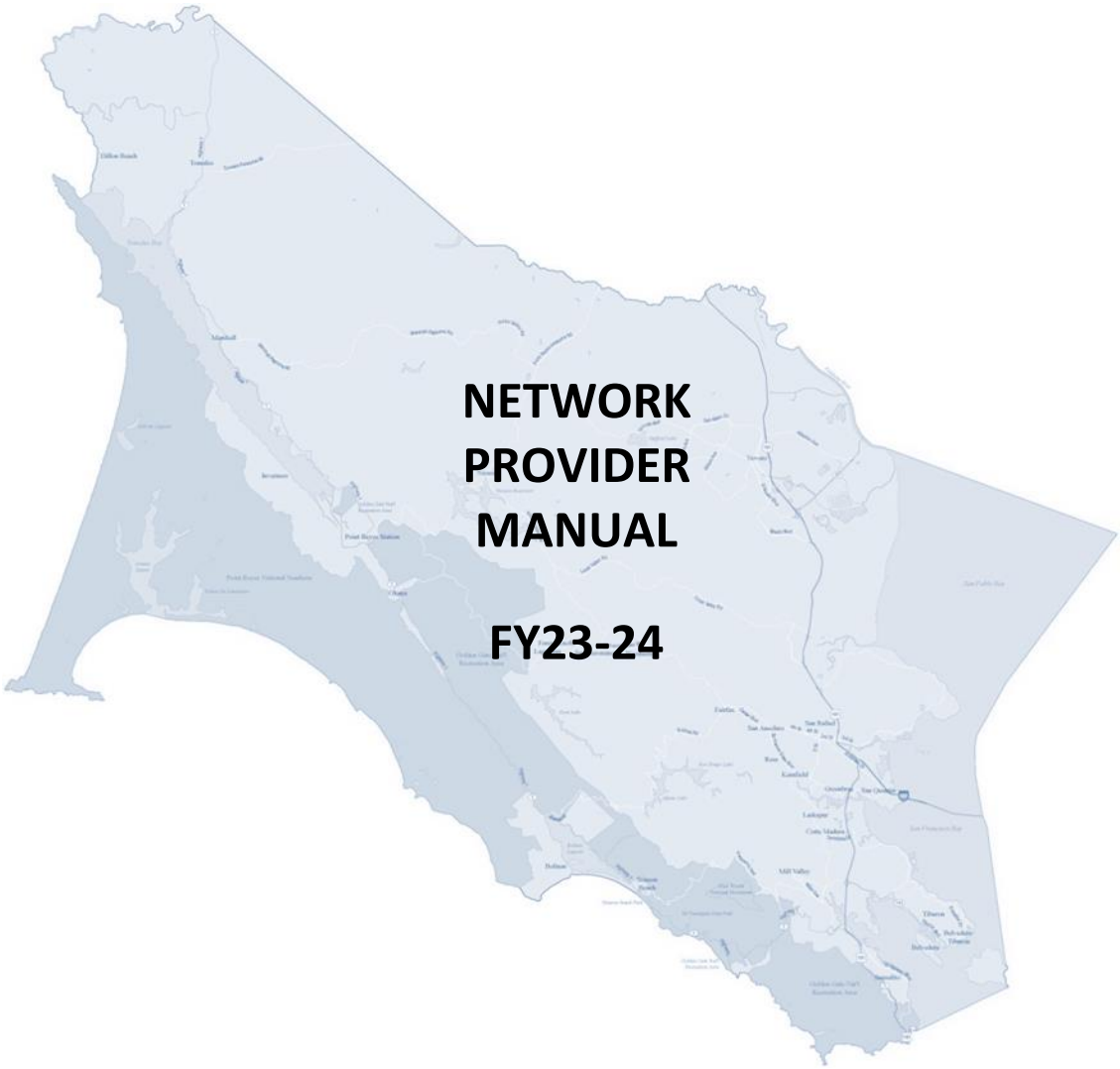
County of Marin
Behavioral Health and Recovery Services



NETWORK PROVIDER MANUAL

FY23-24

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Marin County Behavioral Health and Recovery Services
Outpatient Network Provider Important Phone Numbers

For Providers:

Access Team:
250 Bon Air Road, Greenbrae, CA 94904
Tel: 1-888-818-1115 (24 hours/7 days a week)
Fax: 415-473-2353
Access provides telephonic screening, information, and referral services as well as in person assessments for consumers. Access provides Authorization/Reauthorization services for network providers and is the point of entry into additional BHRS services. Access provides assessments on a walk-in basis on Monday, Wednesday, and Friday mornings. Scheduled appointments are available for the remainder of the week.

Quality Management:
20 N. San Pedro Road,
San Rafael, CA 94903
Tel: (415) 473-2887
Fax: (415) 473-4216
Providers (currently contracted or interesting in contracting) seeking information about processes regarding participation in the Marin County Mental Health Plan such as credentialing, site certification, consumer grievance resolution, informing materials, utilization management, etc.

Accounting:
Tel:415 473-3274
For providers who need assistance with checking monthly Medi-Cal eligibility or for help with questions regarding invoicing or to appeal payment decisions.

For Consumers:

Crisis Stabilization Unit:
250 Bon Air Road, Greenbrae, CA 94904 (24 hours/7 days a week)
Tel: 415-473-6666
Provides services to Marin County residents and visitors experiencing a mental health crisis, such as suicidal depression or psychotic behavior.

Adult Residential Detoxification Services:
Helen Vine Recovery Center
301 Smith Ranch Rd, San Rafael, CA 94903
Tel: (415) 492-0818
Non-medical detoxification program where adults under the influence of drugs and/or alcohol can safely withdraw from the ill effects of intoxication.

Mobile Crisis Response Team (MCRT)
7 days a week 1pm-9pm
Tel: 415-473-6392
Field-based team comprised of a licensed mental health practitioner and a peer provider. The team responds to individuals in the community who are in crisis.

Community Action Marin Warmline:
Phone Support for Peers (7 days a week 1pm-9pm):
Tel: 415-459-6330

National Suicide Prevention Lifeline:
Tel: 1-800-273-8255 (24 hours/7 days a week)

Marin County Patients' Rights Advocate:
(415) 473-2960

INTRODUCTION

As a result of the Medi-Cal Specialty Mental Health Services Consolidation Phase II that took effect on June 1, 1998, all non-hospital Specialty Mental Health Services are administered and provided through the Marin County Mental Health Plan (MHP) for consumers with severe mental health conditions. As of January 1, 2014, those consumers who are determined to have mild to moderate conditions in Marin County are to be served through Partnership Healthplan of California (PHC). These mild to moderate outpatient mental health services are provided through a contract with Beacon Health Options (and, on a more limited basis, by Kaiser Permanente.) The MHP and PHC have entered into a Memorandum of Understanding (MOU) that outlines how consumers are transitioned between the two plans as needed to address their mental health needs.

WELCOME

The Marin MHP (hereafter referred to as Behavioral Health and Recovery Services or BHRS) administers the County of Marin's Specialty Mental Health Medi-Cal program, as well as providing services directly. Outpatient mental health services, inpatient services, as well as other services in the system of care, must be viewed as components in a total continuum of care for all of Marin County's Medi-Cal beneficiaries who meet medical necessity criteria for specialty mental health services. This manual describes the responsibilities of Network Providers as part of this system of care. It mandates a collaborative partnership in which family/client and both county and contract service providers work together to achieve desired outcomes by providing quality services that are accessible, cost effective, and culturally competent.

Thank you for your decision to become a Network Provider for the Marin County Mental Health Plan. As an important link in Marin County's Division of Behavioral Health and Recovery Service's system of care, your successful participation in the Mental Health Outpatient Network is vital to our success. We look forward to working with you to ensure the delivery of Specialty Mental Health Services to eligible Medi-Cal beneficiaries. Should you have any questions, comments, or suggestions regarding the information in this manual, please direct your calls to the Access Team at 1- 888-818-1115

PRINCIPLES

BHRS is guided by the following principles at all levels of consumer services:

- Services are provided to consumers with respect and dignity.
- Services focus on consumers' strengths and abilities.
- Services are provided in a culturally competent manner.
- Services are provided in an organized, collaborative, coordinated, and cost-effective approach to care and treatment.
- Services are consumer-driven and family-focused and aim to achieve positive mental health outcomes for culturally diverse populations across all age groups.
- The emphasis when serving adults with serious and persistent mental illnesses and children and adolescents with serious emotional disturbances is through a comprehensive, community-based, coordinated system of care.
- The service system is "user-friendly" with easy access for consumers and a "seamless" interface with the physical health services provided to restore balance and wellness.
- The service delivery system is accountable for quality services and has defined outcomes a way of measuring effectiveness and efficiency.
- The system is responsive to the consumer through evaluating measurements of consumer satisfaction and having a process for approaching consumer grievance resolution.

PRACTICE GUIDELINES

Behavioral Health and Recovery Services (BHRS) is committed to high quality and effective client care, resulting in client satisfaction and improved recovery. BHRS providers utilize evidence-based practice guideline resources for clinical service delivery. Guidelines provide evidence-based recommendations for the assessment and treatment of behavioral health disorders intent to guide decisions.

The use of practice guidelines such as those available through reputable organizations like APA and SAMHSA, as well as BHRS policies, documentation guides, and provider manuals, is critical in the delivery of Specialty Mental Health Services (SMHS). Although not exclusive, these industry leaders provide practice guidelines on their websites to support the advancement of behavioral health care and treatment outcomes.

APA: The American Psychological Association (APA) is a professional psychological association whose mission is to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives.

SAMSA: The Substance Abuse and Mental Health Services Administration (SMHSA) is the agency with the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

It is BHRS policy that these Practice Guidelines apply to all Behavioral Health and Recovery programs and providers within the Mental Health Plan to ensure:

- appropriate use and monitoring of funds;
- include all partners in treatment planning, including consumers and their families;
- have standards related to quality, access, and coordination of services;
- have equitable access to care;
- have and follow eligibility criteria;
- offer continuity of care;
- provide services in appropriate locations and languages;
- provide culturally competent and age-appropriate services; and
- monitor the effectiveness, accessibility, and quality of services.

Additionally, BHRS (county and contractor) providers shall maintain Practice Guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;
- Consider the needs of the beneficiaries;
- Are adopted in consultation with contracting health care professionals; and
- Are reviewed and updated periodically as appropriate.

REFERENCES:

BHRS Policy No. BHRS-97: Service Delivery Practice Guidelines
MHP Contract, Ex. A, Att. 5, sec. 6(A)
42 CFR 438.236(b)
CCR, tit. 9 1810.326

TYPES OF SERVICES

Documentation standards for the services listed below can be found in the Clinical Documentation Guide.

ASSESSMENT

This service is to evaluate the current status of the individual's mental, emotional, or behavioral health. It can include a mental status exam, establishing a diagnosis, appraisal of the individual's functioning in the community, such as living situation, daily activities, social support systems, relevant cultural issues and history, and health history and status. Assessments includes screening for substance use/abuse and may include the use of testing procedures. The diagnosis, MSE, medication history, and assessment of relevant conditions and psychosocial factors are assessment activities which must be provided by a licensed and/or licensed waived practitioner

consistent with their scope of practice. However, other qualified providers may provide assessment activities such as gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

PLAN DEVELOPMENT

This service is development or revision of Problem Lists or, for those services that need them, treatment plans. Plan Development may be provided by any practitioner. When a new issue is identified there would be a need to update the problem list.

REHABILITATION

This service is to assist the client in improving a skill or the development of a new skill set. Rehabilitation means a recovery or resiliency focused service activity identified to address a behavioral health need. This service is aimed at restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. This procedure may be provided in an individual or group format. This procedure may be provided by any practitioner.

INDIVIDUAL THERAPY

These services include the application of strategies incorporating the principles of development, wellness, adjustment to impairment, and recovery and resiliency. Therapy should assist a client in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a client or group of beneficiaries and may include family therapy directed at improving the client's functioning and at which the client is present. Only Licensed/Registered/Waivered Staff and trainees who have the necessary training and experience can provide individual therapy.

FAMILY THERAPY

Family Therapy involves the client and one or more family members for the purpose of addressing the client's behavioral health impairments through changes in family member interactions.
These may include:
Support family members to understand client's mental health impairments
Assisting the family member learning coping strategies to support the client
Improving family communication to resolve conflicts
Facilitation of the attachment between child and caregiver
Teaching, modelling, and reinforcing parenting skills.

Only Licensed/Registered/Waivered Staff and trainees can provide this procedure provided that they are working within their scope of practice.

GROUP THERAPY

Specialty Mental Health Services may be provided to more than one individual at the same time. One or more practitioners may provide these services. As with individual therapy, only Licensed/Registered/Waivered Staff and trainees who have the necessary training and experience can provide individual therapy.

COLLATERAL

This service is provided to a "Significant Support Person" in the life of the client (e.g., family members, roommates) with the intent of improving or maintaining the mental health of the client. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity. **Note: effective with the transition to CalAIM claiming on 7/1/2023, collateral services cannot be claimed as a stand-alone service**. Claiming for collateral contacts will be dependent on the provision of a covered service. A collateral claim must be submitted together with the claim for the covered service or it will be denied.

MEDICATION SUPPORT SERVICES

This service provided by medical staff where it is within their scope of practice. This service type may include the initial assessment including medical and psychiatric history, current medication, chart review; observation of need for medication due to acuity; prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication; providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate); how the use of the medication may improve the effectiveness of other services a client is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing to not take medications. Medication Support Services supports beneficiaries in taking an active role in making choices about their behavioral health care and helps them make specific, deliberate, and informed decisions about their treatment options.
Medical Staff include Physicians, Registered Nurses, Certified Nurse Specialists, Licensed Vocational Nurses, Psychiatric Technicians, Physician Assistants, Nurse Practitioners, and Pharmacists. Scopes of practices differ within these staff types.

TARGETED CASE MANAGEMENT (TCM)

Targeted Case Management (TCM) services, also known as Brokerage, are services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service; monitoring of the client's progress once he/she receives access to services; and development of the plan for accessing services.
TCM services include:
Inter-and intra-agency communication, coordination, and referral,
Monitoring service delivery to ensure an individual's access to service and the service delivery system,
Linkage services focused on acquiring transportation, housing, or securing financial needs,
Locating and securing an appropriate living environment,
Locating and securing funding,
Negotiation of housing or placement contracts.
Placement and placement follow-up.
Discharge planning for the purpose of coordinating placement of the client upon discharge from a hospital.
Note that there are institutional limitations to TCM. Please refer to the Lockouts and Limitations section of the Documentation Manual.

CRISIS INTERVENTION

Crisis Intervention is an immediate emergency response that is intended to help a client cope with a crisis (potential danger to self or others, severe reactions that is above the client's normal baseline).
Examples of Crisis Intervention include services to clients experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves, (including provision/utilization of food, clothing, and shelter) due to a mental disorder. Service activities may include, but are not limited to Assessment, collateral, and therapy to address the immediate crisis. Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

INTENSIVE CARE COORDINATION (ICC)

Intensive Care Coordination (ICC) services are similar to TCM (Brokerage) but must be delivered using a Child/Youth/Client and Family Team (CFT) to develop and guide the planning and service delivery process. The difference between this service and traditional TCM is that ICC must be used to facilitate implementation of the cross-system/multi-agency collaborative services approach. ICC also differs from TCM in that it typically requires more frequent and active participation by the ICC Coordinator to ensure that the needs of the child/youth are being met. Requires a separate Treatment Plan.

INTENSIVE HOME BASED SERVICES (IHBS)

Intensive Home Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the Child/Youth/Client and their significant support persons to help the child/youth develop skills and achieve their goals and objectives. These are not traditional therapeutic services.
This service differs from rehabilitation services in that it is expected to be of significant intensity to address the intensive mental health needs of the child/youth and is predominantly delivered outside of the office setting such as at the client's home, school, or another community location.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Therapeutic behavioral service (TBS) is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health service. TBS is an intensive one-to-one, short-term outpatient treatment intervention. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility, or to enable a transition from any of those levels to a lower level of residential care. Therapeutic behavioral services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a to a lower level of placement. The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional TBS during a short-term period.
TBS Services may be provided to children and youth under the age of 21 who, in addition to having full cope Medi-Cal and meeting Medical Necessity criteria, also meet TBS class criteria under any of the following:
Child/Youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs;
Child/Youth is being considered by the county for placement in a facility described above;
Child/Youth has undergone at least one emergency psychiatric hospitalization related to current presenting mental health diagnosis within the preceding 24 months;
Child/Youth has previously received TBS while a member of the certified class;
Child/Youth is at risk of psychiatric hospitalization.

EVIDENCE-BASED PRACTICE IN MARIN'S CHILDREN SERVICES

CHILD PARENT PSYCHOTHERAPY (CPP)

Per the Child Trauma Research Program at UCSF, Child Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced at least one traumatic event (e.g., loss of a loved one, serious medical procedures, immigration events, abuse/violence in the home and/or community in this country or country of origin). These young ones often experience behavior problems both in the home and school setting, they also experience attachment and other mental health challenges, including PTSD. Parents also frequently experience the same and need support in navigating and establishing age- appropriate coping tools and how to provide safe containment.

This treatment integrates both attachment theory and psychodynamic theory, plus developmental and CBT perspectives. The primary goal of CPP is to strengthen the bond and support the relationship between caregiver and child, creating a family story that leads to healing. Creating meaning and speaking the truth regarding the traumatic events supports restoring the child's social, behavioral, and cognitive functioning. CPP also integrates cultural norms, immigration related/systemic racism stressors and socioeconomic stressors. Studies show that "CPP results in improvements in children and parent functioning and in the parent-child relationship."

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

Trauma Focused Cognitive Behavior Therapy is the most researched model for treatment of trauma symptoms. It is a model designed for children 8 - 18 years old that can be implemented in as few as 16-20 weeks. Parents or other significant caregivers participate throughout the treatment with an emphasis on psychoeducation, supportive parenting, safety planning, and emotional support to the parent. The intervention involves teaching parents and their child what it means to experience trauma so the child learns healthy ways to cope with thoughts/feelings, how to face their fears and worries, and develop trust and emotional connection.

BRIEF STRATEGIC FAMILY THERAPY (BSFT)

Youth and Family Services clinicians are trained in various evidence informed, family focused modalities, including Brief Strategic Family Therapy. BSFT utilizes a family systems framework to address youth's behavior problems by improving family interactions that are presumed to be directly related to the youth's symptoms. The target population in general is children and adolescents between 8 and 17 years of age displaying or at-risk for developing more severe behavior problems, including substance abuse. With nearly 40 years of clinical research and success across diverse cultural lines, the BSFT approach operates based on the premise that families are the strongest and most enduring force in the development of children and adolescents. Thus, the BSFT model not only addresses presenting symptoms, but it also aims to create better functioning families through shoring up their structure, for lasting change.

COORDINATED SPECIALTY CARE FOR EARLY PSYCHOSIS

Marin's Early Psychosis Program (known as Felton (re)MIND® Marin) provides early psychosis coordinated specialty care services delivered by a multidisciplinary team. Services are provided in outpatient clinic or in other community locations.

Service modalities include:

- Structured diagnostic assessments: comprehensive diagnostic assessments utilizing the SCID (Structured

Clinical Interview for DSM Diagnoses) or SIPS (Structured Interview for Psychosis-Risk Syndrome), as indicated.

- Individual psychotherapy (formulation-based Cognitive Behavioral Therapy for Psychosis - CBTp)
- Medication support – judicious medication management aligned with early psychosis coordinated specialty care standards.
- Strength-based care management: Intensive care management to address the broad spectrum of clients and family needs, including linkage to additional services and resources (housing, benefits, etc.).
- Family psychoeducation: Continuous education about the importance of early intervention, psychosis signs and symptoms, treatment resources, the role of school, work, and community, and social engagement in the recovery process. Family psychoeducation will also promote increased social support for families, problem-solving and coping skills.
- Peer support: Provided through partnership with Marin County BHRS, peer support services will contribute to increased social connectedness, engagement in treatment, and instill hope.
- Supported employment and education: The Felton (re)MIND model adopts the Individual Placement and Support (IPS) model of supported employment, with added focus on supported education.
- Public education and community outreach: The Felton (re)MIND program is actively involved in the community, engaging schools, families, advocacy groups, and other community-based organizations to spread the word that schizophrenia can be effectively treated.

WRAPAROUND SERVICES

The Marin County Sustaining Families Wraparound Program is a team-driven, family-centered, strength-based, and outcome-oriented alternative to high-level group care placements for youth with complex and enduring needs. This program serves clients from the Juvenile Probation, Children and Family Services, and Behavioral Health systems who are at risk of being removed from the community and placed in residential care. The Sustaining Families Wraparound Program offers a range of flexible services including a team-driven goal setting process, intensive behavioral intervention, parenting support, intensive care coordination, and therapeutic crisis intervention. The core principles of Seneca's service include unconditional care, parent-driven, strength- based service planning, individualized care, cultural competence, and interagency collaboration.

PROVIDING OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES AS A NETW0RK PROVIDER:

NETWORK PROVIDERS

Outpatient Network Providers deliver time-limited, evidence-based individual and group psychotherapy services for Marin Medi-Cal beneficiaries. All services provided by Network Providers must be performed by practitioners licensed to practice psychotherapy independently. Agency providers may use interns to provide services to Medi-Cal beneficiaries. All interns must have completed an appropriate graduate degree, work within the scope of their practice, and be supervised according to the requirements of the Board of Behavioral Sciences. These mental health professionals provide services to beneficiaries in accordance with legal and ethical standards and with all relevant professional, federal, state, and/or local regulatory and statutory requirements.

BECOMING A NETWORK PROVIDER

Qualified individual and small agency providers may apply for the opportunity to provide services as Network Providers. Qualified providers include Psychiatrists (MD/DO), Licensed Psychologists (PsyD/ PhD), Licensed Clinical Social Workers (LCSW), and Licensed Marriage and Family Therapists (LMFT) who have been credentialed by BHRS Quality Management. Interested professionals should submit a completed credentialing application to begin the process of becoming a provider. The credentialing process verifies educational history, relevant licenses and certifications, education/continuing education, work/military history, admitting privileges, professional memberships and malpractice insurance history and includes malpractice actions, disciplinary actions, and criminal offenses. Once the potential provider completes the credentialing process, BHRS checks the required excluded provider databases, and enters into a contractual relationship with the provider. To begin this process, contact Access at 1-888-818-1115.

ACCESS CRITERIA AND MEDICAL NECESSITY FOR SPECIALTY MENTAL HEALTH SERVICES:

All Marin Medi-Cal beneficiaries are eligible for an assessment to determine whether the Access Criteria for Specialty Mental Health Services are met. Assessments to determine medical necessity are provided by the BHRS Access Team, which can be reached at 1-888-818-1115.

ACCESS TEAM

The BHRS Access Team functions as the point of entry for outpatient specialty mental health services. The Access Team provides 24/7 information, screenings, and referrals by phone as well as scheduled assessments during business hours for adults and children who are Marin County Medi-Cal beneficiaries. The Access Team provides referrals and authorizations for Specialty Mental Health Services that may be provided by county programs and/or a network of organizational and individual providers. Callers requesting mental health and/or substance use treatment services may be provided screening, referral, and coordination with services from other entities (such as educational, housing, and vocational rehabilitative services) if the nature and severity of the mental health and/or substance use impairment of the individuals does not require specialty services. Callers may be referred to PHC for primary care or the appropriate Medi-Cal managed care plan for mild or moderate services as warranted.

ACCESS CRITERIA FOR SPECIALTY MENTAL HEALTH SERVICES

Criteria for beneficiaries 21 years of age and older:

Beneficiary meets both of the following criteria, (1) and (2) below:

(1) The beneficiary has one or both of the following:
   a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
   b. A reasonable probability of significant deterioration in an important area of life functioning

   And

(2) The condition is due to either of the following:
   a. A diagnosed mental health disorder, according to the criteria of the DSM and the ICD.

      Or

   b. A suspected mental disorder not yet diagnosed.

Criteria for beneficiaries under 21 years of age.

Beneficiary meets either (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

   Or

(2) The beneficiary meets **both** of the following requirements in a. and b., below.
   (a) The beneficiary has **at least one** of the following:
      i. A significant impairment
      ii. A reasonable probability of significant deterioration in an important area of life functioning
      iii. A reasonable probability of not progressing developmentally as appropriate
      iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

      And

   (b) The beneficiary's condition as described above is due to **one of the following**:
      i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
      ii. A suspected mental health disorder that has not yet been diagnosed
      iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

MEDICAL NECESSITY IN CONTEXT OF ACCESS CRITERIA

The California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to improve health outcomes by ensuring that beneficiaries have access to the right care in the right place at the right time. A part of improving this access is by redesigning the medical necessity criteria for Specialty Mental Health Services for children and adults. These changes supersede the previous medical necessity criteria described in Title 9 that are based on ameliorating symptoms and functional impairments brought about by an included diagnosis and are aimed at lessening the burden on beneficiaries to get through the door for treatment. This deemphasis on diagnosis to establish medical necessity is meant to allow more flexibility in the provision of services but is not meant to eliminate diagnoses in clinical practice as a focus for treatment.

All Medi-Cal services provided to persons in care continue to need to meet the standard of being "medically necessary". However, under the CalAIM revision, medical necessity criteria will now be more closely aligned with W&I Code definitions for adults[1], and Title 42[2] for children.

For persons 21 years of age or older, a service is generally "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. This is in addition to the following criteria.

- The person has a significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in an important area of life functioning
- AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

For individuals under 21 years of age a service is "medically necessary" if needed to correct and ameliorate a mental illness or condition. This would include services that sustain, support, improve, or make more tolerable a mental health condition. This is in addition to the following criteria.

- The person is experiencing homelessness, and/or is interacting with the child welfare or criminal justice system
- OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder.
- OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment
- AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

If the Criteria for Specialty Mental Health Services are met, the beneficiary is authorized to receive a defined set of services for a specified period of time. Services may continue beyond the initial authorization period if those services are requested in a timely way and are shown to continue to meet the criteria above. When these criteria are found not to be met, the beneficiary may be referred to other county or community service, social welfare and protective or health care entities as necessary.

NETWORK PROVIDER RESPONSIBILITIES:

MEDI-CAL SITE CERTIFICATION REQUIREMENT

All Network Providers are expected to ensure compliance with Medi-Cal program certification requirements. (see *"DHCS Medi-Cal Site Certification-Recertification Protocol").* Provider Medi-Cal sites are certified by BHRS Quality Management staff for a period of three years. Providers will receive notice from BHRS Quality Management staff regarding the timing of certification visits. Providers must allow BHRS staff access to their sites to allow for certification/recertification visits in order to maintain their status as Network Providers.

TIMELY AND ACCESSIBLE SERVICES

Providers will respond to new authorizations for services from BHRS Access in a timely manner. Providers will contact new beneficiaries within five working days of receiving a referral from the BHRS Access Team. Providers will offer a new beneficiary an initial appointment within ten working days of the referral for routine service requests.

Providers will attempt to contact a new client three times within the first ten working days after receiving a referral. If the provider is unable to reach the beneficiary to schedule an appointment, or if the beneficiary does not initiate services, the provider will inform Access that treatment was not initiated and close the treatment episode. (See ***"MCO Discharge Form"***)

In the event that beneficiaries approach providers directly for services, the provider will assist the beneficiary in communicating with the BHRS Access Team to obtain and assessment and authorization as suitable. Providers will update BHRS Access Team regularly as to their availability to accept new clients.

CLINCAL DOCUMENTATION/FISCAL RECORDS: CREATION, STORAGE AND RETENTION

Network providers are required to keep medical records that document the provision of services. Records must be compliant with BHRS standards (see ***"BHRS Standards for Clinical Records"***) be legible and kept in detail consistent with appropriate professional practice in order to document client care and allow for appropriate follow up and or care transitions. Records must also be available in a format that allows for internal professional review and external audit.

A current Clinical Documentation Guide that provides information regarding the required documentation elements, including changes under CalAIM, domain requirements of assessments, problem lists and progress notes can be found here: Clinical Documentation Guide.

The contract provider must maintain clinical records for at least seven (7) years from the last date of service to the beneficiary (or age 18 plus one year for child records, whichever is later) and must make the books and records (which pertain to the services provided to members under the contract provisions with BHRS) available for inspection, examination or copying by BHRS staff, the State Department of Health Care Services (DHCS) and the U.S. Department of Health and Human Services; at all reasonable times at the provider's place of business or at another mutually agreeable location; and in a form maintained in accordance with the general standards applicable to such record keeping.

PROTECTED HEALTH INFORMATION AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 requires all health care providers to make sure that individual medical information is kept private. Any information relating to an individual that has the possibility of tying that person to his/her health record is confidential. HIPAA applies to information communicated both orally and in writing. It applies to information housed in any files or depositories. It also applies to information stored in any electronic or recording device, database or transmitted through any electronic means. See ***"HHS Confidentiality and Privacy in Healthcare"*** in Contractor Resources for more information.

BENEFICIARY INFORMING MATERIALS -- POSTED AND AVAILABLE MATERIALS

Network Providers post or make available the following materials, which are available in Contractor Resources. Providers must post a notice explaining the grievance, appeal, expedited appeal and fair hearing process. (***"Grievance, Appeal, Fair Hearing, COP Poster"***) Providers must make available to beneficiaries the Grievance Brochure (along with a postage-paid envelope) (***"Grievance Brochure"***), the BHRS Member Handbook ("***MMHP Member Handbook"***), the Beneficiary Handbook ***("MMHP Beneficiary Booklet")*** and a current Provider List (***"MMHP Provider List"***). All materials are available in English, Spanish, Vietnamese, Large Font, and audio formats upon request by calling Access at 1-888-818-1115.

BENEFICIARY INFORMING MATERIALS -- PROVIDED MATERIALS

Network Providers must provide Medi-Cal beneficiaries the following materials (which are provided in Contractor Resources) during their initial sessions and must document receipt of the materials in the medical record. **"*HIPAA Notice of Privacy Practices*"** must be provided to all Medi-Cal beneficiaries or parent/guardians at the first face-to-face contact for services. Receipt must be documented by retaining a signed copy of the **"*Notice of Privacy Practices Acknowledgement*"**. The provider must also post the **"*HIPAA Notice of Privacy"*** in a clear and prominent location where individuals are likely to see it, as well as make the notice available to those who request a copy.
"Advance Health Care Directive" must be provided to all beneficiaries aged 18 and older at the first face-to-face services. Providing this information must be documented in the medical record.
All materials are available in English, Spanish, Vietnamese, Large Font, and audio formats upon request by calling Access at 1-888-818-1115.

CONSUMER GRIEVANCE RESOLUTION

BHRS has established complaint/grievance procedures. These include preparation and distribution of materials concerning clients' rights and the grievance process, as well as ongoing outreach to inform and educate clients and their families about how they can participate in that process. Additionally, this process includes mechanisms to monitor and take action to resolve disputes between beneficiaries and providers and observes defined timelines and legal parameters to assure fair and equal treatment for all.
The complaint/grievance process is the responsibility of BHRS staff. It assures that all beneficiaries and providers have clear avenues to seek timely resolution of grievances and complaints. Both individuals and providers may contact BHRS at any time by phone (415) 473-2887 (Quality Management) or (888)-818-1115 (Access Team) or by mail to begin a problem resolution process. The consumer grievance resolution process can be found in the Grievance Brochure. The Member Handbook describes how beneficiaries should proceed when they are not satisfied with their services.

PAYMENT POLICIES AND PROCEDURES

ELIGIBILITY VERIFICATION

Providers have a responsibility to verify ongoing Marin Medi-Cal (County Code 21) eligibility monthly for the beneficiaries they serve. Providers with a Medi-Cal provider number and PIN number can check eligibility using the EDS Automated Eligibility Verification System (AEVS), https://www.medi-cal.ca.gov/eligibility/login.asp or by calling 1 (800) 456-2387. Providers can sign up for access to the system here: http://www.medi-cal.ca.gov/signup.asp or by calling 1-800-541-5555.

Providers who do not have access to the AEVS system, can call BHRS Accounting at 415 - 473-3274 for assistance. If you reach the confidential voice mail, you can leave: your name and phone number, and the Social Security Number/Client Index Number (CIN), last name and date of birth for the client for whom you need to check eligibility, as well as the month for which you are verifying eligibility.

PLEASE NOTE: Service authorization does not guarantee **on-going** Medi-Cal eligibility. The Access Team verifies eligibility prior to authorizing services; however, eligibility could change at any time. **It is the provider's responsibility to check eligibility on the first of every month to ensure that services are provided only to eligible beneficiaries.**

CLAIMS SUBMISSION

Submit payment requests using the Health Insurance Claim form CMS-1500 (02-12). (See ***"CMS Blank Form"*** and ***"CMS Sample Form"*** for guidance on how to use this form.)

Claim forms can be mailed or faxed to:
Marin Mental Health Plan Accounting
20 North San Pedro Road, Suite 2025A, San Rafael, CA 94903
Fax: (415) 473-5850

Claims are due **by the 10th day of the month that follows the month** in which the services are provided.

CLAIMS PAYMENT

BHRS pays claims by the last day of the month that follows the date of the receipt of a complete, accurate, claim for pre-authorized services. Payment is made for valid claims for mental health services if the following conditions apply: 1) Services were delivered by a contract provider, 2) services delivered were pre-authorized by the BHRS Access Team, 3) services were within the range of pre-selected service codes allowed by scope-of-practice and contract agreements; 4) services were provided in person (unless non-face to face services were pre-authorized) and 5) the client was a full scope Marin Medi-Cal beneficiary at the time of service.

Payment will not be made for:

- Missed appointments. Beneficiaries are encouraged to attend all scheduled appointments. Providers may not charge the MMHP or the beneficiary for missed appointments.
- Incorrect CPT codes. Providers will be paid only for those CPT codes listed in the contract and authorized by the BHRS Access Team.
- Clients in a lock out setting for Medi-Cal claiming, such as juvenile hall, jail, or prison. See the Clinical Documentation Guide for more information on claiming lock outs.
  https://www.marinhhs.org/clinical-documentation-guide

- Services are claimed for a different date of service than they were provided.

BENEFICIARIES WITH OTHER INSURANCE

Just as Medi-Cal eligibility can change, a person's overall health insurance can also change. Medi-Cal is the "payor of last resort", meaning that if a beneficiary has another health insurance plan, that health insurance must be billed first. It is only when another health insurance is billed, and that payor adjudicates the claim and provides a denial of payment that Medi-Cal can be billed.

BHRS cannot bill Medicare, or any other form of insurance on behalf of Network Providers. Providers who wish to take other forms of insurance are responsible for contacting those insurance carriers. Beneficiaries who have insurance in addition to Medi-Cal cannot receive services from Network Providers.

Individuals with Medi-Cal coverage who have an income above a certain level may be required to pay a monthly share of the cost of their services. Clients identified as Share-of-Cost beneficiaries are not referred to the outpatient provider network, but are served, when appropriate, within County-managed resources.

PROVIDER COMPLAINT RESOLUTION: AUTHORIZATION/PAYMENT APPEALS

Network Providers may contact BHRS at any time to begin a problem resolution process. BHRS staff will work with the providers to resolve problems and concerns as quickly and as easily as possible. The provider may institute an appeal at any time during this process.

- Providers may appeal denied requests for authorization or payment, in writing, directly to Quality Management, at the above address.
- A written appeal shall be submitted to BHRS Quality Management within 90 calendar days of the date of receipt of the non-approval of the request for authorization or payment.
- BHRS Quality Management shall have 60 calendar days from receipt of the appeal to inform the provider, in writing, of the decision and its basis.
- BHRS Quality Management shall use personnel not involved in the initial decision to respond to the provider's appeal.
- If the appeal is not granted in full, the provider will be notified of their right to submit an appeal to DHCS. For appeals regarding disallowance of paid claims resulting from client record review findings, the provider may appeal to DHCS in accordance with Title 9, § 1850.350.
- If the appeal is approved, the provider is required to submit a revised request for payment authorization within 30 calendar days from receipt of the BHRS decision to approve the payment authorization request. BHRS will have 14 calendar days from the date of receipt of the provider's revised request for payment authorization to re-submit the claim that is required to process the payment.

QUALITY MANAGEMENT/UTILIZATION REVIEW (QM/UR)

BHRS QM/UR staff are responsible for assuring that high-quality services are provided to beneficiaries in a cost-effective and efficient manner. The QM/UR staff may review services and programs of Network Providers in order to ensure services are accessible, culturally, and linguistically competent, and produce desirable outcomes through the efficient use of resources. QM/UR provide periodic training in medical necessity criteria, documentation standards, patients' rights issues, and other quality components referenced in this manual. (See ***BHRS Clinical Documentation Guide***)

BHRS QM/UR staff monitor beneficiaries' satisfaction with services they receive from contract providers. They also evaluate contract performance based on measurable objectives. If QM/UR staff find that a provider is deficient in providing care, or if other problem areas are discovered, appropriate investigative procedures are initiated. If these deficiencies or problem areas are verified, corrective actions and sanctions may be applied. These sanctions may include mandatory review of all claims, periodic review of medical records, or termination of the provider's contract with the BHRS.

PROVIDER NOTICES

Provider Notices are distributed to providers to inform them of policy, administrative or financial changes and updates. All changes to the provider manuals that are disclosed in Provider Notices have the authority of policy and are binding, as indicated, to County and providers.