GLENN COUNTY
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services

Provider Manual

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QUICK REFERENCE

Contact Information

Glenn County Health and Human Services Agency
Mental Health Services
242 North Villa Avenue
Willows, CA 95988

Local Voice Calls	**(530) 934-6582**
Toll-Free 24-hour Crisis Services	**1-800-500-6582** during office hours OR **1-800-507-3530** after hours/on weekends & holidays
Hearing Impaired TDD	711

Regular Clinic Hours: Monday through Friday, 8 a.m. to 5 p.m.

ALL PLANNED SERVICES MUST BE PREAUTHORIZED BY:

Glenn County Mental Health
Utilization Review Team

PATIENT'S RIGHTS ADVOCATE

(530) 934-6588

Definitions

Beneficiary: This is a Medi-Cal-eligible individual who is a Glenn County resident requesting mental health treatment services. Parents or legal guardians also may call to request services on behalf of a beneficiary.

Contract Provider: This is a licensed mental health professional, organization, or hospital that has contracted with the Glenn County Health and Human Services Agency to provide mental health services to Medi-Cal beneficiaries.

Emergency Condition: The criterion for emergency status is that the individual is a danger to self or others, or is gravely disabled.

Intake Process: A Screener with intake and referral skills training will receive calls from beneficiaries and providers. The Screener will ask questions regarding the general nature of the call and make an appointment with staff as appropriate. Staff are required to obtain basic information to complete a State-mandated contact log.

Medi-Cal: This is California's version of the Federal Medicaid program. This is a State and Federal-funded health insurance program for low-income individuals and families.

Medical Necessity: Medical necessity is required to justify payment for specialty mental health services. See the later section titled "Medical Necessity."

Pre-Authorization: All planned specialty mental health services require pre-authorization. This pre-authorization can be arranged by contacting the Screening and Referral line and completing the intake process.

Screening and Referral Line: This line is the Glenn County Mental Health primary line (530-934-6582) which is available to help Medi-Cal beneficiaries obtain mental health treatment. Callers may ask questions about eligibility for mental health services, and can obtain referrals and/or authorization for mental health services. They also may express a concern or complaint, or get immediate help for a crisis. A provider may also call this number to obtain information on claims. (Note: Individuals who are hearing impaired may call the TDD number, 711.)

Specialty Mental Health Services: This term is used by the State to identify those mental health services that can be reimbursed by Medi-Cal. Included are individual, group, and family therapy.

Urgent Condition: This is a situation experienced by the individual that, without timely intervention and treatment, is certain to result in an immediate emergency psychiatric condition.

Mission Statement

The mission of Glenn County Mental Health is to enable individuals in our community who are affected by mental illness and serious emotional disturbances to achieve the highest quality of life. To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture.

As GCMH pursues this mission, each employee is expected to conduct his or her work with the highest standards of ethics and integrity. Each employee will conduct all business, activities in an ethical and law-abiding fashion. Each employee will maintain a service culture that builds and promotes the awareness of compliance.

GCMH Core Values

- Respect
- Honesty
- Integrity

- Courtesy
- Quality
- Competence

- Staff/Client/Family Partnership
- Confidentiality

GCMH Goals

- Improve client access to mental health treatment.
- Work with clients and other health care providers to arrange for quality care.
- Be sensitive to each client's needs.
- Deliver cost-effective services to clients to help them manage their mental health problems.

PROVIDER SITE CERTIFICATION

All organizational providers who contract with Glenn County Health and Human Services Agency, Mental Health (GCMH) must be certified by GCMH via a direct site-certification process, or through certification-sharing procedures with the provider's host county. The Site Certification requirements cover seven specific categories:

1. Fire safety (a fire safety inspection with local fire marshal is the mandatory preliminary step in this process),
2. Physical plant,
3. Policies and procedures,
4. Physician availability,
5. Staffing,
6. Day care staffing ratios, and
7. Pharmaceutical services.

Site Certifications will be required every three years, or when a provider relocates, changes their type of services, or makes modifications to its physical plant/facility. GCMH will require a written program description from the facility prior to a Site Certification. Site Certification must be completed prior to the start of contracted reimbursable services.

For more information on Site Certification, please refer to DMH Information Notice 04-09, December 17, 2004 (Appendix A).

PROVIDER CREDENTIALING

Licensed psychiatrists (MD), licensed clinical psychologists (PhD/PsyD), licensed clinical social workers (LCSW), licensed marriage and family therapists (LMFT), and licensed registered nurses (RN) (within their scope of practice) are eligible to be credentialed as individual providers of GCMH. Providers serving Glenn County Medi-Cal clients may become part of the GCMH provider network by submitting:

1. A confidential provider application;
2. A copy of their current license;
3. A Certificate of Insurance verifying that the provider has a minimum of $1,000,000 aggregate annually Professional Liability Insurance; and
4. A signed provider contract.

AUTHORIZATION OF SERVICES

Medical Necessity Criteria

All authorizations of planned services require prior justification of medical necessity. For purposes of authorization of planned specialty mental health services, medical necessity is determined by the GCMH Utilization Review (UR) Team. Attachment A – GCMH Level of Service and Medical Necessity form – is the tool used by GCMH to assure consistency and maximum objectivity in their decision-making process. Providers are encouraged to use this tool in their own evaluations of Medi-Cal beneficiaries.

Outpatient Services Authorization Process

The following assumes that the provider is located in Glenn County and that the client is a Glenn County Medi-Cal-eligible beneficiary.

Initial Authorization

All providers must contact GCMH and obtain authorization prior to providing a planned Medi-Cal-reimbursable specialty mental health service.

The provider must provide the GCMH screening staff with the following preliminary information, all of which is required for a State-mandated contact log:

- ✓ Client name
- ✓ Medi-Cal number (The provider is responsible for verifying Medi-Cal coverage.)
- ✓ Date of birth
- ✓ Phone number
- ✓ Language preferred for services
- ✓ Type of services being requested
- ✓ Initial disposition

In general, screening staff will schedule an appointment for the beneficiary to receive an in-person assessment at a GCMH clinic. All intake paperwork will be completed at that time, and clinical staff will obtain the balance of information that the UR Team needs. The UR Team is responsible for determining if services can be authorized beyond the initial assessment and plan development sessions.

Possible UR Team decisions include (1) denial of reimbursement because of a perceived lack of medical necessity; (2) approval and referral within the agency; or (3) approval of a specific number of visits within a specified time frame by the requesting provider.

The UR Team meets weekly for reviews of requests for routine, planned services. The results of the review, whether approval or denial of services, are communicated in writing to the provider and, unless otherwise requested, to the beneficiary. Later sections of this document provide more information about written notifications.

Any beneficiary who requires ***urgent care*** during regular clinic hours (M-F, 8 a.m.-5 p.m.) should be referred immediately to a GCMH clinic for a face-to-face assessment with a mental health clinician and/or physician as needed. Authorizations for subsequent care will be determined within one (1) hour. Outside of regular clinic hours, beneficiaries should be referred to the Emergency Department at Glenn Medical Center in Willows for both emergency and urgent care.

Within sixty (60) calendar days of the Clinical Assessment date, the provider must submit a written Client Treatment Plan for the beneficiary's authorized period of services (see Attachment B for a sample Client Treatment Plan). Failure to provide this plan on a timely basis precludes payment of further services until the plan is submitted.

Authorization of Extended or Add-on Services

If add-on services are required, providers shall request additional services through the UR Team. Documentation supporting the add-on services will be required.

It is anticipated that most clients will not require more than one year of outpatient services (exceptions may be clients requiring medication, Case Management, and high-risk clients). Providers are encouraged to exercise their clinical judgment and to assess with clients when maximum benefit from services has been achieved and a reduction in services or discharge is appropriate. If extended or add-on services are warranted, requests for extended or add-on services should be submitted to the UR Team at least thirty (30) days prior to the last scheduled visit.

Discharge Summary

Providers are required to submit a discharge summary to GCMH within thirty (30) days of the completion or cessation of treatment of any GCMH client.

Prescription Medications

Beneficiaries and providers must look to the California State Department of Health Care Services (DHCS) for authorization and/or reimbursement for prescription medications. Medication reimbursement is not a part of GCMH.

Other Outpatient Authorization Scenarios

Glenn County Professional Provider; Client from another County
Authorization of services to be provided to any beneficiary from another county must be obtained from the home county mental health authorization unit. Service authorization approval must be obtained to assure that the beneficiary's home county will reimburse GCMH for services delivered. The UR Team or designee shall be the primary contact to assure that necessary procedures are fulfilled to obtain the client's home county service approval.

Glenn County Client; Professional Provider from another County
Providers from other counties who seek to treat a GCMH client must follow the same procedures and meet the same requirements as GCMH providers. Out-of-county providers shall contact GCMH at 1-800-500-6582 for pre-authorization of specialty mental health services. In addition, out-of-county providers must complete the Service Authorization Request (SAR) and forward the document to GCMH for review and authorization.

Therapeutic Behavioral Services (TBS)
Authorization, Documentation, and Monitoring

Overview

Therapeutic Behavioral Services (TBS) are an EPSDT-supplemental service for full-scope Medi-Cal beneficiaries under the age of 21 years who meet medical necessity, as well as criteria specific to TBS.

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 client's current living situation or planned transition to a lower level of placement. The purpose of providing TBS is to further the client's overall treatment goals by providing additional therapeutic services during a short period of time.

Authorization Process

Provider requests for Therapeutic Behavioral Services shall be directed to the GCMH TBS Coordinator for assessment consideration. The GCMH TBS Coordinator shall consult with the UR Team regarding appropriateness of the TBS referral and verify that eligibility requirements are met.

The GCMH UR Team will authorize services as appropriate.

The GCMH TBS Coordinator will initiate a treatment meeting with the TBS provider to complete a TBS Treatment Plan and submit the information to the UR Team.

Authorization Timelines

1. Standard Authorization Decisions: GCMH shall provide authorization notice as quickly as the client's health condition requires, but not more than fourteen (14) calendar days from the receipt of the request for service.
   a. The client may request an extension of up to fourteen (14) additional calendar days.
   b. GCMH may request an extension of up to fourteen (14) additional calendar days if more information is required and the extension is in the client's best interest (as determined by GCMH).

2. Expedited Authorization Decisions: for cases in which GCMH or the requesting provider indicates that the standard authorization timeframe could seriously jeopardize the client's life or health, or his/her ability to attain, maintain, or regain maximum function, GCMH must provide authorization notice as quickly as the client's health condition requires, but not more than 3 working days after receipt of the request for service.
   a. The client or provider may request an extension of up to fourteen (14) calendar days.
   b. GCMH may request an extension of up to fourteen (14) calendar days if more information is required and the extension is in the client's best interest (as determined by GCMH).
   c. To utilize this expedited process, the provider shall complete an Expedited Authorization Request form (see Attachment V).

3. Denials or Modifications of Requests for Service
   a. In the event that GCMH denies or modifies the request for services, a Notice of Adverse Benefit Determination (NOABD) will be sent to the client. The provider requesting the service must be notified as well, but may be given notice verbally.
   b. All client protections under Title 9, Chapter 11 are applicable to TBS services. Clients have the right to receive a Notice of Adverse Benefit Determination, access the GCMH appeals process, and access the State Fair Hearing process.

Treatment Plan and Documentation

There must be a written Treatment Plan for Therapeutic Behavioral Services, completed by the provider, as a component of an overall Treatment Plan for specialty mental health services. The TBS Treatment Plan will identify all of the following:

1. Specific target behaviors or symptoms jeopardizing the current placement or presenting a barrier to transitions, e.g. tantrums, property destruction, assaultive behavior in school.

2. Specific interventions to resolve the behaviors or symptoms, such as anger management techniques.

3. Specific outcome measures that can be used to demonstrate the frequency of targeted behaviors has declined, and replaced with adaptive behaviors.

4. Transition Plan: as a short-term service, each TBS Treatment Plan must include a TBS Transition Plan. This plan will outline the process for decreasing and/or discontinuing Therapeutic Behavioral Services when they are no longer needed, or appear to have reached a plateau in benefit effectiveness. When applicable, the plan shall also include a process for the client's transition to adult services when the client turns 21 years old and is no longer eligible for TBS. This plan should assist parents and/or caregivers to gain the skills and strategies to provide continuity of care once this service has been discontinued.

5. The TBS Treatment Plan must be reviewed monthly by GCMH licensed staff to ensure that Therapeutic Behavioral Services continue to be effective and that the client is making progress towards the specified, measurable outcomes. If necessary, the TBS Treatment Plan should be:
   a. Adjusted to identify new target behaviors, interventions, and outcomes as necessary and appropriate; and
   b. Reviewed and updated whenever there is a change in the client's residence.

6. A Progress Note is required for each time period that a Therapeutic Behavioral Services Aide spends with the client. The TBS Progress Note is completed by the Provider and reviewed by GCMH on a monthly basis.
   a. The Progress Note should include significant interventions which address the goals of the Treatment Plan. The Progress Notes do not have to justify staff intervention or activities for all billed minutes, just each time period spent with the client.
   b. TBS staff shall complete documentation on a daily basis.
   c. Time spent traveling and documenting progress notes linked to the services provided are Medi-Cal billable. On-call time for the staff person providing TBS is not Medi-Cal billable.

Supervision and Quality Management

Although GCMH contracts TBS to outside providers, it will continue to maintain responsibility for determining the need for, providing access to, and managing Medi-Cal specialty mental health services.

A. The GCMH Clinical Supervisor will provide the appropriate oversight and is responsible for the following:

   1. Submitting a list of TBS providers to DHCS on an annual basis.
   2. Ensuring that TBS is provided under the direction of an LPHA, per state requirements.

3. Providing information about TBS (and EPSDT) services to beneficiaries under the age of 21, and their beneficiaries, on an annual basis, as well as upon admission to a psychiatric hospital, SNF, IMD, or group home (Levels 12-14).
4. Ensuring that the beneficiary protections outlined in Title 9, including the grievance, appeal, and fair hearing processes, are extended to all beneficiaries and that they are informed of these protections.
5. Ensuring that TBS is provided, if medically necessary, as transition services to a lower level of care for children/youth in a psychiatric hospital, SNF, IMD, or group home (Levels 12-14).
6. Determining TBS eligibility of children/youth prior to their release from an IMD, to ensure that TBS services are available to eligible clients, as appropriate, upon discharge.
7. Ensuring that accurate processes for claiming and reporting are in place, including reviewing provider Treatment Plans and Progress Notes on a monthly basis.

B. The TBS contracting provider is responsible for the following activities:

1. Recruiting and screening Therapeutic Behavioral Services Aides;
2. Training TBS Aides;
3. Providing support to TBS Aides;
4. Coordinating TBS on a day-to-day basis;
5. Maintaining written documentation of all services provided in a standard that meets GCMH requirements; and
6. Perform other duties as assigned by GCMH.

C. Clinical Supervision

1. As noted, TBS must be provided by a licensed practitioner of the healing arts OR by trained staff members who are under the direction of a licensed practitioner of the healing arts, as defined in the contract between DHCS and GCMH.

2. GCMH will direct a qualified staff member to oversee TBS. All decisions regarding clinical treatment of a client who receives TBS must meet GCMH approval prior to authorization. All decisions regarding TBS eligibility, assessment, treatment planning, hiring, retention, training, support, will be subject to the final approval of GCMH.

3. A licensed clinical supervisor or designee of GCMH will be available for consultation on a 24-hour a day, 7 day a week basis to assist TBS Aides in any difficulties that they may encounter related to their contractual obligations. When providing services on a day-to-day basis, TBS Aides will contact the GCMH TBS Coordinator for clarification.

Facility (Inpatient) Services
Authorization Process

The following assumes that the provider is located in Glenn County and that the client is a Glenn County Medi-Cal-eligible beneficiary.

Initial Authorization

Emergency Admissions: Emergency hospital admissions do not require pre-authorization. The hospital is required to notify GCMH at 530-934-6582 within 10 days to coordinate with the UR Team and mental health case management staff.

Planned Admissions**:** All planned inpatient admissions must be pre-authorized by the GCMH UR Team. Providers should contact the GCMH UR Team at 530-934-6582.

Hospital Admissions directly from an Institution for Mental Disability (IMD): Such transfers must be coordinated through the GCMH UR Team. Providers should contact the GCMH UR Team at 530-934-6582.

Urgent Care: Any beneficiary who needs urgent care during regular clinic hours (M-F, 8 a.m.-5 p.m.) should be referred immediately to a GCMH clinic for a face-to-face assessment with a mental health clinician and/or physician, as needed. Authorizations for subsequent care will be determined within one (1) hour. Outside of regular clinic hours, such beneficiary should be referred to the Emergency Department at Glenn Medical Center in Willows for both emergency and urgent care.

Ongoing Review and Authorization

Inpatient services for emergency admissions will be reviewed by GCMH. Upon discharge, the inpatient provider shall submit a Treatment Authorization Request (TAR) for the inpatient days. GCMH will review and authorize services based upon medical necessity, chart documentation, and level of need.

Case Management and Discharge Planning

The hospital staff must complete an assessment of the beneficiary's available support system, including community agencies and others, for all appropriate interventions. The GCMH case manager may assist in this effort. The hospital's discharge planner will be responsible for making appropriate pre- and post-discharge referrals to assure continuity of care and coordination with community services. GCMH staff will facilitate follow-up.

Documentation and Final Review of TAR

TAR/Request for Mental Health Stay in Hospital: Within fourteen (14) days of discharge, the hospital shall provide GCMH with a properly completed TAR form, and a copy of the client's medical record. The QI Program Manager will evaluate the case, and will 1) approve, approve partially, or deny the hospitalization, or 2) return the TAR for additional information. The UR Team will review the request within fourteen (14) calendar days of receipt of the request. Any adverse determination by the UR Team will be subject to final review by a GCMH psychiatrist MD.

Dependent upon the hospital's status as a Medi-Cal provider, GCMH will process payment or return the approved TAR for the hospital to submit through its normal Medi-Cal channels. Any inpatient provider appeal of a denied or modified payment ruled in favor of the provider will be processed for payment with fourteen (14) calendar days of receipt of a revised TAR.

Inpatient Professional Services

Because contracting acute care hospitals have negotiated rates, inpatient professional visits do not need separate GCMH authorization. Reimbursement for professional visits will be dependent upon the authorization of each corresponding bed day (limit: 1 assessment per hospitalization; 1 hospital visit per day).

Other Inpatient Authorization Scenarios

Glenn County Facility Provider; Client from another County
Authorization of services to be provided to any beneficiary from another county must be obtained from the home county mental health authorization unit. Service authorization approval must be obtained to assure that the beneficiary's home county will reimburse GCMH for services delivered.

Glenn County Client; Facility Provider from another County
Beneficiaries who are outside Glenn County when emergency inpatient admission is needed will be referred to the nearest appropriate inpatient facility.

Child & Adolescent Placement

- St. Helena Behavioral
- Sutter Center for Psychiatry
- John Muir (Concord)

Adolescent Only

- Heritage Oaks (Sacramento)
- Alta Bates (Berkeley)
- Cedar Vista (Fresno)

Adults

- North Valley Behavioral Health
- Woodland Memorial
- St. Helena Behavioral (Vallejo and St. Helena)
- Sutter Center for Psychiatry (Sacramento)
- Heritage Oaks
- Sierra Vista (Sacramento)
- John Muir (Concord)

Providers, or the beneficiary or family, should contact the GCMH staff at 530-934-6582 (available 24 hours) for coordination and authorization purposes.

CONFIRMATION LETTERS and NOTICES OF ACTION

Approvals

When the GCMH UR Team authorizes services on behalf of a beneficiary, the provider will be notified orally within 3 days of receiving the assessment documentation.

Denials or Modified Approvals

If GCMH denies a request for planned services as not meeting medical necessity criteria, gives approval to services different than those requested (in type, frequency, or duration), or fails to provide services or problem resolutions within specified timelines, GCMH shall complete a Notice of Adverse Benefit Determination (NOABD) specific to the event and distribute it to both the beneficiary and the service provider within a regulated timeframe.

There are ten types of actions and an appropriate NOABD form for each action:

Type of NOABD	Description of Notice of Action
Denial of Authorization Notice – Encl. 2	GCMH denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Use this notice for denied residential services requests (both MH and SUD). GCMH must mail the notice **within two (2) business days of the decision.**
Payment Denial Notice – Encl. 3	GCMH denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary. GCMH must mail the notice to the beneficiary at the time of any action denying the provider's claim.
Delivery System Notice – Encl. 4	GCMH has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services through the GCMH. The beneficiary will be referred to the Managed Care

Type of NOABD	Description of Notice of Action
	Plan, or other appropriate system, for mental health or other services. GCMH must mail the notice to the beneficiary **within two (2) business days of the decision.**
Modification Notice – Encl. 5	GCMH modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services. GCMH must mail the notice to the beneficiary **within two (2) business days of the decision.**
Termination Notice – Encl. 6	GCMH terminates, reduces or suspends a previously authorized service. GCMH must mail the notice to the beneficiary **within ten (10) days before the date of the action.**
Timely Access Notice – Encl. 7	When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. GCMH must issue this notice if access to services is extended beyond 60 days from the initial request for services. GCMH must mail the notice to the beneficiary at the time of any action regarding the delay.
Financial Liability Notice – Encl. 8	GCMH denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. GCMH must mail the notice to the beneficiary at the time of any action regarding the dispute.
NOABD "Your Rights" Attachment – Encl. 9	A form that informs the beneficiary of critical appeal and State hearing rights. This attachment must be sent to beneficiaries with each NOABD.
Authorization Delay Notice – Encl. 15	When there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When GCMH extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest. GCMH must mail the notice to the beneficiary **within two (2) business days of the decision.**
Grievance and Appeal Timely Resolution Notice – Encl. 16	GCMH has not acted within the timeframes for a disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
NOTE: Services that are reduced, modified, or terminated by outpatient providers that are not subject to prior authorization and are the result of a treatment Team/Clinician decision based on the individual's clinical condition and/or progress in treatment is not subject to an adverse benefit determination notification.	

All NOABD include information which explains the GCMH appeal processes and the State Fair Hearing process.

PROBLEM RESOLUTION PROCESSES

Beneficiary

Overview

Whether beneficiaries are treated by GCMH staff or by contract provider staff, they are entitled to utilize Problem Resolution Process. This process involves procedures for filing *grievances, standard appeals,* and *expedited appeals.* In certain situations, beneficiaries also have access to the State Fair Hearing Process. Providers are required to advise all beneficiaries of their right to use these procedures.

Definitions

- ***Action:*** *An action is when GCMH or its providers do one of the following*:
    - GCMH denies or limits a requested service through the authorization process (this includes the type of service or the level of service);
    - GCMH reduces, suspends, or terminates a previously authorized service;
    - GCMH denies, in whole or in part, payment for a service;
    - GCMH fails to provide services in a timely manner, as determined by GCMH; and/or
    - GCMH fails to act within the timeframes for a disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- *An* ***Appeal*** is a request for review of an action.
- A ***Grievance*** is an expression of dissatisfaction about any matter other than an action. Any problem that a client may have which does not involve an action must be filed as a grievance.
    - Possible grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or staff member, **or failure to respect the client's rights.**

Resolution Policies

- Contract providers shall utilize the GCMH "Problem Resolution Guide" to inform the beneficiary of their rights and processes to file a grievance.

- A beneficiary may choose to discuss his/her grievance with the contract provider prior to initiating the problem resolution process through GCMH.

- A client may authorize another person, including his/her attorney, to act on his/her behalf.
    - In the appeal process, the client may also select a provider as his/her representative.

- Information regarding grievances and appeals shall be maintained in a confidential manner and shall only be discussed with those directly involved in the matter, or as required by state or federal laws or regulations.

- Glenn County Mental Health Plan and its providers will not subject any client who may file a request for problem resolution to discrimination or penalty. Any report of retaliatory behavior by GCMH staff shall be investigated and may be cause for disciplinary action, including possible dismissal depending on the seriousness of the retaliatory action.

- GCMH has designated specific staff member(s) to aid clients in the problem resolution process. This individual will also provide status of a client's grievance or appeal, upon request.

- A GCMH designee shall confidentially maintain a Grievance and Appeal Log for tracking problems reported by clients.
    - The log entry shall include at least the client's name, the date of receipt, the nature of the problem, and the final disposition of the grievance or appeal (i.e., the date the decision is sent to the client or documentation explaining the reason(s) for no final disposition).

State Fair Hearings

- Clients have the right to request a State Fair Hearing at any time before, during, or after the **Appeal Process** has begun.

- Clients cannot request a State Fair Hearing before, during, or after the **grievance process** has begun, *unless* GCMH has failed to act within the timeframe required by the grievance process. This would result in the creation of an action, which is subject to the appeal process and eligible for the State Fair Hearing process.

Providing Information to Clients

- Staff will provide clients with the Client Problem Resolution Guide at admission.
    - Clerical staff shall ensure that a Client Problem Resolution Guide is included in the intake paperwork packet.

- The Client Problem Resolution Guide Brochure and forms are visibly posted and accessible in public waiting areas and other clinic areas at all certified provider sites.
    - Self-addressed envelopes are available in the public waiting area for use by clients who prefer to communicate grievances by mail.

- The Client Problem Resolution Guide Brochure and forms are available to clients in Spanish. Those clients who are visually impaired shall be able to access the information via audio recording and TDD/TTY services. Interpreter services are also available.

- Information regarding the GCMH problem resolution process is also available through the toll-free 24-hour phone system.

Grievance Process

1. Clients may file a grievance (as defined above) verbally or in writing.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf.

3. When a GCMH staff member receives a grievance, he/she shall submit the grievance to the GCMH designee. If the grievance is written, the receiving staff member shall date/time stamp the written document.

4. The GCMH designee shall record the grievance (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt.
    a. The log shall include, but is not limited to:
        i. Name of the client;
        ii. Date of receipt of the grievance;
        iii. Nature of the problem; and
        iv. Final disposition, including:
            1. Date of final decision
            2. Final resolution or explanation of reasons if there was not a disposition
            3. Date the decision or explanation is sent to the client

5. The GCMH designee shall promptly acknowledge receipt of the verbal or written grievance to the client in writing.

6. A decision regarding the grievance must be made within sixty (60) calendar days of receipt of the grievance. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
    a. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if GCMH determines that the delay is necessary and is in the best interest of the client.

7. GCMH will notify the client (or his/her representative) of the grievance decision in writing.
    a. If a client cannot be reached (i.e., returned mail), GCMH will document the notification effort in the Grievance and Appeals Log.

8. GCMH will also notify any provider(s) or staff persons cited in the grievance of the final decision verbally or in writing.

9. If GCMH fails to notify the client or other affected parties of its grievance decision within the allowable timeframe, the client will be given a Notice of Adverse Benefits Determination (NOABD) advising that he/she has a right to request an appeal and/or a State Fair Hearing.
    a. The Notice of Adverse Benefit Determination (NOABD) will be given on the date that the timeframe expires.
    b. NOTE: Clients cannot request a State Fair Hearing before, during, or after the grievance process, unless GCMH has failed to act within the timeframe required by the grievance process.

10. GCMH will strive to provide resolution of a client's grievance as quickly and simply as possible.

Appeals Processes

Standard Appeals

1. Clients may file an appeal (as defined above) verbally or in writing. The appeal must be made in response to an action (as defined above).
    a. The appeal must be filed within ninety (90) days of the date of the action.
    b. A client must follow up a verbal appeal with a signed, written appeal.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf.
    a. In the appeal process, the client may also select a provider as his/her representative.

3. When a GCMH staff member receives an appeal, the receiving staff member shall date/time stamp a written appeal.

4. He/she shall submit the appeal to the GCMH Quality Improvement Supervisor or other designee.
5. The client shall be informed by the receiving staff person that he/she has a right to request a State Fair Hearing at any time before, during, or after the appeal process has begun.
    a. The provision of this information will be noted in the Client Problem Resolution Guide that is given to the client, 1) when he/she files the appeal and, 2) when he/she is notified of the final decision.

6. The GCMH receiving staff member shall record the appeal (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt, prior to forwarding the appeal to the GCMH Quality Improvement Supervisor or designee.

7. The GCMH receiving staff member shall promptly acknowledge receipt of the verbal or written appeal to the client in writing.

8. The client will be given the opportunity to present evidence and allegations of fact or law. This component may be done in person or in writing.

9. Before and during the appeal process, the client and/or his/her representative will be allowed the opportunity to examine the client's chart and any other documents relevant to the appeal.

10. A decision regarding the appeal must be made within forty-five (45) calendar days of receipt of the appeal.
    a. If request for an appeal was first given verbally, the timeline requirements begin on that day, not the day when the written follow-up is received from the client.
    b. All affected parties (including client, providers, staff members, etc.) must be notified of the decision within this timeframe.
    c. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if GCMH determines that the delay is necessary and is in the best interest of the client.

11. The GCMH Quality Improvement Supervisor or designee will notify the client or his/her representative in writing of the appeal decision.
    a. The notice will include the results of the appeal process and the date the appeal was made.
    b. If the decision made was not wholly in favor of the client, the notice shall also contain information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.

12. GCMH will also notify any provider(s) or staff persons cited in the appeal of the final decision verbally or in writing.

13. If Glenn County fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a Notice of Adverse Benefit Determination by the GCMH Quality Improvement Supervisor, advising that the client has a right to request a State Fair Hearing.
    a. The Notice of Adverse Benefit Determination will be given on the date that the timeframe expires.

14. GCMH will promptly provide or arrange and pay for the disputed service(s), if the decision of the appeal reverses the decision to deny services.

Expedited Appeals

1. Clients may file an expedited appeal (as defined above) verbally or in writing. The expedited appeal must be made <u>in response to an action</u> (as defined above).
    a. The expedited appeal process may only be used when the standard appeal process could jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function.

b. NOTE: A client does NOT need to follow up a verbal expedited appeal with a signed, written appeal.

2. A client may authorize another person, including his/her attorney, to act on his/her behalf. In the appeal process, the client may also select a provider as his/her representative.

3. When a GCMH staff member receives an appeal, he/she shall submit the appeal to the GCMH designee. The GCMH designee shall date/time stamp a written expedited appeal.

4. The client shall be informed by the GCMH designee that he/she has a right to request a State Fair Hearing at any time before, during, or after the appeal process has begun.
    a. The provision of this information will be noted in the Client Problem Resolution Guide that is given to the client, 1) when he/she files the appeal and, 2) when he/she is notified of the final decision.

5. The GCMH designee shall record the appeal (verbal or written) in the Grievance and Appeals Log within one (1) working day of the date of receipt and forward the request for an expedited appeal to the GCMH Director.

6. The GCMH Director shall promptly acknowledge receipt of the verbal or written appeal to the client in writing.

7. The GCMH Director will review the request for an expedited appeal.
    a. If the request for an expedited appeal is denied, the appeal will be transferred to the standard appeal process and resolved within the timeframe specified in that process.
    b. GCMH will make reasonable efforts to give the client prompt verbal notice of the denial of the expedited appeal process and follow up with a written notice within two (2) calendar days.
    c. If the request for an expedited appeal is granted, the client will be given the opportunity to present evidence and allegations of fact or law. This component may be done in person or in writing.

8. Before and during the expedited appeal process, the client and/or his/her representative will be allowed the opportunity to examine the client's chart and any other documents relevant to the appeal.

9. A decision regarding the appeal must be made within three (3) working days of receipt of the appeal. All affected parties (including client, providers, staff members, etc.) must be notified verbally, as well as in writing, of the decision within this timeframe.

a. This timeframe may be extended by up to fourteen (14) calendar days if the client requests an extension or if GCMH determines that the delay is necessary and is in the best interest of the client.

10. Glenn County will notify the client or his/her representative of the expedited appeal decision verbally and in writing.
    a. The notice will include the results of the appeal process and the date the appeal was made.
    b. If the decision made was not wholly in favor of the client, the notice shall also contain information regarding the client's right to a State Fair Hearing and the procedures for filing a State Fair Hearing.

11. GCMH will also notify any provider(s) or staff persons cited in the expedited appeal of the final decision verbally or in writing.

12. If GCMH fails to notify the client or other affected parties of its appeal decision within the allowable timeframe, the client will be given a Notice of Adverse Benefit Determination advising that he/she has a right to request a State Fair Hearing.
    a. The Notice of Adverse Benefit Determination will be given on the date that the timeframe expires.

13. GCMH will promptly provide or arrange and pay for the disputed service(s) if the decision of the appeal reverses the decision to deny services.

Clients' Rights regarding Aid Paid Pending

1. In certain instances, GCMH may provide aid paid pending (APP) to beneficiaries who request continued services and have filed a timely request for an **appeal or state fair hearing**.

    - A timely request is ten (10) days from the date the Notice of Adverse Benefit Determination (NOABD) was mailed, or ten (10) days from the date the NOABD was personally given to the beneficiary, or before the effective date of the change, whichever is later.

    - The beneficiary must either have an existing service authorization which has not lapsed, and the service is being terminated, reduced, or denied for renewal by GCMH; or, the beneficiary must have been receiving specialty mental health services under an exempt pattern of care.
        - An exempt *pattern of care* is the denial of a provider's request to continue a pattern of care that has been exempt from authorization by GCMH and would require an NOABD.
        - An exempt pattern of care may exist in a situation when a county has a policy that permits a predetermined amount of services to be provided without prior authorization. (For example, a county allows providers three

visits without prior authorization. A provider subsequently requests authorization for an additional three visits.)

- This action will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, the date an appeal is resolved, or a hearing decision is rendered; or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

2. **Note:** A beneficiary may file an appeal or a state fair hearing request about an action whether or not a Notice of Adverse Benefit Determination (NOABD) has been issued. However, clients must first exhaust the GCMH Problem Resolution Process before filing for a state fair hearing.

Problem Resolution Documentation

Grievance, Standard Appeal, and Expedited Appeal Logs

1. The GCMH designee shall record the appeal (verbal or written) in the appropriate log within one (1) working day of the date of receipt.
    a. The log shall include, but is not limited to:
        i. Name of the beneficiary;
        ii. Date of receipt of the grievance;
        iii. Nature of the problem; and
        iv. Final disposition, including:
            1. Date of final decision;
            2. Final resolution or explanation of reasons if there was not a disposition; and
            3. Date the decision or explanation is sent to the client.

State Fair Hearing and Notice of Adverse Benefit Determination

1. A written Notice of Adverse Benefit Determination shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action. The action shall specify:
    a. The action taken by GCMH
    b. Reason for the action taken
    c. Citation of the specific regulations supporting the action
    d. Client's right to a State Fair Hearing, including:
        i. The method by which a hearing may be obtained
        ii. Client may be self-represented
        iii. Client may be represented by an authorized third party, such as legal counsel, relative, friends, or any other person
    e. Explanation of the circumstances under which specialty mental health services will be continued if a State Fair Hearing is requested
    f. Time limits for requesting a State Fair Hearing
    g. Client's right to request continued services while the hearing is pending and the process for making such a request

2. Clients have the right to request a State Fair Hearing at any time before, during, or after the Appeal Process has begun.

3. Clients cannot request a State Fair Hearing before, during, or after the **Grievance Process** has begun, *unless* GCMH has failed to act within the timeframe required by the grievance process. This would result in the creation of an action, which is subject to the appeal process and eligible for the State Fair Hearing process.

Quality Management – Client Problem Resolution Process

At each GCMH Quality Improvement Committee (QIC) meeting, the QI Program Manager or designee shall provide all related documentation of any new grievances, standard appeals, or expedited appeals. The QIC shall review the decisions and focus on the appropriateness of the GCMH response or other concerns. Overall trend issues shall be analyzed as part of the QIC monitoring process. QIC recommendations and findings shall be documented in the QIC minutes for the Deputy Director to review and the delegation of plans of action, as necessary.

Informed Consent for Services

California law provides that all people, including those who receive mental health services, have the right to give or refuse informed consent to treatment. All mental health clients have a right to: 1) receive an explanation of their diagnosis; 2) receive information about their treatment; and 3) give or refuse to give consent for treatment.

GCMH requires an informed consent for mental health services from all individuals receiving mental health services through GCMH and its providers.

The Informed Consent for Services contains at least the following:

1. Client's right to voluntarily participate in services, to receive information about alternative services, and to request a change of provider at any time;
2. A list of available services;
3. A brief description of medication services, including the client's right to receive written side effect information and that the client needs to sign a Consent for Treatment with Medications form prior to starting medications;
4. A statement of the expectation that client will benefit from services, but there is no guarantee that there will be a benefit;
5. A brief statement around payment;
6. Client confidentiality and privacy rights; and
7. Client rights regarding revoking consent and receiving a copy of the signed consent form, as well as information regarding participation in the development of the Client Treatment Plan and information regarding the problem resolution process.

An Informed Consent for Services shall be signed by new clients (and parent/guardian/Conservator, as appropriate) during the initial assessment appointment.

- The clinician conducting the initial assessment will review the Informed Consent for Services form with the client.

In addition, the form will be signed by the client (and parent/guardian/Conservator, as appropriate) on an annual basis.

The client (and parent/guardian/Conservator, as appropriate) has the right to a copy of the consent form, if desired.

Assessments

GCMH uses a Multi-Cultural Clinical Comprehensive Assessment form, which meets the current State requirements. The following areas are described by the State as a part of a comprehensive client record:

- Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example, living situation, daily activities, and social support.
- Description of client strengths in achieving client plan goals.

- Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
- Information on medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.

- A mental health history shall be clearly documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
- Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs.

- A relevant mental status examination shall be documented.
- A diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

Timeliness and Frequency Standards for Assessments

The GCMH standards for timeliness and frequency for assessments are as follows:

- An Assessment is required as part of the initial intake process.
- An updated Reassessment is required: annually for children/youth, and adults, or when a re-assessment is determined to be necessary.

Client Treatment Plans

NOTE: Therapeutic Behavioral Services (TBS) require a unique Treatment Plan with specific components and timeframes. Refer to the TBS Section beginning on Page for more information.

Per GCMH and State standards, Client Treatment Plans shall:

- Have specific observable and/or quantifiable goals identified in cooperation with the client.
- Identify the proposed type(s) of intervention.
- Have a proposed duration of intervention(s).
- Be consistent with the diagnoses.
- Be signed by:
    - The client, except when client refuses or is unavailable.
    - The person providing the service(s), or
    - A person representing a team or program providing services, or
    - A person representing GCMH.
- Be signed or co-signed by one of the following approved staff categories:
    - Licensed Physician
    - Licensed/Waivered Psychologist
    - Licensed/Waivered Clinical Social Worker
    - Licensed/Waivered Marriage and Family Therapist
    - Registered Nurse
    - Other staff approved by the GCMH Deputy Director

In addition, GCMH and its providers shall ensure that:

- The Client Treatment Plan is used to establish that services are provided under the direction of an approved category of staff.
- The focus of intervention is consistent with the Client Treatment Plan goals.
- A Client Treatment Plan is provided for each of the following types of services: Adult, Children's, Transition Age Youth, and Older Adult Mental Health Services, Adult and Children's Intensive Day Treatment, Adult Crisis Residential, Adult Residential, and Day Rehabilitation.
- In the absence of a client signature, the client's level of participation, agreement, refusal, or unavailability must be documented.
- A copy of the completed Client Treatment Plan is offered to each client.

Timeliness and Frequency Standards for Client Treatment Plans

The GCMH standards for timeliness and frequency of Client Treatment Plans are as follows:

- Client Treatment Plans are to be completed within 60 calendar days of the admit date.
- Client Treatment Plans are to be updated annually, or as needed.
- Crisis residential staff are to complete documentation within seventy-two (72) hours of client's admission.
- The completed Client Treatment Plan shall be faxed to the UR Team for continued reimbursement of services.

Progress Notes

GCMH and Medi-Cal regulations require that a Progress Note be written for each billed service. Progress Note documentation shall be entered by the end of the next business day, after a service is delivered. Progress Notes shall contain the following information:

- Date services were provided
- Service function (type of service delivered: assessment, collateral, direct, etc.)
- Location of service
- Duration of service
- Contact type
- Appointment type
- Brief narrative of what was attempted and/or accomplished by the client, family, and/or staff toward the Client Treatment Plan goals
- Description of changes in client's medical necessity
- Relevant aspects of client care
- Rationale for diagnosis changes
- Client encounters, including relevant clinical decisions and interventions
- Referrals to community resources and other agencies, when appropriate
- Follow-up services, or as appropriate, a discharge summary
- Signature of staff delivering services, including professional degree, licensure or job title, when applicable.

Frequency Standards for Progress Notes

Progress Notes shall be written for on the following schedule of frequency for specific service types:

Every Service Contact	Mental Health Services Collateral Services Medication Support Services Crisis Intervention Case Management/Brokerage
Each Shift	Crisis Residential Crisis Stabilization Psychiatric Health Facility
Daily and Weekly Summary	Day Treatment Intensive
Weekly Summary	Day Rehabilitation Adult Residential

Timeliness Standards for Progress Notes

It is expected that each service will be documented by the end of the third business day from the date of service.

If staff are unable to complete service documentation within the maximum time frame of (3) business days from the date of service, staff are expected to document the service as an Information Note.

In the event of unforeseen incident, the Behavioral Health Deputy Directors or designee, may authorize the entry of late notes beyond this timeframe.

Clinical sessions can usually be scheduled to end at a planned time, for example, fifty (50) minute session, with ten (10) minutes remaining to document the service.

NOTE: The progress note completion date is the date the progress note was signed either electronically or with a handwritten signature by the staff member.

Medication Documentation

GCMH requires the following documentation procedures regarding medication management and monitoring:

1. A signed *Consent for Treatment with Medications Form* must be reviewed with the client by the prescribing physician. This review includes information on side effects and must be signed by the client and filed in the client's chart. This review must be provided each time the client's prescription is initiated to a different class of medications.

2. All identifying information, including allergies, must be completed on a *Doctor's Order Sheet and Medication Record*. Known drugs prescribed by other medical physicians will also be noted.

3. All medication orders/entries must be signed with first and last name and title of physician (no initials).

4. All medication prescribed and/or dispensed by the physician, or given by the nurse with a physician's order, must be noted on the *Doctor's Order Sheet and Medication Record* and recorded in the Progress Note of the client's chart.

5. Clients will be re-evaluated by the psychiatrist at least every three (3) months for dose/frequency of injectable and oral medication. Medication must be re-ordered at least every three (3) months.

6. Physicians may dispense oral medication in amounts greater than a daily dose on an emergency basis only.

7. Laboratory tests for patients on Lithium will be ordered according to minimum protocol. Requirements with initiation of Lithium treatment include:
   a. Lab tests: Thyroid panel and Chemical panel.
   b. Lithium levels at one week after beginning medication.
   c. Maintenance levels will be obtained every 6 months or more frequently as needed.
   d. Baseline EKG for at risk population or persons over 40 years old.

Medication monitoring for all programs is done every two weeks in cooperation with the consulting pharmacist; findings are reviewed at the QIC meetings. Monitoring activities include a periodic review of clinical records and consultation as requested.

Quality Assurance

The GCMH Quality Improvement Program Manager has the responsibility of assuring that high quality services are provided to the client in an effective and efficient manner. The QI Program Manager reviews services and programs of public and private providers in order to ensure:

1. Accessibility;
2. Services that are meaningful and beneficial to the client;
3. Services that are culturally and linguistically competent; and
4. Services that produce highly desirable results through the efficient use of resources.

Quality Improvement

GCMH establishes policies, structure, and processes to ensure continuous quality improvement through its Quality Improvement Committee (QIC). The GCMH QI Program Manager oversees the QIC and coordinates with other performance monitoring activities.

The QIC will monitor clients' satisfaction with services that they are receiving from providers. GCMH staff will evaluate contract performance based on mutually-identified measurable objectives.

If the QIC finds that a provider may be deficient in rendering or managing care, or if other problem areas are discovered, procedures outlined in the Provider Problem Resolution Process will be initiated. If these deficiencies or problem areas are verified, corrective sanctions may be applied. These sanctions may include mandatory reviews of all claims, periodic review of medical records, or termination of the provider's contract with GCMH.

Training

GCMH QI staff shall provide training in medical necessity criteria, clients' rights issues, outcomes, and other quality components referenced in this manual.

BILLING AND PAYMENT

Procedures

Payment policies and procedures contained herein are intended to provide a general overview of how providers receive reimbursement from GCMH. However, each provider's unique contract with Glenn County Health and Human Services Agency supersedes any information contained herein.

Payment Policies

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

- ✓ The services were pre-authorized by the GCMH UR Team.
- ✓ Services were delivered by a contract or otherwise authorized provider.
- ✓ Services were within the range of pre-selected service codes allowed by the provider's scope of practice and contract agreements.
- ✓ The beneficiary is eligible for Medi-Cal. *Note: Service authorization does not guarantee Medi-Cal eligibility. It is the provider's responsibility to assure that the client is eligible. The provider may call GCMH for assistance in verification of eligibility.*

Billing Procedures

The provider's billing must be on the CMS-1500 (HCFA-15) form (standardized insurance claim format). All billings should be sent to:

Glenn County Health and Human Services Agency
242 N. Villa Ave.
Willows, CA 95988

Billings must contain the following information, at a minimum:

- ✓ Beneficiary name
- ✓ Beneficiary Social Security number
- ✓ Beneficiary Medi-Cal number
- ✓ Diagnosis
- ✓ Date, service code, description, total minutes and fee for each service
- ✓ Total amount being billed

Payment Procedures

The processing and payment of claims involves the following steps:

- ✓ Professional service claims are processed on a line-by-line basis. Inpatient facility claims are paid on a total claim basis.
- ✓ Claims are subjected to a comprehensive series of edits and audits.
- ✓ Claims that meet all edit and audit requirements, and are in compliance with payment policies, are processed for payment by the Glenn County Auditor.
- ✓ Checks are printed and mailed weekly, with copies of the related claims attached as an explanation of payment.

Note: Hospitals that bill Medi-Cal directly will be paid through the State's automated payment system.

Payment Inquiries

Billing inquiries may be made by calling 530-934-6582, or in writing with a copy of the original billing attached.

Important Points Regarding Claims

Treatment of any Medi-Cal beneficiary must be performed by the practitioner whose services were authorized. A provider shall not bill for treatment provided by another practitioner or an assistant.

Providers may not legally bill a Medi-Cal beneficiary for services authorized by GCMH.

PROBLEM RESOLUTION PROCESSES

Provider

GCMH will work cooperatively to resolve any problems identified by providers in a sensitive and timely manner, utilizing both a Provider Problem Resolution Process and a Provider Appeal Process. These processes may be accessed by GCMH providers to address payment authorization issues and other complaints and concerns.

Provider Problem Resolution Process

1. A provider, whether an individual professional or an organization, may contact GCMH at any time to resolve payment authorization issues or other complaints and concerns.
    a. GCMH will work cooperatively with the provider to resolve problems in a simple, informal, and timely manner.
    b. The provider may notify GCMH of the complaint or concern verbally (via the QI Program Manager) or in writing.

2. In most cases, if the QI Program Manager or designee cannot immediately resolve the matter, a response to the provider's concern will occur within five (5) working days of notification that a concern exists.
    a. In cases involving Residential Treatment Program Providers, GCMH shall accelerate the time line to respond within forty-eight (48) hours of receipt of the provider's complaint.

3. Whenever GCMH produces a written response to a provider complaint, the response is filed in the Provider Complaint Log.

Provider Appeal Process

1. A provider may appeal a denied or modified request for GCMH payment authorization or a dispute with GCMH concerning the processing or payment of a provider's claim to GCMH.
    a. Providers have the right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun.

2. A provider may initiate the appeal process through a written request submitted to the GCMH QI Program Manager or designee.
    a. The QI Program Manager or designee will document the date of receipt of the appeal in the GCMH Provider Appeal Log. The resolution and date of response to the appeal are also recorded in the log.
    b. The appeal should clearly identify the provider's concerns and may include any supporting documentation that will assist in the problem resolution.
    c. The written appeal shall be submitted to GCMH within ninety (90) calendar days of the date of receipt of the non-approval of payment, or

within ninety (90) calendar days of GCMH's failure to act on the request for payment.

3. The Glenn County Health and Human Services Agency Deputy Director or designee shall review the written appeal and any associated documentation.
    a. If the appeal concerns the denial or modification of a GCMH payment authorization request, GCMH shall utilize staff who were not involved in the initial denial or modification decision.

4. GCMH shall respond to the provider's appeal with a decision in writing within sixty (60) calendar days from the receipt of the provider's appeal request.
    a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider, and any action required by the provider to implement the decision.
    b. If the appeal is denied or not granted in full, the provider shall be notified of any right to submit an appeal to the California Department of Health Care Services.

5. If applicable, GCMH may request a provider to submit a revised request for GCMH payment authorization.
    a. The provider shall submit a revised request within thirty (30) calendar days from receipt of GCMH's decision to approve the GCMH payment authorization request.
    b. GCMH shall process the provider's revised request for payment within fourteen (14) calendar days from the date of receipt of the provider's revised request for payment authorization.

6. If GCMH does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied by GCMH.

Provider Appeals to the California Department of Health Care Services

1. Hospitals and inpatient services providers may appeal directly to the California Department of Health Care Services (DHCS) when a GCMH payment authorization request for emergency services has been denied or modified via the provider resolution process. Such denials or modifications are eligible for DHCS appeals if the GCMH decision was based on the following issues:
    a. The provider did not comply with the required timelines for notification or submission of the MHP payment request, or
    b. The medical necessity criteria were not met.

2. If a provider chooses to appeal to DHCS, the appeal shall be submitted in writing, along with supporting documentation, within thirty (30) calendar days from the date of GCMH's written decision of denial.

a. The provider may appeal to DHCS within thirty (30) calendar days after sixty (60) calendar days from submission to GCMH, if GCMH fails to respond.
b. Supporting documentation shall include, but not be limited to:
    i. Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.
    ii. Clinical records supporting the existence of medical necessity if at issue.
    iii. A summary of reasons why the MHP should have approved the MHP payment authorization.
    iv. A contact person(s) name, address and phone number.

3. DHCS shall notify GCMH and the provider of its receipt of a request for appeal within seven (7) calendar days.
    a. The notice to GCMH shall include a request for specific documentation supporting denial of the GCMH payment authorization and for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal.
        i. GCMH shall submit the requested documentation within 21 calendar days or DHCS shall decide the appeal based solely on the documentation filed by the provider.

4. DHCS shall have sixty (60) calendar days from the receipt of the GCMH documentation, or from the twenty-first (21st) calendar day after the request for documentation (whichever is earlier), to notify the provider and GCMH of its decision, in writing.
    a. The written response shall include a statement of reasons for the decision that address each issue identified by the provider and GCMH, and any actions required by the provider and GCMH to implement the decision.
    b. At the election of the provider, if DHCS fails to act within the sixty (60) calendar days, the appeal may be considered to have been denied by DHCS.
    c. DHCS may allow both a provider representative(s) and the GCMH representative(s) an opportunity to present oral argument to DHCS.

5. If the appeal is upheld, the provider shall submit a revised request for GCMH payment authorization within thirty (30) calendar days from receipt of the DHCS decision to uphold the appeal.
    a. If applicable, the MHP shall have fourteen (14) calendar days from the receipt of the provider's revised MHP payment authorization request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

CONTRACT PROVIDER

Responsibilities

Providers who treat GCMH beneficiaries have responsibilities to:

- ✓ Verify Medi-Cal eligibility of beneficiaries for whom they seek authorization for services.

- ✓ Inform beneficiaries of their right to access the GCMH grievance and appeals processes, including the right to access a State Fair Hearing at any time during the appeals processes. The contract provider shall give each beneficiary a copy of the GCMH beneficiary brochure and problem resolution guide during the first meeting with the client.

- ✓ Provide the GCMH UR Team with all requested information in order to facilitate initial and/or extended authorization of services, and assist the beneficiary with the process of any necessary communication with the UR Team.

- ✓ Seek reimbursement from GCMH for only those services with are specified by, and authorized by, the UR Team.

- ✓ Schedule an initial visit with an authorized beneficiary within twenty (20) working days of receipt of authorization.

- ✓ Request consultation with the UR Team regarding any potentially planned admission of a beneficiary into an inpatient facility.

- ✓ Provide services to beneficiaries in accordance with legal and ethical standards as stipulated by all relevant professional, federal, state, and/or local regulatory and statutory requirements.

- ✓ Maintain clinical records according to GCMH standards. Records must be legible and kept in detail consistent with appropriate medical and professional practice in order to:
  - Permit effective internal professional review and external medical audit process, and
  - Facilitate an adequate system for follow-up treatment.
  - Maintain clinical records for at least seven (7) years from the last date of service to the beneficiary; produce and maintain documentation that pertains to the services provided to beneficiaries under the contract provisions of GCMH, available for inspection, examination or copying;
    - By GCMH, the State Department of Health Care Services and the United States Department of Health and Human Services;

- At all reasonable times at the provider's place of business or at another mutually agreed upon location; and
- In a form maintained in accordance with the general standards applicable to such record keeping.

✓ Use DSM-V diagnostic codes, or the most recent version of the DSM Manual. *ICD-9-CM codes are not acceptable.*

✓ Follow strict confidentiality guidelines to assure the beneficiary's privacy when referrals to other agencies and providers are necessary. Information regarding the beneficiary will not be provided without written permission from the beneficiary or the beneficiary's legal representative.

✓ Provide Therapeutic Behavioral Health Services (TBS) in compliance with State and GCMH requirements and standards, including developing TBS Treatment Plans, Progress Notes, and other mandatory documentation in required timeframes. Provider shall make this documentation available for GCMH review on a regular basis and upon request.

✓ Maintain a log of beneficiary grievances and appeals. For more information, see the section on the beneficiary problem solving procedure.