the result of the State Fair Hearing **upholds** the FCMHP's

decision to deny or limit services that **were** furnished while the State Fair Hearing or Appeal was pending, the beneficiary may be required to pay the costs of the services provided paid pending the State Fair Hearing or Appeal.

8.1.2 Notice of Adverse Benefit Decision

A Notice of Adverse Benefit Decision (NOABD) is written notification to beneficiary when the FCMHP makes any adverse benefit determinations. A NOABD provides information to the beneficiary about their appeal rights and other rights under the Medi-Cal program.

- Providers will use NOABD templates or the equivalent of these templates generated from DBH's Electronic Health Record System to issue the following NOABDs:

- NOABD Delivery System – Providers will issue this NOABD template, following an assessment, when the person served does not meet medical necessary criteria for specialty mental health services and they refer the beneficiary to the Managed Care Plan or other appropriate system for mental health and/or other services. The NOABD Delivery System must be issued to the beneficiary within two business days of the decision.

- NOABD Timely Access – Provider will issue this NOABD template when a person service has requested specialty mental health services and the first available/offered appointment is outside of timely access standards. The NOABD Timely Access must be issued within two business days of the decision.

- NOABD Termination – Provider will issue this NOABD template when terminating, reducing, or suspended a previously authorized service. The NOABD Termination must be issued to the beneficiary within 10 days prior to the date of the action.

When issuing a NOABD, providers must enclose the 1) NOABD Your Rights, 2) Language Assistance Taglines, and 3) Beneficiary Discrimination Notice.

Providers must issue a NOABD and the required enclosures in

the beneficiary's preferred Fresno County threshold language.

In addition to issuing a NOABD to a beneficiary, providers must retain a copy of the NOABD and place it in the beneficiary's file and send a copy to Managed Care.

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SECTION 9: CULTURAL AND LINGUISTIC STANDARDS

9.0 General Overview

The population of California is one of the most culturally and linguistically diverse in the United States. The Fresno County Mental Health Plan (FCMHP) is committed to providing mental health services in a manner that takes into consideration the cultural and linguistic needs of our beneficiary population.

9.1 Cultural and Linguistic Standards

Mental health services will be presented in a culturally and linguistically appropriate manner. The FCMHP will support the health providers in the delivery of these services through training, services, materials, and consultation.

9.2 Cultural and Linguistic Definitions

9.2.1 Culture

Culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs. A particular individual's cultural identity may involve the following parameters among others: ethnicity, race, language of origin, acculturation, gender, socioeconomic class, religious/spiritual beliefs, and sexual preference.

9.2.2 Cultural Sensitivity

Cultural sensitivity is the awareness of the differences between and the nuances of one's own and other cultures. When providing services to clients of a different culture, it is important to be sensitive to their needs and expectations in order to provide the best level of service.

9.2.3 Cultural Appropriateness

Cultural appropriateness is demonstrating both sensitivity to cultural differences and similarities and effective use of cultural symbols to communicate a message.

9.2.4 Cultural Competence

Cultural competence is a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons from the community in developing focused interventions, communications, and other supports.

9.2.5 Culturally Competent Mental Health System

A culturally competent mental health system is one that acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation to services to meet culturally unique needs.

9.3 Cultural Competency Training

The FCMHP will implement, monitor, and enforce Cultural Linguistic Appropriate Services (CLAS) Standards and Cultural Competency Plan Requirements; therefore, all providers are required to complete one cultural competency training per year. Groups and organizations must submit a monthly staffing report so DBH can track the participation of all providers. Group providers may submit the monthly staffing report to Managed Care. Organization may submit the monthly staffing report to the Contract Analyst.

The FCMHP also provides a foundational cultural competency training on a periodic basis, which is open to all FCMHP providers, once every five years. Upon completion of the foundational training, the provider directory will be updated to reflect completion of cultural competency training. For groups and organizations, the provider directory will reflect completion once all providers within the group/organization has completed the foundational training. If you are interested in enrolling in the foundational training, contact Managed Care via phone (559-600-4645) or email (mcare@fresnocountyca.gov) and we will reply with the next available date of a Cultural Competency training (if available).

9.4 Language Assistance Services

Providers who work with beneficiaries who are limited-English proficient (LEP) or non-English speaking must use either bilingual staff members proficient in the language of the beneficiary or interpreter services.

Interpretation/Translation services shall be made available in all languages, not just the threshold languages of Fresno County (which are English, Spanish, and Hmong.)

The County of Fresno will share its' list of certified interpreters to providers upon request, but the provider will be responsible for the cost of these services. Providers may use telephone translation services for making appointments or getting information from beneficiaries but will likewise be fully responsible for the cost of these services. In no case will the beneficiary be billed for the use of interpreter services.

The FCMHP strongly discourages the use of minors, family members, guardians, conservators, or friends as interpreters. If the beneficiary insists on providing their own interpreter, the provider will document their request in the beneficiary's record and have the beneficiary sign both a release and a third party confidentiality acknowledgement. These forms will be filed in the beneficiary's medical record.

Providers who work with LEP or non-English speaking beneficiaries will have notices prominently posted at their practice site(s) explaining that interpreter services are available at no cost to the beneficiary.

9.5 Client Forms

All written communication with beneficiaries must be translated into the beneficiary's preferred language to ensure that all beneficiaries receive information in the language that they understand. Examples include consent for treatment forms, medication consent forms, and material explaining the side effects of medication.

9.6 Beneficiary Handbook

The Beneficiary Handbook includes a directory of services and forms for the Problem Resolution System. The FCMHP will make these materials available in English, Spanish, and Hmong. Providers may download copies of the Beneficiary Handbook and other forms from the Department's website at http://www.co.fresno.ca.us/departments/behavioral-health/managed-care/consumer-and-provider-downloads.

9.7 Compliance with Interpreter Services

Services offered through the FCMHP are subject to Office of Civil Rights mandates. Providers are expected to comply with these standards. Failure to comply may be used as grounds for termination of the provider's agreement with the FCMHP.

SECTION 10: SITE CERTIFICATION/MEDICAL RECORD REVIEW

10.0 Site Certification/Recertification

In order for a provider to receive Medi-Cal beneficiary referrals and begin billing for services, the provider must first be Medi-Cal certified by the Department of Health Care Services through its local Mental Health Plan (MHP). The Fresno County Mental Health Plan (FCMHP) is required to conduct a Medi-Cal site certification during the credentialing process to ensure compliance with all federal and state guidelines; however, the exact timing will be up to the discretion of the FCMHP. Compliance with site certification standards is monitored by FCMHP staff. (Refer to Certification Survey Checklist, the Individual and Group Provider Site Certification form, and the Organizational Provider Facility Site form, at the end of this section).

For **Individual and Group providers**, site recertification will also be conducted whenever a provider changes an office or treatment site during the contract period. The FCMHP may revisit the site, as necessary, to follow-up on any areas requiring compliance correction. The provider is required to correct any deficiency(ies) and demonstrate compliance of site certification requirements to the FCMHP within 30 days of notification.

For **Organizational providers**, an additional certification review may be conducted when:

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

- There are unusual events, accidents or injuries requiring medical treatment for clients, staff or members of the community.

Failure to provide evidence of correction of or compliance with the deficiencies within the 30 days will result in withholding of payments for current and future claims and/or contract termination.

10.1 Medical Record Review

The FCMHP staff may perform an onsite medical records review annually or when circumstances indicate oversight is needed. If medical record keeping does not meet standards, the FCMHP may potentially withhold payment as stated in the contractual agreement until a satisfactory Plan of Correction is submitted. Subsequent visits will be made as necessary to follow-up on any areas requiring correction. The provider is required to correct any deficiencies and to demonstrate correction of these deficiencies to the FCMHP staff. (Please refer to FCMHP Chart Review Summary Checklist and How to Fill-out the Plan of Correction Form at the end of this section.)

10.2 Reasons for Recoupment or Disallowance during a Medical Record Review

- Documentation in the chart does not establish that the client has an included ICD-10 diagnosis per California Code of Regulations, (CCR) title 9, chapter 11, section 1830.205(b)(1)(A-R).

- Documentation in the chart does not establish that, as a result of a mental disorder, the client has at least one of the following impairments:

    - A significant impairment in an important area of life functioning

    - A probability of significant deterioration in an important area of life functioning

    - A probability that the child will not progress developmentally as individually appropriate

    - For clients under the age of 21, a defect or mental illness that specialty mental health services can correct or ameliorate

- Documentation in the chart does not establish that the focus of the proposed intervention is to address:
    - A significant impairment in an important area of life functioning; or
    - A probability of significant deterioration in an important area of life functioning; or
    - A probability the child will not progress developmentally as individually appropriate; and
    - For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental health disorder that specialty mental health services can correct or ameliorate.
- Documentation in the chart does not establish the expectation that the proposed intervention will do, at least one of the following:
    - Significantly diminish the impairment
    - Prevent significant deterioration in an important area of life functioning
    - Allow the child to progress developmentally as individually appropriate
- The Plan of Care was not completed prior to provision of all planned specialty mental health services.
- The initial Plan of Care (a.k.a. client plan, treatment plan) was not completed within 60 days of the intake unless there is documentation supporting the need for more time.
- The Plan of Care was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.
- No documentation of client or legal guardian participation in and agreement with the plan or written explanation of the client's refusal or unavailability to sign as required.
- No progress note was found for service claimed. Every claim for service must be supported by a progress note or clinical

documentation that must be present in the client record prior to the submission of the claim.

- The time claimed was greater than the time documented. Recoupment of the entire service on that date will be implemented. There will be no partial recoupment.

- The progress note indicates that the service was provided while the client resided in a setting where the client was ineligible for FFP, i.e. IMD, jail, and other similar settings, or in a setting subject to lockouts per Title 9 CCR, Chapter 11.

- The progress note clearly indicates that the service was provided to a client in juvenile hall and when ineligible for Medi-Cal.

- The progress note indicates that the service provided was for academic, educational, vocational service that has work or work training as its actual purpose, recreation, or socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific target behaviors.

- The claim for a group activity was not properly apportioned to all clients present.

- The progress note did not contain the signature of the person providing the service.

- The progress note indicates that the service provided was solely transportation.

- The progress note indicates that the service provided was solely clerical.

- The progress note indicates that the service provided was solely payee related.

- No service was provided, or the progress note indicates activities not consistent with the type of service contact claimed.

- The service was not provided within the scope of practice of the person delivering the service.

- The progress note was not legible.

- Missed appointments (as no services provided) are not reimbursable.

- Personal care services performed for the client are not reimbursable. Examples include grooming, personal hygiene, assisting with medication, child or respite care, housekeeping, and the preparation of meals.

- Travel time between two provider sites (i.e. two billing providers, or the provider's second office) is not reimbursable. Travel time may only be claimed from a provider site to an off-site location (i.e. client's home). Provider sites include satellites and school site operations.

10.3 Site and Medical Record Review Procedure

- The FCMHP staff will contact the provider to arrange a convenient date and time for the review.

- The provider is expected to provide the FCMHP staff with all materials requested for review on the date, at the time agreed upon. Any additional or missing documentation must be provided prior to the reviewers' departure on the date of audit.

- The FCMHP will send the provider an audit summary within 30 calendar days after the review. The provider will be asked to make corrective actions, if necessary, by completing the Statement of Deficiencies and Plan of Correction Form. (Refer to form at the end of this section).

- The FCMHP will ask providers for a Plan of Correction based on the following deficiencies.

    - Notes are illegible.

    - Treatment does not address the primary DSM-V diagnosis, i.e., treatment is not consistent with the presenting mental health symptoms.

    - Interventions are not consistent with the behavioral goals on the Plan of Care (except during crisis visits).

    - Notes are not specific and individualized to the client.

    - Specific strategies or techniques used as interventions are not documented.

    - Notes are not consistent with the type of service being billed.

- Failure to submit the Plan of Correction form within 30 days of receipt of the audit summary will result in withholding of payment for current and future claims and/or contract termination.

- Providers who were asked to make corrective actions will receive a follow-up audit summary stating the FCMHP's response to the proposed corrections.

- Appeals process following a medical records review

    - Immediately following the medical records review, the provider will receive a copy of the *FCMHP Missing Documentation and Potential Disallowance Worksheet* that specifies the disallowed claims and the amounts to be recouped.

    - If the provider wishes to appeal any of the recoupment findings, the provider may do so by submitting an appeal, in writing, within ten (10) working days after the receipt of the *FCMHP Missing Documentation and Potential Disallowance Worksheet*. Please address the appeal to the attention of:

      Clinical Supervisor, Appeals
      Department of Behavioral Health
      Managed Care Division
      P.O. Box 45003
      Fresno, California 93718-9886

    - Please send an electronic version of the appeal to mcare@FresnoCountyCA.gov

    - Any claimed service without supporting documentation noted during the onsite review will be automatically disallowed, unless the provider is able to provide evidence of missing documentation during the day of the review, while the reviewers are on-site. Documentation submitted after the date of the medical records review will not be accepted.

- For Institute(s) of Mental Diseases (IMD) or Out-of-County, non-contracted inpatient psychiatric hospitals that see Fresno County Medi-Cal beneficiaries, the FCMHP may visit the IMD or hospital facility(ies) and perform a medical record review of Fresno County cases, to ensure compliance with FCMHP standards.

Section 10:

Site Certification/Medical Record Review

Forms and Attachments

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FRESNO COUNTY MENTAL HEALTH PLAN
INDIVIDUAL/GROUP PROVIDER SITE CERTIFICATION CHECKLIST

☐ Initial Certification ☐ Fire Clearance Date: Click or tap to enter a date.

Date of Onsight Review: Click or tap to enter a date. Provider Type: Choose an item.

Provider Name: _____ Provider #: _ _____

Address: _____ Phone #: _____

City/State/ZIP: _____ Fax #: _____

Hours of Service: _____ % of Medi-Cal: _____

When you schedule appointments, do you place any restrictions on times when Medi-Cal clients can be seen?
☐ Yes ☐ No

Date provider attended County's Documentation & Billing/Compliance Training: Click or tap to enter a date.

Average No. of Medi-Cal Beneficiaries Served (Monthly):

Ages Served:

SITE CERTIFICATION SUMMARY

☐ Certification/Re-certification approved effective Click or tap to enter a date. to Click or tap to enter a date.

☐ Certification/Re-certification approved effective Click or tap to enter a date. to Click or tap to enter a date. with recommendations below:

☐ **Plan of Correction (POC) required** (see "Comments" section of any item checked not in compliance).
POC must be submitted on the provided form within 30 days of the date of this notification.

OTHER FINDINGS:

FOLLOW-UP:

REVIEWERS: _____ Title: _____ Date: Click or tap to enter a date.

_____ Title: _____ Date: Click or tap to enter a date.

Distribution: ☐ Original to Provider ☐ Credentialing File ☐ DBH Contracts Staff Analyst Other

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FRESNO COUNTY MENTAL HEALTH PLAN
SITE CERTIFICATION CHECKLIST
Individual/Group Provider

PROVIDER NAME: _____ **DATE OF REVIEW:** _____

Documents Required (Collected prior to completion of on-site visit):				
	Criteria Met			**Comments/Guidelines for Review**
	Yes	**No**	**N/A**	
Head of Service Licensure/Evidence	☐	☐	☐	
Fire Clearance/Fire Inspection Report with no violations (dated within past 12 months)	☐	☐	☐	
Commercial General Liability Insurance w/limits per Agreement	☐	☐	☐	
Automobile Liability Insurance w/limits per Agreement	☐	☐	☐	NOTE: Only required if the provider will be using their vehicle in the course of the provision of services (i.e., traveling out to the community to provide therapy)
Professional Liability Insurance with limits per Agreement	☐	☐	☐	
Child Abuse/Molestation and Social Services Liability Coverage (may be specific endorsement on General Commercial Liability policy/umbrella or separate policies)	☐	☐	☐	
For providers employing associates: Workers Compensation Insurance	☐	☐	☐	
ON SITE REVIEW **All Providers: Categories 1-3; Providers with Medication Support: Categories 1-4**				
CATEGORY 1: OFFICE/FACILITY	**Criteria Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA	**Yes**	**No**	**N/A**	
1. The office/facility and its property are clean, sanitary, and in good repair, free from hazards that might pose a danger, with fire exits clear and unobstructed.	☐	☐	☐	
2. Sufficient, confidential space allocated for client and office administrative services.	☐	☐	☐	
3. ADA requirements: Building is maintained in a manner to provide for physical safety of consumers, visitors, personnel and meets ADA accessibility	☐	☐	☐	
a. Office/facility is wheelchair accessible.	☐	☐	☐	
b. Handicapped accessible restroom is available.	☐	☐	☐	
c. Designated handicapped parking is available.	☐	☐	☐	
4. Mental Health Plan Consumer Handbook, grievance forms, appeal/expedited appeals forms, change of	☐	☐	☐	

	provider forms and self-addressed envelopes are available in a prominent area.				
5.	Office has FCMHP postings on display that explain the grievance, appeal, expedited appeal, and fair hearings processes (Spanish, Hmong, and/or other translations as it applies to provider credentialing).	☐	☐	☐	
6.	Written information about obtaining emergency care during non-office hours is posted and available.	☐	☐	☐	
CATEGORY 2: CULTURAL ISSUES		**Criterial Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA		**Yes**	**No**	**N/A**	
1.	Evidence provider attends an annual training (either County-sponsored or equivalent) on cultural issues of persons served.	☐	☐	☐	
2.	Consumer information and consent forms are available in the consumer's primary language if need be, or an interpreter can be made available.	☐	☐	☐	
CATEGORY 3: MEDICAL RECORDS/CONFIDENTIALITY		**Criteria Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA		**Yes**	**No**	**N/A**	
1.	All confidential and protected health information (PHI) is secure. Client records are not located where the public can view or have physical access to storage.	☐	☐	☐	
2.	Separate storage system maintains inactive medical records.	☐	☐	☐	
CATEGORY 4: MEDICATION SUPPORT SERVICES ***(Psychiatry only)***		**Criteria Met**			**Comments/Guidelines for Review**
EVALUATION CRITERIA		**YES**	**NO**	**N/A**	
1.	Prescription pads are inaccessible to the public.	☐	☐	☐	
2.	Does the provider store or maintain medications on site?	☐	☐	☐	If the response is "No," indicate that in the "Criteria Met" column and skip the remaining category.
3.	**MEDICATION STORAGE** All drugs are stored in a locked area with access limited to those medical personal authorized to prescribe, dispense, or administer medication.	☐	☐	☐	Review temperature log-is it current? Check room and refrigerator thermometers to verify that they are at the appropriate temperatures.
4.	All medications are stored at proper temperatures: Room temperature medications at 59 - 86 degrees F; Refrigerated medications at 36 - 45 degrees F	☐	☐	☐	
5.	Verify that food and other items are not stored in the same refrigerator as the medications.	☐	☐	☐	No food should be stored in the same refrigerator as medications.

6.	Medications intended for external-use-only are stored separately from oral and injectable medications.	☐	☐	☐	Ask to see medications for external use only-check labels & expiration dates. Verify external medications are stored separately from oral and injectable medications.
7.	Controlled drugs (Schedule II, III, and IV) are kept separate from non-controlled drugs.	☐	☐	☐	
8.	**INCOMING (RECEIPT) MEDICATION LOG** All medications entering the facility are logged, including sample medications, prescriptions for individual patents, and house supply. For each medication, the log is maintained for one year and documents:	☐	☐	☐	
a.	Drug name;	☐	☐	☐	
b.	Strength and quantity;	☐	☐	☐	
c.	Name of patient;	☐	☐	☐	
d.	The date ordered;	☐	☐	☐	
e.	The date received and name of issuing pharmacy or drug company	☐	☐	☐	
9.	**LABELING** Medications obtained by prescription are labeled in compliance with federal and state laws, including but not limited to:	☐	☐	☐	
a.	Drug name;	☐	☐	☐	
b.	Strength and quantity;	☐	☐	☐	
c.	Name of patient;	☐	☐	☐	
d.	The date ordered;	☐	☐	☐	
e.	The date received and name of issuing pharmacy or drug company.	☐	☐	☐	
10.	**MEDICATION DISPENSING LOG** All medications dispensed are logged, regardless of source. The log includes:	☐	☐	☐	
a.	The date and time the medication was administered;	☐	☐	☐	
b.	The source of the medication;	☐	☐	☐	
C.	The lot and/or vial number if the medication was dispensed from a multi-dose container or sample	☐	☐	☐	
d.	The name of the patient receiving the medication;	☐	☐	☐	
e.	The dose of the medication given;	☐	☐	☐	
f.	The route of administration;	☐	☐	☐	
g.	The signature/licensure/unique identifying number of authorized staff who administered.	☐	☐	☐	

CATEGORY 4: MEDICATION SUPPORT SERVICES *(continued)*		Criteria Met			Comments/Guidelines for Review
EVALUATION CRITERIA		Yes	No	N/A	
11.	**AUDITING SUPPLIES OF CONTROLLED SUBSTANCES** Separate logs are maintained for Schedule II, III & IV drugs	☐	☐	☐	Verify which staff the facility has designated access to the Schedule II, III, and IV controlled drugs.
12.	For controlled substances, evidence records are reconciled at least daily and retained at least one year	☐	☐	☐	Review the current controlled substances medication log to determine if appropriate licensed staff is reconciling the log at least daily or every shift.
13.	**CONTROLLED SUBSTANCE LOGS** Does the controlled substance log include:	☐	☐	☐	Review the controlled substances medication record and verify the required information is documented. **NOTE:** If supplied as part of a unit dose medication system, it does not need to be separate from other medication records.
a.	Patient's name;	☐	☐	☐	
b.	The signature/licensure/unique identifying number of authorized staff who prescribed;	☐	☐	☐	
c.	Prescription number;	☐	☐	☐	
d.	Drug name;	☐	☐	☐	
e.	Strength;	☐	☐	☐	
f.	Dose administered;	☐	☐	☐	
g.	Date and time administered;	☐	☐	☐	
h.	The signature/licensure/unique identifying number of authorized staff who administered the drug.	☐	☐	☐	
14.	Medication disposed of after the expiration date.	☐	☐	☐	
15.	**MEDICATION DISPOSAL LOG** A medication disposal log is maintained to ensure proper disposal of expired, contaminated, deteriorated, and abandoned drugs in a manner consistem with state and federal laws. The log includes:	☐	☐	☐	
a.	The name of the patient;	☐	☐	☐	
b.	Medication name and strength;	☐	☐	☐	
c.	The prescription number;	☐	☐	☐	
d.	Amount destroyed;	☐	☐	☐	
e.	Date of destruction;	☐	☐	☐	
f.	Name and signature of witnesses.	☐	☐	☐	
16.	Evidence the medication disposal log is retained for at least three (3) years.	☐	☐	☐	

FRESNO COUNTY MENTAL HEALTH PLAN

2021 CHART REVIEW DOCUMENTATION CHECKLIST - OUTPATIENT SERVICES (Non-STRTP)

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
CONSENT FOR TREATMENT/ONSET OF TREATMENT						
1	Consent for treatment is present and appropriately executed (i.e., by client 18 and older, legal guardian, court order, Deputy Conservator) and in the record for each voluntary episode of inpatient hospitalization, voluntary crisis stabilization services and prior to starting outpatient services.					**Q**
2	There is evidence in the medical record client was offered a choice of provider.					**Q**
ASSESSMENT						
3	Client was offered Advance Directive information (Adults only).					**Q**
4	The assessment was completed in accordance with FCMHP's established standards for timeliness and frequency.					**Q**
5	**The assessment includes ALL of the following:**					**Q**
	a) **Presenting problem**; chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information.					
	b) **Relevant conditions and psychosocial factors** affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma.					
	c) **Mental Health History**; previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. Other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.					
	d) **Medical History**; relevant physical health conditions reported by the client or significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal events and relevant/significant developmental history.					
	e) **Medications**; information about medications the client has received, or is receiving, to treat MH and medical conditions, including duration of treatment. Should include the absence or presence of allergies or adverse reactions.					
	f) **Client strengths** in achieving goals related to their MH needs and functional impairments as a result of the MH diagnosis.					
	g) **Risks**; situations that present a risk to the client and/or others, including past or current trauma (e.g. suicidal/homicidal risks and grave disability are noted and updated).					
	h) **Substance exposure/substance Use**; past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs.					
	i) **A mental status examination**					
	j) **A complete, accurate diagnosis;** a diagnosis utilizing DSM 5 criteria, corresponding to the current ICD diagnosis code, and in accordance with the covered diagnoses for reimbursment of outpatient SMHS must be documented, consistent with the presenting problems, history, MSE and/or other clinical data; including any current substance use disorder diagnosis. Accounts for all sx/impairments identified in content of Assessment.					**R1**
6	The assessment includes the date of service, signature of person providing the service (or electronic equivalent), employee ID number, type of professional degree, licensure or job title, and the date the documentation was entered into the medical record. Assessment is completed by an LPHA (including registered/waivered) that was credentialed as MHP provider at the time of the assessment or within FCMHP documentation standards.					**R2**

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE				Class
		Y	N	NA	%	
7	Cultural issues (including language, gender identity, and sexual orientation) are noted in the assessment.					Q
8	Duration times (service duration, doc/travel, total), date, language, location and ICD code match what was billed in Avatar. (Recoupment of assessment activity only when assessment activity is within audit timeframe.)					R8
9	Medical record contains the MHP-required outcomes measurement tools with appropriate frequency.					Q
CLIENT PLAN (a.k.a. Treatment Plan; Plan of Care)						
10	The client plan is completed within 60 days of the assessment unless there is documentation supporting the need for more time.					R4
11	The client plan is completed on an annual basis or as specified in the MHP's documentation guidelines and is reviewed and/or updated as appropriate in response to a crisis event resulting in emergency services or whenever there is a significant change in the client's condition. (Recoupment of all services within audit timeframe not based on a current, valid client plan enacted with all planned service interventions included prior to services being delivered, except for assessment, plan development, certain TCM and ICC activities, and crisis intervention/assessment. All prior to being claimed.)					R2, R4
12	The client plan includes specific, observable, and quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the identified mental health diagnosis.					Q
13	The client plan identifies the proposed type(s) of interventions/modalities, including a detailed description of each intervention to be provided.					Q
14	The client plan includes the proposed frequency and duration of the intervention(s).					Q
15	The client plan includes interventions that focus on and address the identified functional impairments as a result of the MH disorder identified by the mental health assessment.					Q
16	Interventions are consistent with client plan goal(s)/treatment objective(s).					Q
17	The Treatment Plan is consistent with the qualifying diagnosis and need for service identified per the assessment. (Documentation must substantiate that the focus of interventions is to address the benficiary's mental health condition.)					R4
18	The client plan is signed by one of the following: The person providing the service; or the person representing a team providing the service; or the person representing a team or program providing the service; **OR**					R4
	As a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is NOT of the approved categories, one (1) of the following must co-sign: A Physician; A Licensed/Registered/Waivered Psychologist, SW, PCC, or MFT; NP or RN.					
19	The client plan includes the client's signature or the signature of the client's legal representative when: the client is expected to be in long-term treatment, as determined by the MHP, and, the client plan provides that the client will be receiving more than one type of SMHS; **OR**					Q
	In absence of a client signature, documentation of the client's participation in and agreement with the plan (e.g., Court ordered treatment; reference of participation and agreement in the body of plan; or a description of the client's participation and agreement in the medical record) and there is a written explanation why it is absent and documents ongoing attempts to obtain the appropriate signature(s).					

FRESNO COUNTY MENTAL HEALTH PLAN

2021 CHART REVIEW DOCUMENTATION CHECKLIST - OUTPATIENT SERVICES (Non-STRTP)

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
20	Documentation that the contractor/provider offered a copy of the treatment plan to the client. Documentation includes acceptance/decline.					Q
21	Cultural issues (e.g., language, culture/ethnicity) are noted in the client plan.					Q
22	For a non-English speaker, the client plan documents how the client plan was developed.					Q
23	The duration, date, ICD code, location on client plan match what has been billed in Avatar. (Recoupment if plan development activity is within the audit timeframe.)					R8
MEDICAL NECESSITY						
24	As based on the beneficiary's need for services established by a clinical assessment, the client conidition meets **all three** (25a, b, and c) **of the following medical necessity criteria listed below** (Recoupment of all services if all three not met):					R1-3
	a) A current, accurate, and complete ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract.					
	b) The client, as a result of an included ICD-10 diagnosis or emotional disturbance (listed in 25a), must have at least ONE of the following criteria (1-4 below) wich is substantiated in documentaion:					
	1. Significant impairment in an important area of life functioning; OR					
	2. Probability of significant deterioration in an important area of life functioning; OR					
	3. Probability that the child will not progress developmentally as individually appropriate; OR					
	4. For full scope Medi-cal beneficiaries under the age of 21 years, a condition as a result of the mental health disorder or emotional disturbance that SMHS can correct or ameliorate (EPSDT standard).					
	c) The proposed and actual intervention(s) meet the intervention criteria listed below:					
	1. The focus of the proposed and actual intervention(s) is to address the condition identified, or for full scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental health disorder or emotional disturbance that SMHS can correct or ameliorate.					
	2. The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (a-d) below:					
	a) Significantly diminish the impairment.					
	b) Prevent significant deterioration in an important area of life functioning.					
	c) Allow the child to progress developmentally as individually appropriate.					
	d) For full scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.					
25	If the client did not meet medical necessity, an NOABD was provided to the client/family and a copy is in the chart.					Q
PROGRESS NOTES						
26	Progress notes document the following:					R2, R5-8

FRESNO COUNTY MENTAL HEALTH PLAN

2021 CHART REVIEW DOCUMENTATION CHECKLIST - OUTPATIENT SERVICES (Non-STRTP)

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
	a) Interventions applied and the client's response to the interventions. (Notes must document that the focus of the intervention is to address the beneficiary's included mental health condition and that the expectation of the intervention is that it will significantly diminish the imparment, prevent significant deterioration in an important area of life functioning, allow the child to progress develompmentally as individually appropriate, or for full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.)					
	b) The date the services were provided.					
	c) The location where services were provided.					
	d) The amount of time taken to provide services is documented on the progress note and matches claim for service.					
	e) The signature of the person(s) rendering the service (or electronic equivalent), license number or employee ID number, type of professional degree, and licensure or job title.					
27	The progress note is completed in accordance with the timeliness and frequency requirements specific to the Fresno County MHP documentation standards.					**Q**
28	Services billed to the FCMHP are consistent with the documentation in the client's record and include the following:					**R8**
	a) The date and units of time of service that match claim					
	b) The correct purpose of visit/service code of the SMHS claimed.					
	c) The name of the provider on the claim matches the name of the provider that rendered the service.					
29	There is a progress note for every service claimed by the provider.					**R8**
30	Progress note indicates service is provided in an eligible setting (not an IMD, jail, juvenile hall prior to disposition/adjudication, during day treatment program hours, or other lockout setting).					**R 9-10**
31	Progress or lack of progress toward treatment goals are documented and refer to the most recent treatment plan goals.					**Q**
32	Notes for billable service must include documentation of a valid and eligible SMHS service, even if the client was a no show or cancels appointment.					**R15**
33	Service was provided within the scope of practice of the person delivering the service.					**R16**
34	Service not solely for substance use disorder.					**R7**
35	Service provided was **not** solely for one of the following:					**R11**
	a) academic educational services					
	b) vocational services that has work or work training as its actual purpose					
	c) recreation					
	d) socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors					
	e) transportation					
	f) clerical					
	g) payee related					
36	Medical necessity for continued treatment is documented for each claimed service. The progress note decribes how the service provided reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioining, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.					**R4-7**

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
37	Evidence-based practice used and appropriately documented in text of progress note (i.e. Dialectical Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Cognitive Behavioral Therapy, Structural Family Therapy, Motivational Interviewing, etc.).					**Q**
38	Staff interventions and client response to life-threatening conditions, i.e., suicidal/homicidal ideation and grave disability are documented.					**S**
39	Evidence of collaboration and referrals to community resources or other agencies when appropriate.					**Q**
40	Discharge summary or plan for follow-up care, when appropriate, must include the reason for discharge and referral. If no referrals are provided, the reason for no referrals is documented.					**Q**
41	If the client has ceased services, there is documentation to explain follow up referrals, attempts to contact or reasons for termination.					**Q**
42	If the diagnosis has changed for any reason, and a clinical assessment was not completed, appropriate documentation with clinical justification is noted in a progress note. The clinical documentation must provide the current DSM and/or ICD-based reasoning for the diagnostic change.					**R1-3**
43	If multiple providers are concurrently treating the client, documented evidence of communication between the providers is noted in the chart.					**Q**
44	If a client had a recent 5150 episode or inpatient psychiatric hospitalization, appropriate follow up was documented and provided (e.g., Treatment plan was reviewed and updated when appropriate).					**Q**
45	The "Primary Diagnosis" selected at the time of the service is an included Medi-Cal diagnosis (for billable services only).					**R2, R7**
46	Effort to contact the client after missed appointments is documented.					**Q**
TYPE OF SERVICE CONTACT (Purpose of Visit Mental Health Services & Crisis)						
47	**103** (Assessment) notes focus on information gathering activities and determination of medical necessity.					**R8, R15**
48	**126** (Individual psychotherapy), **156** (family psychotherapy), and **83** (individual or family psychotherapy) notes show a service that focuses primarily on symptom reduction for the client even if it is a family session.					**R8, R15**
49	**82 Notes** (Group therapy) demonstrate a service that focuses on symptom reduction and is provided to multiple clients in one session. The progress note includes:					**R8, R12, R15**
	a) The group note must be individualized to speak to the specific progress of the individual client.					
	b) Time is properly apportioned to all clients present and, if applicable, to multiple providers. Group formula components included on progress note.					
50	When services are being provided to, or on behalf of, a client involving one (1) or more providers at one point in time, the progress notes or other relevant documentation in the medical record include:					**R12-13**
	a) Medical necessity for having more than one provider.					
	b) The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary, with signature(s) of all person(s) providing the services.					
	c) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable.					
	d) The total number of beneficiaries participating in the service activity.					

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
51	**150 Notes** (Collateral) show contact with the client's significant support person(s) including consultation and training to assist in better utilization of services and understanding of the client's mental illness per the MH assessment and client plan.					**R8, R15**
52	**153 Notes** (group collateral) show a service that focuses on symptom reduction and is provided to multiple significant support persons in one session. The notes must be individualized to speak to the specific progress of each client represented. Group formula is applied to number of clients represented. Group service meets criteria of Items 49(a-b) and 50(a-d) above.					**R8, R12-13, R15**
53	**158** (Individual rehab) or **85** (Group rehab) show client was offered assistance, training, counseling, support, or encouragement with mental health stated symptoms, and impairments per POC. (Group notes must be individualized to speak to the specific progress of each client represented. Group formula is applied to number of clients represented. Group service meets criteria of Items 49(a-b) and 50(a-d) above.)					**R8, R12-13, R15**
54	**159 Notes** (Plan Development) show a service activity which consists of development and approval of the client's plan, and/or monitoring of the client's progress.					**R8, R15**
55	**205 Notes** (Case management linkage and consultation) show client was linked, assisted, monitored, or advocated for by staff per the client plan (i.e., services were not for providing transportation or completing a task for the client).					**R8, R15**
	a) **205 Notes** (Case management linkage and consultation) show appropriate follow up when a referral has been made.					**R8, R15**
56	**206 Notes** (Case management placement) show client was offered assistance in locating and securing an appropriate living environment or funding per POC.					**R8, R15**
57	**31 Notes** (Crisis Intervention - Other) or **181 Notes** (Crisis Intervention - Therapy) show client's condition required (and received) a more timely response than a regularly scheduled visit and provided interventions to attempt to de-escalate the client's urgent mental health condition.					**R8, R15**
58	**180 Notes** (Crisis Intervention Assessment) show appropriate risk assessments and safety assessments to correspond with the crisis episode. Risk and safety assessments must include documentation of both risk and protective factors, collateral supports with contact information, homicidal and suicidal risk and contingency plans.					**R8, R15**
59	**127 Intensive Home Based Services Authorization** An approved MHP IHBS authorization is in the record prior to the delivery of IHBS. IHBS claims prior to date of MHP authorization will be disallowed.					**R3, R4**
60	**127 Notes** (Intensive Home-Based Services - IHBS) show a service in the home or home-like setting that is targeted to a minor client (or their significant support person) with significant intensity to address the intensive mental health needs of the child/youth consistent with the POC. The IHBS activity contains medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, **and focuses on <u>at least one</u> of the following:**					**R8, R15**
	a) Shows a service focused on development of functional skills to improve self-care, self-regulation, or other functional impairments; or					
	b) Shows a service focused on improvement of self-management of symptoms (including self-administration of medications as appropriate), or					
	c) Shows a service focused on education of child and/or caregivers about, and how to manage MH symptoms, or					
	d) Shows a service that supports the development, maintenance and use of support networks, or					

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
	e) Shows a service to address behaviors that interfere with a stable/permanent family life, or					
	f) Shows a service to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community, or					
	g) Shows a service to address behaviors that interfere with seeking and maintaining a job, or					
	h) Shows a service to address behaviors that interfere with transitional independent living objectives.					
61	**207 Notes** (Intensive Care Coordination - ICC) show a service that facilitates development and implementation of cross-system/multi-agency collaboration as described by the *Child and Family Team (CFT)* **to support the client's mental health needs per POC, and contains <u>at least one</u> of the following**:					**R8, R15**
	a) *ICC assessing activities* , to identify client/family's needs and strengths; reviewing information from family and other sources; evaluating effectiveness of previous interventions; or					
	b) *ICC service planning and implementation activities* , including developing goals of ICC Plan; ensuring active participation of CFT members; identifying interventions/course of action; or					
	c) *ICC monitoring and adapting activities* to ensure identified services and activities are progressing appropriately; or					
	d) *ICC transition activities* to foster long-term stability with effective use of natural supports and community resources.					
62	Crisis residential, crisis stabilization (one per 23 hour period), day treatment, DTI, and/or adult residential services are documented daily.					**R8, R20**
CULTURAL COMPETENCE						
63	Regarding cultural/linguistic services and availability in alternative formats and there is evidence the client is made aware that SMHS are available in their preferred language as documented by one or more of the following:					**Q**
	a) Documentation that mental health interpreter services are offered and provided, when applicable.					
	b) When the need for language assistance is identified in the assessment, there is documentation of linking clients to culturally-specific and/or linguistic services as described in the MHP's Cultural Competence Plan Requirements.					
	c) When applicable, service-related personal correspondence is provided in the client's preferred language.					
	d) When applicable, treatment specific information is provided to the client in an alternative format (e.g., braille, audio, large print, etc.).					
OVERALL QUESTIONS						
64	Non-electronic client records are legible.					**R5-7**
65	Release(s) of information present in the medical record when appropriate.					**H**
66	Mandated reporting to CPS, APS completed if necessary and documented.					**S**
67	Mandated Tarasoff notification made to law enforcement and intended victim.					**S**
68	Client signature of authorization for payment and release of information for claiming purposes located in the client record and is dated prior to services claimed (Found on CMS 1500 form lines 12 and 13 or elsewhere in chart).					**R**
MEDICATION SUPPORT SERVICES						

FRESNO COUNTY MENTAL HEALTH PLAN

2021 CHART REVIEW DOCUMENTATION CHECKLIST - OUTPATIENT SERVICES (Non-STRTP)

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class
69	**170, 170T (190 for telemedicine provider) Assessment (New Patient)** Psychiatric diagnostic evaluation with medical services. Code is used by a Physician, or NP for diagnostic assessment or reassessment. **Face-to-Face**					**R8, R15**
70	**172, 172T (192 for telemedicine provider) Brief (Established Patient)** This code is used by a Physician, PA or NP, for a client with a problem focused history, a problem focused examination, with straight forward medical decisions. The presenting problem is usually self-limited or minor. **Face-to-Face**					**R8, R15**
71	**173, 173T (193 for telemedicine provier) Expanded (Regular follow up visit of Established Patient)** This code is used by a Physician, PA or NP, for a client with an expanded problem focused history, an expanded problem focused examination. The presenting problem(s) are of low to moderate severity. **Face-to-Face**					**R8, R15**
72	**40 notes** (Med refills/injection) used for meds administered by RN/LVN/LPT. Also used for nursing interventions related to medication refill needs.					**R8, R15**
73	**41, 41T notes** (Meds education/administration) focus on informing client and significant support persons about the psych meds being prescribed. May also be used for general nursing interventions such as MD consultation, MD consent (completion of the JV 220), and other nursing services which do not fall under the category of med refill/injection. Or **Code 205 -Linkage/Consultation.**					**R8, R15**
74	The Medical Progress notes document the following and match claims for billing:					**R8**
	a) The date the services were provided.					
	b) The amount of time/units to provide services is documented on the progress note and matches the claim for service.					
	c) The signature of the person providing the service, license number or employee ID number, type of professional degree, and licensure or job title.					
	d) The diagnosis on the medical progress note matches the diagnosis claimed.					
75	The provider obtained and retained a current written medication consent form signed by the client 18 years of age and older, legal guardian, court order or conservator for each medication prescribed and in accordance with timeliness and frequency standards specified in the MHP's documentation standards.					**S**
76	Medication consent for psychiatric medications include the following required elements: Reason; alternative treatments available, if any; type of medication; dosage; frequency; method of administration; duration; probable side effects; possible side effects if taken longer than 3 months; consent may be withdrawn at any time.					**S**
77	The medication consent includes: The date of service; The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title, license number; and the date the documentation was entered in the medical record.					**S**
78	Medication is appropriate for diagnosis or treatment of symptoms.					**S**
79	Medication orders: dosage, frequency, duration, route, are present in documentation.					**S**
80	Lab work ordered as required to monitor for safety concerns.					**S**
81	Abnormal Involutary Movement Scale/AIMS survey or similar is current or discussed in progress notes.					**S**
82	Compliance to medication regimen is documented.					**S**
83	Response of target symptoms to medication is documented.					**S**
84	Drug allergy is prominently documented as an alert.					**S**
85	Referral to PCP or other community resources or other agencies when appropriate.					**Q**

FCMHP Missing Documentation and Potential Disallowances Worksheet

Audit Date

Provider/Organization

Consumer Name

				Reason for Disallowance/Recoupment											
Service Date	Service	Units	Cost	Not MH or billable serv or lockout	No DOC	Incorr SVC Code	POC Issues	Dup Claim	Dur Issue	No-Show	No Med Nec/ Excl Dx	Incorr Dx, time	SVC not auth	Other	Comments

X

**Provider/Organization Representative Signature

Date

X

Utilization Review Specialist Signature

Date

Total Potential Disallowances

$

If the provider wishes to appeal any of the recoupment findings, the provider may do so by submitting a written appeal within ten (10) working days following the receipt of this worksheet. Disallowances for missing documentation not presented to reviewers while on-site may not be appealed. Please address the appeal to the attention of: Katherine M Rexroat LMFT, Clinical Supervisor, DBH Managed Care P.O. Box 45003 Fresno CA, 93718-9886; or send to mcare@co.fresno.ca.us.

**Representative signature certifies that all items listed above were discussed prior to the conclusion to the audit review.

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FRESNO COUNTY MENTAL HEALTH PLAN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Provider		Street Address, City, State, Zip Code	
Category	Summary Statement of Deficiencies	Provider's Plan of Correction	Completion Date
(The Managed Care team will enter information into this box.) This box will list the documentation standard that Medi-Cal and/or the FCMHP requires (which was found to be missing or weak in the chart review). This information is quoted from the Audit Tool Summary.	(The Managed Care team will enter information into this box.) This is box where Managed Care identifies the specific document and/or documents in the chart review that did not meet the Medi-Cal and/or FCMHP standards. If the problem is a recoupment issue, Managed Care will identify that in this box also. This information is also quoted from the Audit Tool Summary.	(The Provider will enter information into this box.) This is where the agency identifies what the agency will do or what the agency has done to make certain that in all future audits the standard(s) identified under "Category" will be in compliance with Medi-Cal and/or the FCMHP.	(The Provider will enter information into this box.) This is where the agency will document the completion date of the "Provider's Plan of Correction"
Provider's Signature*		Title	Date
*			

How to Fill-out the Plan Of Correction Form

If deficiencies are cited, an approved plan of correction is required to continue program participation.

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SECTION 11: MEDICAL RECORDS

11.0 Consent for Treatment

Consent for treatment must be given at the initial office visit. This is accomplished by the beneficiary, parent or guardian signing a consent form. This form must be maintained in the beneficiary's medical record. Refer to the end of this section for a sample of Consent for Treatment form. This form allows free exchange of information between the provider and the Fresno County mental health clinical staff. Provider may copy the language used in this form.

Minors, in certain circumstances, have the right to access confidential services without parental consent, therefore minors are authorized to sign the Consent form for any confidential services and/or information regarding medical treatment specific to those confidential services. In certain circumstances, records and information are not to be released to parent(s) without the minor's authorization. (A sample Authorization form is provided at the end of this section. Please also refer to the summary of Legal Consent Requirements for Medical Treatment of Minors, also provided at the end of this section.)

11.1 Medication Consent

The Fresno County Mental Health Plan (FCMHP) requires providers to obtain a Medication Consent when medications are prescribed. The beneficiary, or legal guardian, must sign the Medication Consent form when starting a new medication, and whenever a change in medication class or addition of new class of psychotropics occurs (e.g., addition of antidepressant to medication regime, change from antidepressant to anti-psychotic medication). This form must be available in the beneficiary's primary language if beneficiary is monolingual. The consent must be kept in the medical record at all times.

11.2 Release of Medical Records and Distribution

The privacy of the beneficiary's protected health information (PHI) must be maintained. Information will be used and disclosed in accordance with the California Medical Information Act, Welfare and Institutions Code Section 5328 – 5328.9, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. An authorization must be obtained before a beneficiary's PHI can be used or disclosed for purposes other than treatment, payment, healthcare operations, or as required or permitted by law.

Historically, such a document has been referred to as a signed "release". Under HIPAA, the correct term is "authorization".

For example, authorizations are required for marketing, underwriting, and in some cases, research. Under HIPAA, a covered entity must seek authorization for **every** separate occasion.

A copy of the authorization form should be given to the beneficiary or person providing the authorization, and the original authorization form should be filed in the beneficiary's medical record.

Records received from other health care providers about the beneficiary should be filed in the medical record. Such records may be released only by proper authorization of the beneficiary or legal representative.

Authorizations must:

1. Be given in writing.

2. Be linked to a specific purpose.

3. Be signed by the individual.

4. Identify the people who might use the PHI, or to whom it might be disclosed.

5. Set an expiration date or event beyond which the authorization ceases to be valid. If a date or event is not specified, then typically the authorization is valid for one year.

With a subpoena, an officer of the Federal, State, or municipal court can access a beneficiary's records. Agencies such as the FDA or other authorities that comply with reporting requirements in Title 17 of the California Code of Regulations must also be granted access to confidential information.

Beneficiary records must be available to FCMHP staff, and the California Department of Health Care Services, as defined in the Provider Agreement, for fiscal audits, program compliance and beneficiary complaints.

With limited exceptions, a beneficiary or personal representative has the right of access to inspect and obtain a copy of their own medical records, including copies of medical records from other providers which are used in the evaluation and treatment of the beneficiary and contained in the provider's medical record. If the provider does not maintain the requested protected health information and knows where the requested information

is maintained, it must inform the beneficiary where to direct the request for access. The beneficiary must present identification when requesting a copy of their medical record.

Minors, in certain circumstances, have the right to access confidential services without parental consent. Therefore, medical records and/or information regarding medical treatment specific to those confidential services are not to be released to parent(s) without the minors' consent. Please refer to attachment at the end of this section for a summary of the Legal Consent Requirements for Medical Treatment of Minors in Various Circumstances.

Copies of the beneficiary's records are to be transferred to requesting providers upon the consent of the beneficiary.

11.3 Medical Record Copy Charges

The provider may not bill the FCMHP for charges associated with copying of records. Beneficiaries may not be charged for copying of records unless the record is requested for personal use.

11.4 Availability of Medical Records at Each Encounter

Each providers' medical records system must allow for prompt retrieval of the medical records and must be available to the FCMHP at each encounter, for the purpose of review.

11.5 Security of Medical Records

The medical record must be secure and inaccessible to unauthorized access to prevent loss, tampering, and disclosure of information, alteration, or destruction of the record.

Information must be accessible only to:

(1) Authorized staff within the provider's office,
(2) The FCMHP staff with identification, or
(3) Persons authorized through a legal instrument (e.g., subpoena).

As per the Provider Agreement/Contract, provisions must be made for the FCMHP to have appropriate access to the beneficiary's medical records for purposes of quality and utilization review.

11.6 Storage and Maintenance

Medical records must be stored in one central medical records area and must be inaccessible (preferably locked) to unauthorized persons.

Inactive records must be accessible for a period of time which meets state and federal requirements, currently seven years, or to the age of majority for minors, whichever period is longer.

11.7 Department of Health Care Services (DHCS) Medical Records Standards

In addition to the standards identified above, the FCMHP monitors provider records against the following medical record standards:

- Each beneficiary must have a separate medical record.
- All pages in the record are filed chronologically.
- Each page in the record contains the beneficiary's name or I.D. number for ease of identification.
- Personal, biological, and demographic data includes age, sex, address, telephone number, and marital status. This data should be updated as often as appropriate.
- A copy of the Consent for Treatment form is maintained in the medical record.
- All entries are signed and dated. The signature can be handwritten or completed electronically in accordance with FCMHP PPG 1-3-8G, "Electronic Signatures for Electronic Health Record Documentation".
- The author of all entries is identified by name and title/licensure.
- The records are legible, documented accurately and in a timely manner.
- Allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies or NKA) is noted if the beneficiary has no allergies.

- Medical history, including serious accidents, operations, illnesses, is recorded and identified. For children, medical history also includes birth information and mother's prenatal care.

- Records must contain evidence that missed appointments are followed-up by contacting the beneficiary to reschedule the appointment.

11.8 Monitoring Procedures for Providers' Compliance with Medical Records Standards

The medical record review includes a review of a predetermined number of randomly selected medical records to assess the content, completion, and conformance to the FCMHP's Medical Records standards.

Any deficiencies that are identified will be communicated to the provider via a post-facility audit summary. Corrective actions must be instituted if standards are not met. The FCMHP may withhold payment if medical records do not conform to FCMHP standards.

11.9 Resources

If you have any questions regarding confidentiality, Authorizations or request for information, you may call the FCMHP's Medical Records division for assistance at 600-9032.

Other resources available are The California Hospital Association Consent Manual and The California Patient Privacy Manual. These can be obtained by calling the California Hospital Association at (916) 443-7401 or via their website: www.calhospital.org

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Section 11:

Medical Records

Forms and Attachments

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Consent Requirements for
MEDICAL TREATMENT OF MINORS

IF MINOR IS:	*Is parental consent required?*	*Are parents responsible for costs? †*	*Is minor's consent sufficient?*	*May M.D. inform parents of treatment without minor's consent?*
Unmarried, no special circumstances	Yes	Yes	No	Yes
Unmarried, emergency care and parents not available [Business and Professions Code § 2397]	No	Yes	Yes, if capable	Yes
Married or previously married [Family Code § 7002]	No	No	Yes	No
Emancipated (declaration by court, identification card from DMV) [Family Code §§ 7002, 7050, 7140]	No	Probably Not[1]	Yes	No
Self-sufficient (15 or older, not living at home, manages own financial affairs) [Family Code § 6922]	No	No	Yes	[1]
Not married, care related to prevention or treatment of pregnancy, except sterilization [Family Code § 6925]	No	No	Yes	No
Not married, seeking abortion [Family Code § 6925]	No	No	Yes	No
Not married, pregnant, care not related to prevention or treatment of pregnancy and no other special circumstances	Yes	Yes	No	Yes
On active duty with Armed Forces [Family Code § 7002]	No	No	Yes	No
12 or older, care related to diagnosis or treatment of a communicable reportable disease or to prevention of an STD [Family Code § 6926]	No	No	Yes	No
12 or older, care for rape[1] [Family Code § 6927]	No	No	Yes	Yes, usually
Care for sexual assault[1] [Family Code § 6928]	No	No	Yes	Yes, usually
12 or older, care for alcohol or drug abuse[1] [Family Code § 6929]	No[2]	Only if parents are participating in counseling	Yes	Yes, usually
12 or older, care for mental health treatment, outpatient only[1] [Family Code § 6924; Health and Safety Code Section 124260]	No	Only if parents are participating in counseling	Yes	Yes, usually
17 or older, blood donation only [Health and Safety Code § 1607.5]	No	No	Yes	Probably not

[1] Special requirements or exceptions may apply. See *Chapter 4* of the *Consent Manual* or *Chapter 3* of *Minors & Health Care Law.*

[2] Parental consent *is* required for a minor's participation in replacement narcotic abuse treatment (such as methadone, LAAM or buprenorphine products) in a program licensed pursuant to Health and Safety Code Section 11875 (now codified at Section 11839 *et. seq.* [Family Code § 6929(e)]

Note: Notwithstanding the above information, a psychotherapist may not disclose mental health information to a parent who has lost physical custody of a child in a juvenile court dependency hearing unless the parent has obtained a court order granting access to the information.

† Reference: Welfare and Institutions Code Section 14010

Minors are defined as all persons under 18 years of age.

03/17

CALIFORNIA HOSPITAL ASSOCIATION

1215 K Street, Suite 800 • Sacramento, CA 95814 • (916) 443-7401 • www.calhospital.org

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Section: Mental Health

Effective Date: 11/01/2010 **Revised Date:** 11/21/2018

Policy Title: Informed Medication Consent

Approved by: Dawan Utecht (Director of Behavioral Health), Elizabeth Vasquez (Compliance Officer), Lesby Flores (Division Manager - Children's)

POLICY: All clients (adults, parent/legal guardians of minors) will be informed about recommended psychotropic medications and sign an Informed Medication Consent form. Prescribers must inform the client/parent/legal guardian of the risks and benefits of the proposed medication treatment and the risks and benefits of alternative treatments, including absence of treatment. The proposed medication must be explained so that the client/parent/legal guardian understands and is able to make an informed decision.

PURPOSE: To comply with State consent requirements and ensure that clients are informed about medications that are being recommended for the treatment of mental illness prior to the administration of medication, with the exception of emergency medications.

REFERENCE: Welfare and Institutions Code, Sections 359.5 (d), 369, 369.5, 739.5, 5325, 5326.2, 5326.3, 5326.5, 5327, 5332, 5350; CCR Title 9, Section 850-857; California Rules of the Court, Rule 5.640. Rule 1432.5; Fresno County DBH Guidance Regarding Consent for Behavioral Health Treatment Services for Minor Clients, California Family Code, Section 6550-6552, MHSUDS Information Notice No: 17-040.

DEFINITIONS:

Psychotropic medications: Medications that are administered that affect the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psycho stimulants, and medications used for side effects caused by psychotropic medications.

Judicial Council Forms: Forms used to establish parent/guardianship rights to consent and to obtain authorization to administer psychotropic medication to a ward of the court. **These forms are to be used in conjunction with obtaining an Informed Medication Consent from the client (adults, parent/legal guardians of minors, minors).**

PROCEDURE:

I. The prescribing psychiatrist, physician assistant (PA) or nurse practitioner (NP) must ensure the Informed Medication Consent **(see Attachment 1 – Informed Medication Consent - English)** from the adult client or parent/legal guardian of a minor client is acquired prior to the administration of psychotropic medications. Clients will be treated with psychotropic medications after having been informed of his or her rights to accept or refuse such medications. The parent/legal guardian of a minor client must be informed of the benefits and risks of medication. **The Judicial Council forms (JV220) are not sufficient to ensure informed medication consent**.

II. Informed Medication Consent is signed by either an adult client or parent/legal guardian in person. If the client or parent/legal guardian is unable to sign in person an electronic copy or fax will be sufficient to be given for the client or parent/legal guardian along with written explanation of the right to refuse medication and advised of the risks and benefits of the medication. A completed sample Informed Medication Consent Form generated by the electronic medical record is shown in **Attachment 4 – Informed Medication Consent Multi-Language**.

A. In order to make an informed decision, the adult/parent/legal guardian/minor is to be provided with sufficient information by the treating psychiatrist/PA/NP prescribing such medication, which shall include the following:

1. Their right to accept or refuse medication (California State law requirement).
2. Nature of the adult/minor client's target symptoms and/or mental condition which the proposed medication(s) have been-recommended.
3. Reasons for taking such medication including the likelihood of improving or not improving without such medication.
4. The right to withdraw the previously given consent at any time by stating such intention to any member of the treating staff.
5. Reasonable alternative treatments, if any.
6. Type, frequency and amount (including the use of PRN orders}, method (such as oral or injection) and expected duration of taking the medications.
7. Probable side effects of these medications commonly known to occur, and any particular side effects likely to occur in this particular adult or minor client.
8. Side effects may include persistent involuntary movements of the face, tongue or mouth and might at times include similar movements of the hands and feet. These symptoms of Tardive Dyskinesia and others are

potentially irreversible side effects that may appear even after these medications have been discontinued.

9. Possible additional side effects which may occur to minors taking such medications beyond three (3) months.
10. Medication records should be reviewed and signed by client at least every 12 months for accurate medications, even if there are no changes.

B. The prescribing practitioner shall ensure that an Informed Medication Consent Form is signed by the adult/parent/legal guardian indicating that the aforementioned information **(Section II. A 1-10)** have been discussed with the adult/parent/legal guardian/minor.

C. If the adult/parent/legal guardian refuses to consent to medication, this information will be documented in the progress note.

D. If the client verbally agrees to take the medication, but declines to sign the consent, an entry will be made in the progress note stating the verbal agreement. Ongoing efforts should be made and documented at each subsequent visit to encourage client/parent/legal guardian to sign the consent.

1. The adult/parent/legal guardian may withdraw their consent to psychotropic medication at any time by stating such intention to the psychiatrist or nursing staff. The withdrawal of consent shall be noted immediately in the medical record and appropriate medical staff are to be notified.
2. The following classifications of medications require an Informed Medication Consent:
    a. Anti-anxiety agents;
    b. Hypnotic agents;
    c. All classes of antidepressants, including MAO inhibitors;
    d. Neuroleptic agents;
    e. Lithium carbonate;
    f. Extra pyramidal motor system side effect medications including Cogentin/Artane/Benadryl, and
    g. All other medications which are being used for psychiatric purposes including, but not limited to, alpha agonists, beta blockers and anticonvulsants.

E. The following steps will be adhered to in completing the Informed Medication Consent Form:

1. The form will be clearly/properly labeled with the adult/minor/parent/legal guardian name and client medical record number.
2. The appropriate section labeled medication will be used to document the category of each medication prescribed either brand or generic, and Type will be used to designate the type of family the medication belongs to (antidepressant, antipsychotic, etc.).
3. Any medication designated for "off label use" specifications can be listed on the line marked "Off label use" or placing a check in the box marked "Other".
4. The client/parent/legal guardian's signature and the date of the signature is recorded on the appropriate lines on the form.

III. **This Section Applies to Conserved Clients:** The client and conservator will be informed of the proposed medication in the same manner as for clients who are not conserved. The **exception** is that after providing all required information to the client, the following must be completed:

A. The prescribing practitioner (MD, PA, NP) will place the unsigned Informed Medication Consent form in the client's medical record to be signed by the conservator or deputy of the conservator as verification that the aforementioned information was discussed with the consumer.

B. The prescribing practitioner (MD, PA, NP) will document in the medical record the client's acceptance or refusal of medication or refusal to sign the informed medication consent.

C. This signed Informed Medication Consent is considered valid and verifies that all information has been discussed with the conserved client.

IV. **This Section Applies to Clients Using Caregiver's Affidavits:** The Caregiver's Affidavit **(see Attachment 5 – Caregiver Authorization Affidavit)** serves as a document giving an adult "qualified relative" authorization to consent for all mental health, medical treatment (including consent for administration of medications) and dental treatment for the entrusted care of the minor client**. Therefore, the "qualified relative" must sign the Informed Medication Consent form when it involves prescribing of medications**.

A. The "qualified relative" is defined in Consent for Treatment policy (2.1.19) under section Procedure subsection "C" Third Party. The Caregiver's Affidavit gives consent to medical, mental health and dental care of the minor. The Caregiver's Affidavit is placed in the client's file. The Affidavit ends when the parent/legal guardian returns to care for the minor and notifies treating staff member(s). The

affidavit is invalid after the provider receives notice that the minor no longer lives with this ("qualified relative") person.

V. **This Section Applies Only to Minors**: If the minor is a dependent of the Fresno County Superior Court – Juvenile Division, then designated licensed nursing staff will secure the Judicial Council Form JV-220 for the prescribed medication as well as the Informed Medication Consent Form. In lieu of JV-220 for counties that do not utilize court orders, other official documents approved by the Division Manager will be acceptable. **Please refer to Protocols Guide: How to Identify/Complete Appropriate Judicial Council Forms for a description on how to complete the JV-220 forms for wards of the court.**

A. In emergencies, psychotropic medications may be administered to a minor without consent by the parent/legal guardian, or court authorization.

1. Medications will be ordered only for circumstances which appear to present an imminent danger to the self and/or to others. An emergency exists when a sudden marked change in the minor's condition requiring immediate action is necessary for the preservation of the life or the prevention of bodily harm to the minor and/or others.

B. For minors with parents or legal guardians: The parent/legal guardian will be notified once the emergency is resolve. The designated nursing staff will inform the parent/legal guardian of the medication purpose, potential side effects and any other information pertinent to the minor's need for medication.

VI. **This Section Applies Only to Adult Clients**: In emergencies, psychotropic medications may be administered to an adult client with or without consent by the client

A. Medications shall be ordered on emergency basis only for circumstances posing imminent danger to self and/or others. An emergency exists when a sudden marked change in the client's condition occurs, requiring immediate action for the preservation of life or the prevention of serious bodily harm to the client or to others.

B. In emergency situations such medications shall be limited to that which is required to treat the emergency condition and must be provided in ways that are least restrictive to the personal liberty of the client.

VII. The Informed Medication Consent process must be repeated, including **Sections I and II** above, in the following circumstances:

A. The client previously refused to accept the medication but subsequently agrees to accept the medication.

B. The medication has been discontinued and subsequently restarted after an interval of one (1) year.

C. New information about the medication, such as side effects, risks, indications, or other significant information is recognized.

County of Fresno

RETURN TO TABLE OF CONTENTS

AUTHORIZATION FOR ACCESS, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Last 4 Digits of Social Security Number: _____ Record# _____

Access, Use, and Disclosure of Health Information

I authorize the access, use, or disclosure of the above named individual's health information, which may contain medical, mental health, or substance abuse history and treatment information, as follows:

Name of the organization or individual **authorized to access, use, or disclose** the information (information to be released from): _____

Address: _____

Name of the organization or individual **authorized to receive and use** the information (information to be released to): _____

Address: _____

The **type and amount of information** to be accessed, used, or disclosed is as follows:

- ☐ Diagnosis
- ☐ History & Physical
- ☐ Assessment
- ☐ Lab Report
- ☐ Medication Record
- ☐ Plan of Care
- ☐ Immunization Record
- ☐ Progress Note
- ☐ Other _____

Dates of information from: _____ to: _____

Exception or information I do not want disclosed: _____

This information will be used for the following **purpose:**

- ☐ Coordination/Continuity of Care
- ☐ Eligibility for Public Assistance
- ☐ Disability Claim
- ☐ Legal
- ☐ Social Security Appeal
- ☐ Other _____
- ☐ Insurance

Restrictions

California law does not allow the organization or individual receiving this information to access, use, or make further disclosure of my protected health information unless the organization or individual obtains another authorization from me or unless access, use, and disclosure is specifically required or permitted by law.

Rights

I understand that I have the following rights with respect to this Authorization:

1. I may refuse to sign this authorization.
2. I have a right to receive a copy of this authorization.
3. I may revoke this Authorization at any time by signing the revocation at the bottom of this form or by a written notice of revocation signed by me or on my behalf. I can mail it or personally deliver to the following address:

   _____

   I understand that the revocation will be effective upon receipt. I understand that the revocation will not apply to information that has already been released in response to this authorization.
4. I may not be required to sign this Authorization as a condition to obtaining treatment, payment, or my eligibility for benefits.
5. I am entitled to notice if Fresno County will access, use, or disclose the protected health information for marketing and receive payment for the access, use, or disclosure of my protected health information.
6. I understand that I may request a restriction or limitation on the protected health information to be accessed, used, or disclosed.
7. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by confidentiality laws including the Health Insurance Portability and Accountability Act (HIPAA).

Expiration

This Authorization will expire on: _____ If I do not specify an expiration date or event, this authorization will expire in **one year**.

Signature

I knowingly and voluntarily sign this authorization:

Signature _____ Date _____
Printed Name _____ Telephone Number _____

Address _____

If signed by someone other than client/consumer, state your legal relationship to the client/consumer: _____

Witness/Language Interpreter _____

☐ I revoke this authorization Signature: _____ Date _____

Fresno County Mental Health Plan
Electronic Signature Agreement

This Agreement governs the rights, duties, and responsibilities of authorized service providers of Fresno County Mental Health Plan (FCMHP) in the use of an electronic signature in the FCMHP electronic health record. The undersigned (I) understands that this Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is stolen, lost, compromised, unaccounted for, or destroyed. I agree to the following terms and conditions:

I agree that my electronic signature will be valid until I request a new electronic signature or earlier if it is revoked or terminated per the terms of this agreement. The terms of this Agreement shall apply to each such renewal.

I will use my electronic signature\password to establish my identity and sign electronic health record documents and forms. I am solely responsible for protecting my electronic signature\password. I agree to keep my electronic signature\password secret and secure by taking reasonable security measures to prevent it from being lost, modified or otherwise compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored.

If I suspect or discover that my electronic signature\password has been or is in danger of being stolen, lost, disclosed, used by an unauthorized party, or otherwise compromised, then I will immediately notify the County Mental Health Director or his/her designee and request that my electronic signature be revoked and my password be reset. I will then immediately cease all use of any electronic signature until my password is reset. I understand that I may also request revocation at any time for any other reason.

If I have requested that my electronic signature be revoked, or I am notified that someone else has requested that my electronic signature be suspended or revoked due to suspicion that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document. I agree that my electronic signature will appear as follows:

Employee Signature _____ Date _____

Employee Printed:_____
First Name, Last Name, Relevant License or Job Title, Employee ID#

Supervisor's Signature _____ Date _____

Title _____

☐ New Employee (I.D.# to be entered by DBH Personnel within 2 weeks of hire date)

Original to be filed in Employee's DBH Personnel file

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SECTION 12: DOCUMENTATION STANDARDS

The Fresno County Mental Health Plan (FCMHP) requires its providers to follow the documentation standards set by the State Department of Health Care Services (DHCS).

12.0 Client and Service Information (CSI) Changes

The State of California is required to report certain data in order to maintain Federal Block Grant funding. The required changes have been incorporated into the Assessment, Plan of Care, Reauthorization, and Progress Notes when possible. A CSI Supplement form was developed to record data that could not be added easily to existing forms and is a required component for authorization. The additional or updated fields are: Client Index Number, Trauma, Ethnicity, Race, Preferred Language, Special Populations, Client as Caregiver, Substance Abuse/Dependence, General Medical Conditions, and Global Assessment of Functioning. The CSI Supplement form is available at the end of this section.

12.1 Assessment

An assessment is a process of gathering information about a patient with the purpose of making a diagnosis. The following areas are described as a part of a comprehensive patient assessment record:

- Presenting problems affecting the beneficiary's mental health status and relevant physical health/general medical conditions are documented; for example, living situation and impairment in daily activities. The client's responsibilities as a caregiver to dependent children and adults are documented.

- Relevant general medical conditions reported by beneficiary are prominently identified and updated as appropriate.

- Documentation includes medications that have been prescribed by FCMHP physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.

- Documentation describes beneficiary's strengths and social supports in achieving plans or goals.

- Recent trauma or special status situations that present a risk to beneficiary or others are prominently documented and updated as appropriate.

- Beneficiary's self-report of allergies and adverse reactions to medications or lack of known allergies/sensitivities are clearly documented.

- A mental health history is documented, including:

- Previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant laboratory tests, and consultation reports.

- For children and adolescents, prenatal and perinatal events and a complete developmental history are documented.

- Documentation includes past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the counter drugs.

- A relevant mental status examination and review of symptoms is documented.

- A complete five-axis diagnosis from the most current DSM, or diagnosis from the most current ICD, is documented, consistent with the presenting problems, history, mental status evaluation, and/or other assessment data. Diagnosis should include any existing substance abuse/dependence.

12.2 Plan of Care

A Plan of Care is a treatment plan that outlines and documents the plan of treatment and proposed intervention(s). If the beneficiary's medical record does not have a valid Plan of Care, or there are services provided prior to the existence of a Plan of Care, then those services may be disallowed.

12.2.1 Plan of Care Contents

The beneficiary's Plan of Care must:

- State specific, observable or quantifiable goals

- Identify the proposed type(s) of intervention(s)
- State a proposed duration of intervention(s)

- Be signed by the person providing the service(s) and the client or their representative.

12.2.2 Plan of Care Standards

- Plan of Care addresses the symptoms associated with the diagnosis and impairment.
- Focus of intervention is consistent with the plan goals.
- Beneficiary signature on the plan will be used as the means by which the FCMHP documents the participation of the beneficiary in development of the plan.
- If the beneficiary refuses to sign the plan of care, or is unavailable for signature, a written explanation of the refusal or unavailability will be included.

> Examples of documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary's signature on the plan, or a description of the beneficiary's participation and agreement in progress notes.

- The FCMHP will offer a copy of the plan to the beneficiary at the time of signature.

12.3 Progress Notes

Progress Notes are used to document all client contacts while the client is in treatment. Every claim for service must be supported by a progress note or clinical documentation.

12.3.1 Progress Notes Standards

- The client record provides timely documentation of relevant aspects of beneficiary's care.
- The record is legible.
- All entries include the date of service, start and end time, and duration of services.
- Providers use beneficiary's records to document encounters, including relevant clinical decisions, interventions, and service strategies employed.
- All entries in the medical record include the signature of the person providing the service, professional degree

or licensure or job title, and the relevant identification number, if applicable.

- The medical record documents beneficiary's progress in treatment or impediments to treatment.

- The progress note includes space for updating changes in diagnosis, housing, recent trauma, general medical condition, and substance abuse.
- The medical record documents referrals to community resources and other agencies, when appropriate.

- The medical record documents client contact following missed appointments, a timely discharge summary, and any necessary follow-up care.

Section 12:

Documentation Standards

Forms and Attachments

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FRESNO COUNTY MENTAL HEALTH PLAN
Client and Service Information (CSI)—SUPPLEMENT

Consumer Name: **Social Security No.**

ETHNICITY Ask client—Are you of Hispanic or Latino Heritage?

☐ Yes ☐ No ☐ Unknown

RACE: Ask client to select the race(s) that best identifies him/her.
If "Hispanic/Latino only" select (8) Other.

☐	1	White or Caucasian	☐	M	Samoan
☐	3	Black or African American	☐	N	Asian Indian
☐	5	American Indian or Alaska Native	☐	O	Other Asian
☐	7	Filipino	☐	P	Native Hawaiian
☐	C	Chinese	☐	R	Guamanian
☐	H	Cambodian	☐	S	Mien
☐	I	Hmong	☐	T	Laotian
☐	J	Japanese	☐	V	Vietnamese
☐	K	Korean	☐	8	Other
☐	L	Other Pacific Islander	☐	9	Unknown/Not Reported

LANGUAGE: Primary – Primary language utilized by the client.
Preferred – Language which the client would prefer to receive mental health services.

Primary	Preferred	Code	Language	Primary	Preferred	Code	Language
☐	☐	0	American Sign Language (ASL)	☐	☐	H	Hmong
☐	☐	1	Spanish	☐	☐	I	Lao
☐	☐	2	Cantonese	☐	☐	J	Turkish
☐	☐	3	Japanese	☐	☐	K	Hebrew
☐	☐	4	Korean	☐	☐	L	French
☐	☐	5	Tagalog	☐	☐	M	Polish
☐	☐	6	Other Non-English	☐	☐	N	Russian
☐	☐	7	English	☐	☐	P	Portuguese
☐	☐	A	Other Sign language	☐	☐	Q	Italian
☐	☐	B	Mandarin	☐	☐	R	Arabic
☐	☐	C	Other Chinese Dialects	☐	☐	S	Samoan
☐	☐	D	Cambodian	☐	☐	T	Thai
☐	☐	E	Armenian	☐	☐	U	Farsi
☐	☐	F	Ilocano	☐	☐	V	Vietnamese
☐	☐	G	Mien	☐	☐	9	Unknown/Not Reported

SPECIAL POPULATIONS

☐ IEP (3632/26.5) ☐ CALWORKS ☐ Child Welfare (CPS) ☐ Probation ☐ Parole

☐ Healthy Families ☐ Governor's Homeless Initiative (GHI) ☐ Assisted Outpatient Treatment Services (AB 1421)

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SECTION 13: COORDINATION OF PHYSICAL AND MENTAL HEALTH CARE

13.0 CalViva Health Medi-Cal Managed Care Plan

13.0.1 Referral for Mental Health Services

A CalViva Health Medi-Cal beneficiary of Fresno County may be referred to the Fresno County Mental Health Plan (FCMHP) after the beneficiary's primary care physician (PCP) evaluates the beneficiary and determines their condition meets the definition of a serious mental illness (SMI).

With or without referral, the FCMHP is responsible to provide 24 hours a day, 7 days a week access to specialty mental health services for CalViva Health's Medi-Cal beneficiaries who meet medical necessity criteria.

13.0.2 CalViva Health and the FCMHP

CalViva Health, as a Medi-Cal Managed Care Program, is responsible for the physical health care of those Medi-Cal members who are assigned to or enrolled with CalViva Health, as well as the mental health care of those members who have mild to moderate impairments in regards to their mental health. The FCMHP is responsible for the mental health care of members with a serious mental illness (SMI).

In order for the FCMHP and CalViva to serve those CalViva members who have SMI, the FCMHP and CalViva have established a Memorandum of Understanding (MOU). This MOU establishes responsibilities for both CalViva and the FCMHP.

The FCMHP's responsibilities for SMI CalViva members include, but are not limited to:

- Medication treatment for mental health conditions that would not be responsive to physical healthcare-based treatment and for conditions that meet FCMHP medical necessity criteria.

- All other outpatient specialty mental health services covered by the MHP when the CalViva Health member's mental health condition meets MHP medical necessity criteria, such as individual and group psychotherapy,

case management, crisis interventions, treatment planning assessment, and linkage with community resources.

- Hospital-based specialty mental health ancillary services, such as magnetic resonance imaging (MRI).

- Professional services/fees of a mental health specialist provided in an emergency room to a plan member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met.

- Facility charges resulting from the emergency services and care of a plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission for the member for psychiatric inpatient hospital services at the same facility.

CalViva's responsibilities for CalViva members include, but are not limited to:

- Medication and treatment for conditions that would be responsive to physical healthcare-based treatment, and for mental health disorders that are due to a general medical condition.

- CalViva will provide or arrange for covered physical health medical services, primary mental health intervention for members with "Excluded Diagnoses", and outpatient mental health services within CalViva's scope of practice.

- CalViva shall cover and pay for all professional services/fees and facility charges resulting from the emergency services and care of a plan member when such services and care do not result in the admission of the member for psychiatric inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility, or when the member has an excluded diagnosis that is not billable for specialty mental health services.

13.0.3 Pharmacy and Laboratory Services

Per the MOU, CalViva Health coordinates pharmaceutical, medication, laboratory, and related services with the FCMHP.

- CalViva will allow FCMHP credentialed providers access to pharmacy and laboratory services as specialty providers.
- CalViva will provide the FCMHP with a list of participating pharmacies and laboratories and provide an updated list as minimum on a quarterly basis.
- CalViva will provide the FCMHP with a CalViva Health formulary and information regarding drug formulary procedures.
- CalViva will coordinate with the FCMHP to ensure that covered psychotropic drugs prescribed by MHP providers are available through the TAR process or formulary for dispensing by CalViva Health network pharmacies, unless otherwise stipulated by state regulation. (See MMCD Policy Letter No. 00-01 REV.)
- CalViva will provide members with the same drug accessibility written by out-of-plan psychiatrists as in-network providers.
- CalViva will coordinate and assist the FCMHP or FCMHP credentialed providers in the delivery of laboratory radiological or radioisotope services.

For an updated list of CalViva Health's contracted pharmacies, please call 1-888-893-1569.

13.1 Anthem Blue Cross Medi-Cal Managed Care Plan

13.1.1 Referral

An Anthem Blue Cross Medi-Cal beneficiary of Fresno County may be referred to the Fresno County Mental Health Plan (FCMHP) after the beneficiary's primary care physician (PCP) evaluates the beneficiary and determines their condition meets the definition of a serious mental illness (SMI).

With or without referral, the FCMHP is responsible to provide 24 hours a day, 7 days a week access to specialty mental health services for Anthem Blue Cross Medi-Cal beneficiaries who meet medical necessity criteria.

13.1.2 Anthem Blue Cross and the FCMHP

Anthem Blue Cross, as a Medi-Cal Managed Care Program, is responsible for the physical health care of those Medi-Cal members who are assigned to or enrolled with Anthem Blue Cross, as well as the mental health care of those members who have mild to moderate impairments in regards to their mental health. The FCMHP is responsible for the mental health care of members have a serious mental illness (SMI).

In order for the FCMHP and Anthem Blue Cross to serve those Anthem Blue Cross members who have SMI, the FCMHP and Anthem Blue Cross have established a Memorandum of Understanding (MOU). This MOU establishes responsibilities for both Anthem Blue Cross and the FCMHP.

The FCMHP's responsibilities for Anthem Blue Cross members include, but are not limited to:

- Medication treatment for mental health conditions that would not be responsive to physical healthcare-based treatment and for conditions that meet FCMHP medical necessity criteria.

- All other outpatient specialty mental health services covered by the MHP when the Anthem Blue Cross member's mental health condition meets MHP medical necessity criteria, such as individual and group psychotherapy, case management, crisis interventions, treatment planning assessment, and linkage with community resources.

- Hospital-based specialty mental health ancillary services, such as magnetic resonance imaging (MRI).

- Professional services/fees of a mental health specialist provided in an emergency room to a plan member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met.

- Facility charges resulting from the emergency services and care of a plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission for the member for psychiatric inpatient hospital services at the same facility.

Anthem Blue Cross's responsibilities for Anthem Blue Cross members include, but are not limited to:

- Medication and treatment for conditions that would be responsive to physical healthcare-based treatment, and for mental health disorders that are due to a general medical condition.

- Anthem Blue Cross will provide or arrange for covered physical health medical services, primary mental health intervention for members with "Excluded Diagnoses", and outpatient mental health services within Anthem Blue Cross's scope of practice.

- Anthem Blue Cross shall cover and pay for all professional services/fees and facility charges resulting from the emergency services and care of a plan member when such services and care do not result in the admission of the member for psychiatric inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility, or when the member has an excluded diagnosis that is not billable for specialty mental health services.

13.1.3 Pharmacy and Laboratory Services

Per the MOU, Anthem Blue Cross coordinates pharmaceutical, medication, laboratory, and related services with the FCMHP.

- Anthem Blue Cross will allow FCMHP credentialed providers access to pharmacy and laboratory services as specialty providers.
- Anthem Blue Cross will provide the FCMHP with a list of participating pharmacies and laboratories and provide an updated list as minimum on a quarterly basis.
- Anthem Blue Cross will provide the FCMHP with an Anthem Blue Cross formulary and information regarding drug formulary procedures.
- Anthem Blue Cross will coordinate with the FCMHP to ensure that covered psychotropic drugs prescribed by MHP providers are available through the TAR process or formulary for dispensing by Anthem Blue Cross network pharmacies, unless otherwise stipulated by state regulation. (See MMCD Policy Letter No. 00-01 REV.)
- Anthem Blue Cross will provide members with the same drug accessibility written by out-of-plan psychiatrists as in-network providers.
- Anthem Blue Cross will coordinate and assist the FCMHP or FCMHP credentialed providers in the delivery of laboratory radiological or radioisotope services.

SECTION 14: COURT-REFERRED CASES

14.0 Court-Referred Cases

14.0.1 Referrals

Select organizational Providers may accept referrals from the County through the DBH Child Welfare Mental Health (CWMH) Team and attempt to contact the client within a week of receipt of the referral. A face-to-face appointment must be completed within 20 days of receipt of the referral. If an appointment cannot be scheduled within this timeframe, the provider must return the referral packet to the Fresno County Mental Health Plan (FCMHP) Child Welfare Mental Health (CWMH) Team as soon as possible.

14.0.2 Payment

Requests for payment for services will follow the same procedure as outlined in the Billing Section.

14.0.3 Quarterly Report

The Department of Social Services and the court require the submission of quarterly activity reports detailing the work accomplished during the reporting period, work to be accomplished during the subsequent reporting period, and problems, existing or anticipated which should be brought to the County's attention through the CWMH Team.

14.1 Specialty Mental Health Services – Definitions and Requirements

14.1.1 Mental Health Assessment

Information Desired by the Judge:

1. Does the individual (minor or adult) have a need for mental health treatment? Can the individual benefit from such treatment?
2. Does the individual need access to other mental health services?
3. Does the individual need an evaluation for psychiatric medication?

Definition

A structured, analytical interview of the client conducted by a Licensed/Waivered Mental Health Clinician, which includes a clinical assessment, mental status examination, and definition or rule out of clinical diagnosis (DSM 5). Requires review of available records of any previous mental health treatment, and CPS referral documents, with contact as possible with the referring social worker.

Outcome

A written clinical summary with any recommendations for mental health services. As necessary, a referral for a psychiatric or psychological evaluation regarding the need for medication and/or a consultation regarding a diagnosis and treatment plan. A letter to the CPS social worker or case manager based on the assessment, with indication of any need for treatment (may include recommendations or suggestions on the overall case plan, such as whether the client would benefit from drug treatment, anger management, or parenting programs) and information regarding whether, and to whom the client was referred for further evaluations.

Service Code Utilized and Billing

When billing for this service, provider shall use the assessment code: **103**. A maximum of 120 assessment minutes will be authorized and may be billed if utilized. If the mental health assessment is of an infant 0-36 months old, up to 180 units will be allowed. The Infant and Family Mental Health (IFMH) Addendum must be completed and submitted with the assessment and plan of care.

14.1.2 Psychological Evaluation I

Information Desired by the Judge

Will be specified by the court at the time the study is requested and will be included in the referral packet information. However, information requested will often be in the nature of:

1. Does the individual have a disabling mental disorder (e.g., schizophrenia, schizoaffective disorder, depressive disorder, or bipolar disorder)?

2. Does the individual show evidence of mental retardation?

3. Does the individual have a disabling brain disorder due to organic condition?

4. Does the individual have a diagnosed condition/disability that impairs their parenting, and if so, what services should be provided to remedy the impairment?

5. Is the parent capable of utilizing reunification services?

Outcome

A formal written report to the court that includes comprehensive diagnostic information and an overall assessment of functioning, with recommendations for treatment of any problem(s) deemed necessary per clinical assessment, and answers to questions asked.

Definition

A structured analytical interview with the client conducted by a Licensed Psychologist or Waivered Psychologist under supervision of a Licensed Psychologist that includes a clinical assessment, mental status examination, and may include use of testing instruments, and definition or rule out of clinical diagnosis (DSM 5). Also includes a review of CPS and mental health services received to date and contact with relevant others as necessary and possible.

Service Code Utilized and Billing

When billing for this service, provider shall use the assessment code: **96**. A maximum of 480 individual assessment minutes (equivalent to 8 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.3a Psychological Evaluation II-a

Information Desired by the Judge

1. Does the parent(s) or guardian(s) suffer from a mental disability? Mental disability is defined to mean that the parent suffers any mental incapacity or disorder which renders the parent unable to adequately care for and control the child.

2. If the parent suffers from such a mental disability, does the disability render the parent incapable of utilizing reunification services?

3. If the parent suffers from such a mental disability and that disability does not render the parent incapable of utilizing reunification services, does the mental disability nevertheless make it unlikely that the parent will be capable of learning from reunification services within the statutory time limits so that he/she will be able to adequately care for the child?

Definition

A structured analytical interview with the parent or guardian, which consists of clinical assessment, use of testing instruments, mental status examination, definition or rule out of clinical diagnosis (DSM 5), and is performed only by a Licensed Psychologist with a doctoral degree in psychology and at least five (5) years of postgraduate experience (no waivered staff). Also includes a review of CPS and mental health services received to date and contact with relevant others as necessary and possible.

Outcome

A formal written report to the court that includes an overall assessment of functioning and answers to the above three questions. If, in the evaluator's opinion, the parent could learn from reunification services within the statutory time limits, the report should include recommendations regarding what services should be included.

Service Code and Billing

When billing for this service, provider shall use the assessment code: **96**. A maximum of 600 minutes (equivalent to 10 hours of service time) will be pre-authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. If provider needs more than 10 hours to perform this service, the provider must contact Managed Care for prior authorization. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.3b Psychological Evaluation II-b

Evaluation pursuant to Welfare and Institutions Code 361.5(b)(5) – severe physical abuse of a child under the age of 5

Information Desired by the Judge

The Juvenile Court may order reunification services be provided to the parent or guardian, only if the Court can find, based upon competent evidence, that: 1) Reunification services are likely to prevent re-abuse or continued neglect of the child; or that, 2) Failure to try reunification will be detrimental to the child because the child is closely and positively attached to that parent. Please note that the child/parent attachment referenced here is that which is felt or exhibited by the minor towards the parent, not vice versa.

The following are the issues you need to address in your report regarding your evaluation of the parent/guardian and the minor. The law identifies the following factors as being "among the factors indicating that reunification services are unlikely to be successful."

1. The failure of the parent to respond to previous services.

2. The fact that the child was abused while the parent was under the influence of drugs or alcohol.

3. A past history of violent behavior.

4. Whether the parent's behavior is unlikely to be changed by services.

Outcome

A formal written report to the court that includes comprehensive diagnostic information and an overall assessment of functioning, with recommendations for treatment of any problem(s) deemed necessary per clinical assessment, and opinions as to whether reunification services are likely to prevent re-abuse or continued neglect of the child and whether failure to try reunification will be detrimental to the child because the child is closely and positively attached to that parent.

Definition

A structured analytical interview with the parent or guardian, which consists of clinical assessment, use of testing instruments, mental status examination, and definition or rule out of clinical diagnosis (DSM 5). Also includes a review of CPS and mental health services received to date and contact with relevant others as necessary and possible.

Service Code and Billing

When billing for this service, provider shall use the assessment code: **96**. A maximum of 480 individual assessment minutes (equivalent to 8 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.3c Psychological Evaluation II-c

Evaluation pursuant to Welfare and Institutions Code 361.5(b)(6) – severe physical harm or severe sexual abuse

Information Desired by the Judge

The court may deny reunification services to a parent whose child has been made a dependent of the Juvenile Court as a result of severe sexual abuse or the infliction of severe physical harm on that child or a sibling. In order to deny reunification services to a parent, the statute requires the court to find that "it would not benefit the child to pursue reunification services with the offending parent or guardian".

The Court has ordered the minor and the parent/guardian to undergo a psychological evaluation to assist in determining whether or not the minor would benefit from the pursuit of reunification services with the parent/guardian. In determining whether providing reunification services will benefit the minor, the court is to consider any information it finds relevant, including:

1. The specific act or omission comprising the severe sexual abuse or the severe physical harm inflicted on the child.

2. The circumstances under which the abuse or harm was inflicted on the child.

3. The severity of the emotional trauma suffered by the child.

4. Any history of abuse of other children by the offending parent or guardian.

5. The likelihood that the child may be safely returned to the care of the offending parent or guardian within 18 months with no continuing supervision.

6. Whether or not the child desires to be reunified with the offending parent or guardian.

Please consider these factors and any other information you consider relevant in rendering your opinion as to whether or not the minor would benefit from the pursuit of reunification services.

Outcome

A formal written report to the court that includes comprehensive diagnostic information and an overall assessment of functioning, with recommendations for treatment of any problems(s) deemed necessary per clinical assessment, and an opinion as to whether providing reunification services will benefit the minor.

Definition

A structured analytical interview with the minor, parent or guardian, which consists of clinical assessment, use of testing instruments, mental status examination, and definition or

rule out of clinical diagnosis (DSM 5). Also includes a review of CPS and mental health services received to date and contact with relevant others as necessary and possible.

Service Code Utilized and Billing

When billing for this service, provider shall use the assessment code: **96**. A maximum of 480 individual assessment minutes (equivalent to 8 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.4 Psychological Evaluation – Risk Assessment

Definition

This study is conducted to determine the level of risk a child will experience if returned to (or, in some cases, allowed to visit with) their parent. The study is most frequently requested at the initial detention hearing or during the reunification period, after services have been provided to a parent, and prior to the child being returned home. A structured analytical interview with the parent or guardian, which consists of clinical assessment, use of testing instruments, mental status examination, and definition or rule out of clinical diagnosis (DSM 5). Also includes a review of CPS and mental health services received to date and contact with relevant others as necessary and possible.

Outcome

A formal written report to the court that includes comprehensive diagnostic information and an overall assessment of functioning, with recommendations for treatment of any problem(s) deemed necessary per clinical assessment, and an opinion as to whether there is risk of the child being physically, sexually, and/or emotionally abused by the parent if the child is allowed to visit with the parent or is returned home. If the opinion is that there would be risk in visitation, the provider should include recommendations regarding what (if any) visitation is recommended. For example, would supervision eliminate the risk? Are there

particular persons who should/should not supervise? Would visitation limited to certain locales eliminate the risk, etc.?

Service Code and Billing

When billing for this service, provider shall use the assessment code: **96**. A maximum of 480 individual assessment minutes (equivalent to 8 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.5 Family Psychodynamic Formulation

Information Desired by the Judge

1. What are the conflicts and dysfunction that exist within the family unit?
2. Can the family work together to resolve their conflicts/dysfunction to meet the best interests of the child?
3. What are the needs of the family as a unit?
4. What is needed for the family to reach an appropriate resolution regarding the placement of the child?

Definition

A structured analytical interview conducted by a Licensed Mental Health Clinician or Waivered Psychologist if under the supervision of Licensed Psychologist, which consists of a clinical assessment (define or rule out clinical diagnosis using DSM IV-TR) and family session(s) with all relevant family members, to identify the roles inhabited by the members and their interactive patterns. Also includes a review of all available CPS and mental health records and interview with relevant professionals (CPS, school personnel, therapists, etc.).

Outcome

A formal written report that includes an evaluation of family psychodynamics, the impact on family members, recommendation for any needed mental health treatment services and/or other interventions that may assist the family

to reach a needed resolution (for example, appropriate placement of a child).

Service Code and Billing

When billing for this service, provider shall use the assessment code: **98**. A maximum of 600 minutes (equivalent to 10 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. If provider needs more than 10 hours to perform this service, the provider must contact Managed Care for prior authorization. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.6 Bonding Study

14.1.6a Bonding I: Information Desired by the Judge

1. Do the child and the parent have a parent/child relationship (as opposed to that of a child with a friend, occasional baby-sitter, or extended family member)? If yes, describe the relationship.
2. If the answer to question #1 is yes, does the child have a substantial, positive emotional attachment to the parent such that the child would be greatly harmed if this parent/child relationship were terminated?
3. If the answer to question #2 is yes, would continuing this parent/child relationship promote the well-being of the child to such a degree as to outweigh the well-being the child would gain in a permanent home with adoptive parents?

Definition

This study is conducted when the case is set for a permanent plan hearing and possible termination of parental rights. It is a structured forensic, analytical interview including a mental health assessment (define or rule out clinical diagnosis using DSM 5) of both parent(s) and the child(ren). It includes assessment of the interaction between the parent(s) and the child(ren) and may include the use of testing instruments as needed to more accurately gauge the strength of the bond between parent and child. It may also include the current care provider(s) or prospective adoptive parent(s) when ordered by the court.

These studies are to be performed only by a Licensed Mental Health Clinician with appropriate experience or a Waivered Psychologist working under a qualified Licensed Psychologist. Qualified clinician will have completed: 20 hour training in Child Custody that is required by the BOP in California for psychologists (if the child is 0-36 months old), training in the Marshak Interaction Method, and training or experience in providing forensic evaluations for the court.

14.1.6b Bonding II: Information Desired by the Judge

Will be specified by the court at the time the study is requested, and will be included in the referral packet information.

Definition

The study is requested for a specific purpose other than Bonding I. It is a structured forensic, analytical interview including a mental health assessment (define or rule out clinical diagnosis using DSM 5) of both parents or whoever has been identified by the court to participate in the study and the child(ren). It includes assessment of the interaction between the parent(s) and the child(ren). Testing instruments may be used as needed to more accurately gauge the strength of the bond between parent and child. Bonding Study II may be performed by a qualified licensed mental health clinician as defined in Bonding I section.

Reporting on Bonding Studies I and II

Outcome

A formal written report that includes an assessment of the attachment between child and parent, the observations and results from the interview with parent and child (or other adult), and answers to the identified questions.

Service Code Utilized and Billing

When billing for Bonding I or II Studies the provider shall use the assessment code: **97**. A maximum of 600 minutes (equivalent to 10 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. If provider needs more than 10 hours to perform this service, the provider must contact Managed Care for prior authorization. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

14.1.7 Attachment Assessment

A baseline assessment for purposes of reunification planning, recommendations to dependency court, and mental health treatment planning.

Information Desired by the Judge

1. Is the child attached to the parent/caretaker? In answering this question describe the nature of the attachment relationship based on the adult's behaviors, the child's behaviors and the interaction of the two.
2. Is the parent/caretaker bonded to the child? In answering this question describe the nature of the attachment relationship based on the adult's behaviors, the child's behaviors and the interaction of the two.
3. Are there any concerns about parent/caretaker's history or behaviors that would prevent a recommendation for that parent/caretaker to have contact with or participate in parent-child attachment treatment with this child? In answering this question describe the nature of reported history or observed behaviors that raises this concern.
4. Is there evidence to suggest that this parent/caretaker dyad is at risk for attachment related difficulties? If yes,

is mental health intervention recommended? If yes, please answer the following:

a) What type of services would be most likely to optimize the attachment?
b) Who should participate in the intervention?
c) How intensively and over what time period should services be provided?

5. Does the child already show evidence of attachment-related difficulties or disturbance? If yes, is mental health intervention recommended? If yes, please answer the following:
   a) What type of services would be most likely to optimize the attachment?
   b) Who should participate in the intervention?
   c) How intensively and over what time period should services be provided?

Definition

The Attachment Assessment is requested for reunification and treatment planning. It is a structured analytical interview performed only by a Licensed Mental Health Clinician with appropriate experience that includes a clinical assessment of the interaction between the parent/care provider(s) and the child. IFMH training is required if any of the children are 0-36 months old. The Court may order the assessment of any parents being considered for reunification or any other adults who are being considered for permanent placement. The Clinician may choose, for behavior comparison or treatment planning, to assess the relationship with the current foster parent or other adults in the child's life who have had a major role as an attachment figure or emotional support. Testing instruments may be used as needed to more accurately gauge the strength and quality of the attachment between parent and child.

Outcome

A formal written report for the court that includes an assessment of the attachment between child and parent and/or caregivers, the observations and results from the interview with parent/caregivers and child, and answers to the identified questions. A formal assessment and Plan of Care submitted to Managed Care to authorize further services if treatment is deemed medically necessary.

Service Code Utilized and Billing

When billing for this service, provider shall use the assessment code: **99**. A maximum of 600 minutes (equivalent to 10 hours of service time) will be authorized and may be billed if utilized. Time spent in writing the report and collateral contacts are included in the package. If provider needs more than 10 hours to perform this service, provider must contact Managed Care for prior authorization. Progress notes documenting the time spent must be prepared and a copy of the report must be included with the final claim.

Provider must refer beneficiary to the FCMHP when provider determines that additional mental health services are necessary after performing a psychological evaluation, bonding study, family psychodynamic formulation, or attachment assessment. The same provider who performed these special services and recommended treatment cannot provide continuing mental health treatment to the same beneficiary.

14.1.8 Court Testimony

Outcome

On-site court testimony of assessment and evaluation findings; recommendations for treatment and service plan regarding reunification, maintenance, and termination of parental rights; justification for recommendations.

Service Code Utilized and Billing

When billing for this service, provider shall use the code: **3CT**. Provider may bill only for the actual time spent testifying in court.

14.1.9 Court Report

Outcome

Documented report of assessment and evaluation findings; progress in treatment; recommendations for treatment and service plan regarding unification, maintenance and termination of parental rights; and justification for recommendations.

If a court report (**CR**) is submitted covering the quarter for which a **QR** is due, provider may submit this report to MC, using the **QR** form or a format that includes all the required elements in addition to the **CR**. This will keep providers in compliance with the **QR** requirement (Section 14.1.3) and avoid duplication.

Service Code Utilized and Billing

When billing for this service, provider shall use the code: **3CR.** Provider may only bill for court reports separately when prepared for purposes **other** than for the four services described above.

Clinician's Quarterly Reports must be billed using the code: **3QR**. Provider may only bill for **CR** or **QR**. Double billing will be disallowed if providing similar information for the same period of service.

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SECTION 15: FORMS AND DEFINITION OF TERMS

The following forms were developed by the Fresno County Mental Health Plan (FCMHP) to assist the provider in the documentation process. All forms are available on the Managed Care Website at the following website URL (unless otherwise specified):

http://www.co.fresno.ca.us/departments/behavioral-health/managed-care/consumer-and-provider-downloads

15.0 Assessment

The Assessment Form will be used during the initial office visit to gather client information as outlined in Section 12 Documentation Standards. The form may be completed on the second office visit if information gathered during the initial visit is insufficient to formulate an adequate plan of care.

A comprehensive assessment may not be necessary when a client requests mental health services immediately after an expired authorized period. However, another comprehensive assessment may be warranted when a client seeks mental health services after an extended period, such as nine months or more, without treatment.

15.1 Plan of Care

The Plan of Care will be used to document the plan of treatment and proposed intervention(s).

15.2 Infant/Toddler Addendum to Assessment

The Infant/Toddler Addendum to Assessment form replaces the Problem Severity section of the Clinical Mental Health Assessment form and will be completed for clients 0-36 months of age. You may find this form at the following web address:
http://www.co.fresno.ca.us/home/showdocument?id=1989

15.3 Progress Notes

The Progress Notes form will be used to document all client contacts while the client is in treatment.

15.4 Discharge Summary

This form will be used when a provider discharges a client due to no show, completion of treatment, or other reasons. The FCMHP also uses this form to track termination of services due to no shows.

15.5 Medication Referral Form

The provider will use this form when referring a client for medication services. In addition, the provider must also provide a completed clinical assessment and plan of care that specifies the need for medication, and the client will need to complete a release of information form in order to be referred to a Psychiatrist.

15.6 Definition of Terms

Access Line (1-800-654-3937)

The Access Line is a statewide, toll-free telephone line with linguistic capability available to clients/beneficiaries 24 hours a day, 7 days a week. The 24-hour line provides information on how to access specialty mental health services, including services needed to treat a client's urgent condition, and how to use the client problem resolution and fair hearing process.

Beneficiary

A beneficiary is an individual who has been certified as eligible under the Medi-Cal program according to Title 22, California Code of Regulations, Section 51000.2. A beneficiary may be readily identified as a Fresno County beneficiary by reviewing their Benefits Identification Card (BIC). Their BIC should indicate the Fresno County Code (10). Other counties' beneficiaries will have a different county code, ranging from 01 to 58.

Client

A client is an individual who is currently requesting or receiving mental health services from any Fresno County mental health service site, and/or has received services in the past.

Contract Provider

A contract provider is a licensed mental health practitioner (or a group of practitioners) who enters into an agreement with the FCMHP to provide specialty mental health services to Fresno County Medi-Cal beneficiaries. A contract provider may be an individual, group, or organizational provider.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Mental Health Services

EPSDT is a Medi-Cal entitlement program that provides comprehensive health care services for beneficiaries 0-21 years of age. Therapeutic Behavioral Services (TBS) are considered an EPSDT service.

Fresno County Mental Health Clinical Staff

A licensed, waivered or registered mental health practitioner located within Fresno County mental health service sites. These practitioners are employees of Fresno County.

Fresno County Mental Health Plan (FCMHP)

The Fresno County FCMHP is the county organization responsible for the mental health needs of all Medi-Cal eligible residents of Fresno County.

Medical Necessity

Medical Necessity is the principal criteria by which the FCMHP decides authorization and/or reauthorization for covered specialty services.

Primary Care Physician

A primary care physician is a physician responsible for supervising, coordinating, and providing initial and primary care to beneficiaries. Other responsibilities include initiating referrals for specialist care and maintaining the continuity of beneficiary's care.

Provider

A provider is a contracted individual, group, or organization, or Fresno County mental health staff member, who provides mental health services to Fresno County mental health clients.

Provider Relations Specialist

A PRS is a FCMHP staff member who acts as a liaison between the FCMHP and contract providers.

Service Authorization Request (SAR)

The SAR unit is the FCMHP's unit composed of Utilization Review Specialists who are responsible for the review and authorization of Service Authorization Requests made by providers.

Specialty Mental Health Services

"Specialty Mental Health Services" means, per Title 9 of the California Code of Regulations:

- Rehabilitative Services which includes mental health services, medication support services, day treatment intensive, day treatment rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.

- Psychiatric Inpatient Hospital Services

- Targeted Case Management

- Psychiatrist Services

- Psychologist Services

- EPSDT Supplemental Specialty Mental Health Services

- Psychiatric Nursing Facility Services.

Urgent condition

A clinical situation experienced by a beneficiary that without timely intervention is likely to result in an emergency psychiatric condition.

Utilization Review Specialist (URS)

A URS is a FCMHP staff member and county employee who is a licensed or registered mental health practitioner. They are responsible for reviewing providers' admission data and clinical documentation to ensure compliance with federal, state, and county regulations, and proper utilization of treatment resources.

SECTION 16: INSURANCE AND OTHER REQUIREMENTS

The Fresno County Mental Health Plan (FCMHP) requires all contracted individual, group, and organizational providers to maintain certain levels of insurance coverage. This section will go into some detail on the most common insurance requirements. It is not intended as an exhaustive list of insurance requirements. It will also cover some other common requirements that are specified in most FCMHP provider agreements.

16.0 Insurance Requirements

Individual providers contracted with the County of Fresno to provide Specialty Mental Health Services (SMHS) are required to have four types of insurance – Professional Liability, Commercial General Liability, Comprehensive Automobile Liability, and Child Abuse/Molestation and Social Services Coverage. **Group** providers contracted with the County of Fresno have the same requirements as Individual providers, with the caveat that they may be required to have Worker's Compensation Insurance, per the California Labor Code, depending on the structure of the Group provider. All questions regarding Individual and Group provider insurance can be answered by the assigned contract analyst.

Organizational providers contracted with the County of Fresno to provide Specialty Mental Health Services (SMHS) are generally required to have at least four types of insurance – Professional Liability, Commercial General Liability, Comprehensive Automobile Liability, and Worker's Compensation. Your organization may be required to have additional insurance coverage; please refer to your Agreement with the FCMHP for more details. If you have any questions about your agreement with the FCMHP or about your specific insurance requirements, please contact your assigned contract analyst.

16.0.1 Professional Liability Insurance

Professional Liability insurance (also commonly known as 'Malpractice Insurance') is insurance to cover claims resulting from malpractice, negligence, misrepresentation, violations of good faith, or error or failure to render an opinion or offer a service. Providers are required to have Professional Liability insurance with limits of not less than $1,000,000 per occurrence, with a $3,000,000 annual aggregate. The annual aggregate means that the insurance can pay up to that dollar amount of claims per year.

Individual providers are required to have and maintain their own personal Professional Liability insurance. Group providers can opt to have Professional Liability insurance that covers all clinicians in the group or require their clinicians to be individually insured.

Both Individual and Group providers must maintain, at their sole expense, in full force and effect, the same level of Professional Liability insurance for a full three years after terminating their Agreement with the County of Fresno. This is to ensure that old claims that might arise even after you have terminated your Agreement with the County will still be covered.

16.0.2 Commercial General Liability Insurance

Commercial General Liability insurance (CGL) is general business liability coverage. This insurance would be used to cover claims involving property damage, bodily harm, and criminal acts that may have occurred at or involve your practice/office site. CGL insurance must have a minimum of $1,000,000 of coverage per occurrence, with an annual aggregate of $2,000,000. The policy shall be issued on a per occurrence basis.

Additionally, an endorsement to the CGL insurance policy must be obtained, naming the County of Fresno, its officers, agents, and employees, individually and collectively, as additional insured, but only insofar as the operations under this Agreement are concerned. County employees will occasionally be present at your practice/office site on official business, so this endorsement is crucial. This insurance shall not be cancelled or changed without a minimum of thirty (30) days advance written notice given to the County.

Per the Agreement, your CGL policy (with the County as additional insured) shall be the primary insurance for any bodily injury or property damage claims made by County officers / agents / employees etc. present at your practice/office site while on official business. This means that any insurance maintained by the County, its officers, agents, and employees shall be excess only and not be used to pay for claims that would be covered by your policy.

16.0.3 Comprehensive Automobile Liability Insurance

Comprehensive Automobile Liability insurance is insurance to cover claims involving bodily harm and/or property damage that are the result of an auto accident. All Individual and Group providers are required to have this insurance. The County of Fresno cannot authorize any exemptions to this requirement. As before, Group providers may opt to obtain insurance that will cover the entire group or require that each individual maintain their own insurance.

Providers are required to have Comprehensive Automobile Liability insurance with a bodily injury limit of no less than $250,000 per person, $500,000 per accident, and for property damages of no less than $50,000. Providers may also opt for a combined single limit of $1,000,000. This insurance should cover both the use of owned and non-owned autos that may be used in connection with the Agreement.

This insurance would provide coverage in the event that you are injured in an automobile accident while travelling between your practice/site and a Medi-Cal beneficiary's home for a treatment session. It would also provide coverage for any travel you may undertake between your practice/site and the Managed Care Office.

16.0.4 Worker's Compensation Insurance (Group Providers and Some Organizational Providers Only)

Group providers that employ multiple clinicians as well as support staff may be required by the California Labor Code (Section 3700) to have a Worker's Compensation Insurance policy. Per the Individual and Group Agreement, a Group provider is solely liable and responsible for providing to, or on behalf of, its employees all-legally required employee benefits, which may include Worker's Compensation insurance.

If a Group provider employs one or more employees, then it must satisfy the requirement of the law. California Labor Code 3351 defines who is an employee, and therefore who can be covered under a Worker's Compensation policy. Group providers should consult with a reliable, competent insurance broker/agent who can explain coverage eligibility issues and present options based on the organization of the Group.

16.0.5 Child Abuse/Molestation and Social Services Coverage

Individual and Group providers are required to have Child Abuse/Molestation and Social Services Coverage (CAMSS) because many Professional Liability policies specifically exclude and do not cover Sexual misconduct or other such situations. CAMSS coverage must have a limit of no less than $1,000,000 per occurrence, with a $2,000,000 annual aggregate. The policy is to be on a per occurrence basis. This insurance may be obtained as a separate policy or as an endorsement on the Commercial General Liability insurance.

Individual providers *may* be able to use their Professional Liability insurance coverage to meet this requirement, if their policy does not exclude Molestation / Sexual Abuse / Misconduct from coverage. The Contract Analyst for the Individual and Group Master Agreement will require a copy of the policy in question and will need to forward it to the appropriate Department in order to have the policy reviewed for compliance with this requirement.

Group providers are required to maintain separate Child Abuse/Molestation and Social Services coverage (whether as a separate policy or as an endorsement to Commercial General Liability coverage.) This would provide coverage for the entire Group against damages caused by the actions of an individual clinician or staff member.

16.0.6 Wrap-Up

Individual and Group providers are required to provide verification of all required insurance within 30 days of signing the Agreement with the County of Fresno. Providers must maintain these insurance policies at the given standards at all times while contracted with the County. For any questions or inquiries regarding the Insurance requirements, please refer to your agreement with the FCMHP and determine who your insurance contact is. In many cases, this will be your contract analyst.

16.1 Termination of Agreement Requirements

Any individual or group provider wishing to terminate their Agreement with the FCMHP may do so by requesting a Termination Request Letter from their Provider Relations Specialist (PRS). The letter must be signed

and dated correctly, with the following information in order to be considered valid:

- Termination Effective Date (Termination requires 60-day advance notice.)
- **(Optional)** You may list your reason(s) for termination.
- Caseload Status (Please provide the number of Fresno County Medi-Cal beneficiaries you are currently seeing. List names as follows to comply with HIPAA regulations: C. Johnson, B. Simpson, J. Winger, Q. Mallory, etc.)
- Signature
- Date
- Your printed name
- Tax ID (For verification purposes)

16.1.1 Provider Transition Plan

Should an individual or group provider choose to terminate their contract with the FCMHP, have their contract with the FCMHP plan terminated, or not have their contract renewed, the provider involved is responsible to assist in the transition of a beneficiary under their care. The provider may contact a Utilization Review Specialist at Managed Care (600-4645) for assistance with transitioning beneficiaries. The FCMHP will ensure that the beneficiary receives the same level of service from a provider of their choice during the transition.

16.2 Disclosure Requirements - Criminal History and Civil Actions

All providers contracted with the FCMHP are required to disclose if any of the following conditions apply to them, their owners, officers, corporate managers, and partners:

- Within the three-year period preceding the Agreement award, they have been convicted of, or had a civil judgment rendered against them for:
    - Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction.
    - Violation of a federal or state antitrust statute.

- Embezzlement, theft, forgery, bribery, falsification, or destruction of records.
- False statements or receipt of stolen property.

- Within a three-year period preceding their Agreement award, they have had a public transaction (federal, state, or local) terminated for cause or default.

Disclosure of the above information will not automatically eliminate a provider from further business consideration. It will, however, be considered as part of the determination of whether to continue and/or renew the provider's agreement. Any additional information or explanation that a provider elects to submit with the disclosed information will be considered.

A failure by any provider to disclose required information as listed above may result in immediate termination of a provider's agreement with the FCMHP due to failure to comply with the terms and conditions of the Agreement.

Contracted providers must immediately advise the FCMHP in writing if at any point they become suspended, debarred, excluded, or ineligible for participation in federal or state funded programs, or from receiving federal funds as listed in the excluded parties' list system (http://www.sam.gov), or if any of the above listed conditions become applicable to the provider.

16.3 Screening for Excluded/Ineligible Persons and Entities (Organizational Providers Only)

All organizational providers contracted with the FCMHP are required to screen for excluded persons and entities by accessing or querying the applicable licensing board(s), the National Practitioner Data Bank (NPDB), Office of Inspector General's List of Excluded Individuals/Entities (LEIE), System for Award Management Excluded Parties List (SAM-EPLS), and Medi-Cal Suspended and Ineligible List prior to hire and monthly thereafter.

All staff should be recorded onto the "Ineligible Persons Screening Monthly Report", which captures information about staff, such as Names, Discipline/Degree, Title/Position, Date of Search, whether or not they have any exclusions, and the name of the person performing the search. This report, along with an Ineligible Screening Guide, is available online at Managed Care's website at the following address: https://www.co.fresno.ca.us/departments/behavioral-health/managed-care/ineligible-persons-screening

The report must be completed and submitted to Managed Care by the 15th of each month, in PDF format, to the Managed Care Mailbox at: mcare@fresnocountyca.gov

16.3.1 Discovery of Excluded/Ineligible Persons

Should an organizational provider discover that one of their practitioners, employees, contractors, or subcontractors matches an excluded person or entity during a review of the SAM-EPLS, OIG LEIE, or Medi-Cal Suspended and Ineligible Person List, the provider must notify Managed Care immediately. If there is any doubt about whether a person screened matches an excluded person/entity on any of these lists, the provider should still contact Managed Care immediately. Managed Care staff will work with the provider to confirm any potential discoveries.

Once a discovery is made, and the person/entity is positively identified as being excluded, Managed Care will require evidence that demonstrates the excluded person/entity is no longer employed/contracted by the organizational provider. Organizational providers are not permitted to employ or contract with any excluded individual or entity.

Reporting of excluded persons/entities must be made immediately, because the FCMHP is required to notify the state Department of Health Care Services of the discovery of any excluded person or entity working for a FCMHP contracted provider. All payments or overpayments made to an excluded person/entity need to be identified, along with evidence of termination of employment/contract, so that these can be provided to DHCS in a timely manner.

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Section 16:

Insurance and Other Requirements

Forms and Attachments

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Mandated Insurance Coverage for Individual and Group Providers - Quick Reference Guide

As an Individual or Group Provider contracted with the Fresno County Mental Health Plan to provide specialty mental health services, you are required to have certain insurance coverage in order to operate a practice and treat Fresno County Medi-Cal beneficiaries. This quick reference guide will break down and explain the various types of insurance coverage you will need, as well as the dollar amounts of coverage required.

Commercial General Liability Insurance

Commercial General Liability insurance (CGL) is general business liability coverage, which could cover claims involving property damage, bodily harm that might occur on the premises, and coverage against criminal acts targeting the business or its employees. As a contracted provider with the Fresno County Mental Health Plan, your Commercial General Liability coverage must meet the standards listed below:

- CGL must have a **minimum** of $1,000,000 of coverage per occurrence, with an annual aggregate of $2,000,000. The policy shall be issued on a per occurrence basis. This means that your insurance policy must cover at least $1,000,000 of damages per potential accident, and it must be able to pay for at least two such instances in a given year (thus the annual *aggregate* of $2,000,000.)
- The County may require specific coverage including completed operations, product liability, contractual liability, Explosion, Collapse, and Underground (XCU), fire legal liability or any other liability insurance deemed necessary because of the nature of the Agreement.
- An endorsement to the CGL insurance policy must be obtained, naming the County of Fresno, its officers, agents, and employees, individually and collectively, as additional insured, but only insofar as the operations under this Agreement are concerned. County employees will occasionally be present onsite at your site(s), for purpose of auditing and review per the Agreement, and occasionally for other official purposes, so this endorsement is crucial.
    - You may also designate the County of Fresno as your Insurance Certificate Holder (with the mailing address: P.O. Box 45003, Fresno, CA 93718), and designate the Certificate Holder as additional insured in order to meet this requirement.

- Such coverage for additional insured shall be the primary insurance for any claims, meaning that any insurance maintained by the County, its officers, agents, and employees, shall be excess only and not be used to pay for claims that would be covered by your policy.

Comprehensive Automobile Liability Insurance

Comprehensive Automobile Liability Insurance is insurance to cover claims stemming from bodily injury and property damage costs that are the result of a car accident. As a contracted provider with the Fresno County Mental Health Plan, you may occasionally need to use a vehicle to travel to a client's home or residence during your workday. There may also be other travel required as part of the Agreement, so you must have Comprehensive Automobile Liability Insurance. The County of Fresno cannot authorize any exemptions to the Comprehensive Automobile Liability insurance requirement. Your Comprehensive Automobile Liability Insurance must meet the standards listed below:

- A bodily injury limit of no less than $250,000 per person, $500,000 per accident, and for property damages of no less than $50,000, or coverage with a combined single limit of $1,000,000. Your insurance should cover the use of both vehicles you own, and non-owned vehicles used in connection with this Agreement.

Professional Liability Insurance

A Provider is required to have Professional Liability Insurance if they are a licensed professional clinician, or employ licensed professional clinicians (Psychiatrist, Ph.D., R.N., L.C.S.W., L.M.F.T., etc.) Professional Liability Insurance is insurance to cover claims resulting from negligence, misrepresentation, violations of good faith, or error or failure to render an opinion or offer a service. Professionals are expected to have a certain level of competence in their disciplines. Mistakes by professionals, while rare, do happen, and can be costly. Professional Liability Insurance policies, when properly customized to the profession, can reduce or eliminate much of this risk. Your Professional Liability Insurance must meet the standards listed below:

- Professional Liability Insurance with limits of not less than $1,000,000 per occurrence, $3,000,000 annual aggregate. It must be able to pay for at least three such instances in a given year (thus the annual aggregate of $3,000,000.)

- A provider must also maintain, at its sole expense, in full force and effect, the same level of Professional Liability Insurance for a full three years following termination of the Agreement. This is to ensure that old claims are covered that might arise even after you have terminated/withdrawn from the Agreement with Fresno County.

Worker's Compensation Insurance

For group providers that may employ several clinicians as well as support staff, a policy of Worker's Compensation Insurance may be required by the California Labor Code. Per the Individual and Group Master Agreement with the Fresno County Mental Health Plan, a group provider is solely liable and responsible for providing to, or on behalf of, its employees all legally-required employee benefits, which may include Worker's Compensation insurance. All California employers must provide workers' compensation benefits to their employees under California Labor Code Section 3700. If a business employs one or more employees, then it must satisfy the requirement of the law. California Labor Code Section 3351 defines who is an employee, and therefore who can be covered under a workers' compensation policy. Whether a business is a sole proprietorship, a partnership, or a corporation, it is beneficial to develop a working relationship with a reliable, competent broker-agent who can explain coverage eligibility issues and present options based on the organization model of a business.

Child Abuse/Molestation and Social Services Coverage

As a contracted provider with the Fresno County Mental Health Plan, who will often provide treatment and other services to vulnerable clients, such as children, elderly adults, and those with intellectual and developmental difficulties, you are required to maintain Child Abuse/Molestation and Social Services Coverage. The coverage could be separate policies (both Child Abuse/Molestation and Social Services coverage), combined, or you could also acquire General Commercial Liability insurance with a specific endorsement covering Child Abuse/Molestation and Social Services Liability. These policies must meet the standards below:

- The policies must have a limit of not less than $1,000,000 per occurrence, with a $2,000,000 annual aggregate. The policies are to be on a per occurrence basis.

- Individual Providers *may* be able to use their Professional Liability insurance coverage to meet this requirement, if it **does not exclude** Molestation/Sexual Abuse from coverage. A copy of your full Professional Liability policy would be required to verify this.
- **Group** providers are required to maintain separate Child Abuse/Molestation and Social Services coverage (whether as a separate policy or as an endorsement to Commercial General Liability coverage.) This would provide coverage for the entire group against damages caused by the actions of an individual.

Wrap-Up

You must provide proof of all above listed insurance within 30 days from the date that you sign the Agreement with Fresno County. You must maintain your insurance policies at the above given standards at all times while you are a contracted provider with the Fresno County Mental Health Plan. You are not allowed to cancel or change your insurance coverage without a minimum of thirty (30) days advance written notice given to the County.

SECTION 17: COUNTY RESOURCES

17.0 Hotlines and Emergency Numbers

EMERGENCY 911
Fresno County Mental Health Plan Statewide
Toll-Free 24-Hour Access Line 1-800-654-3937
Children's Mental Health – Crisis .....(559) 600-6760
Child Welfare (Child Protective Services) .....(559) 600-8320
Adult Protective Services 1-800-418-1426

17.1 Assistance Programs

CalFresh/Medi-Cal/CalWORKs Case Information .....(559) 600-1377
CalFresh/Medi-Cal/CalWORKs Call Center 1-855-832-8082
General Relief .....(559) 600-2650
In-Home Supportive Services .....(559) 600-6666
Veterans Service Office .....(559) 600-5436

17.2 Financial Aid

Fresno EOC Utilities Payment Assistance.....(559) 463-1135
Social Security & Medicare Eligibility Information 1-800-772-1213

17.3 Health Care

Fresno County Department of Public Health .....(559) 600-3200

17.4 Mental Health

Fresno County MHP 24-Hour Toll-Free Access Line 1-800-654-3937

Adult Services
Urgent Care Wellness Center .....(559) 600-9171
Exodus Psychiatric Health Facility (PHF).....(559) 600-5199
Exodus Crisis Stabilization Center.....(559) 453-1008
Metro Services .....(559) 600-4099
Latino Team .....(559) 600-4099
Perinatal Program.....(559) 600-1033
Pathways to Recovery .....(559) 600-6075
Older Adult Mental Health Clinic .....(559) 600-5755

County Resources

Children's Services

Youth Wellness Center.....(559) 600-6784
Children's Mental Health Services (Outpatient) .....(559) 600-8918
Exodus Crisis Stabilization Center.....(559) 512-8700
Central Star PHF .....(559) 600-2382
Central Star Community Services .....(559) 840-4937

Rural Mental Health Clinics

Coalinga Rural Mental Health Clinic .....(855) 343-1057
Kerman Rural Mental Health Clinic .....(855) 225-7604
Pinedale Rural Mental Health Clinic.....(855) 343-1057
Sanger Rural Mental Health Clinic.....(855) 343-1057
Reedley Rural Mental Health Clinic.....(855) 343-1057
Selma Rural Mental Health Clinic .....(855) 343-1057

If you need more information regarding listing of other services, e.g., culturally specific services, please call Managed Care at (559) 600-4645.