Appendix A
Systems of Care

Appendix B
Compliance and Confidentiality

Appendix C
Accessing Services

Children's Mental Health Services

PROVIDER:
Month/Year:

Request for Services Log

Title 9, Section 1810.405

Contractual Requirements
May use for wait time calculations

Inquiry date	Name	Indicate Y or N			Referring Party / District	Res-ponse code	Dispo code	Appointment Date (reason for no appt. or unusual delays)
		M/C	AB 2726	MHSA				

Response Codes
E = Emergent - access within the same day
U = Urgent - access within 72 hours
H = Patient D/C'ed from inpatient program (72 hr rapid response assessmer
R = Routine - within 5 days
I = Request for Information/referra

Disposition Codes
1) Made appt **6)** No appt or referral made
2) Referred out for Routine services
3) Provided client with County health insurance referral informatio
4) Referred out for non-Mental Health service
5) Referred out for Urgent services

For assistance contact: **QI Unit at (619) 584-5026**

2/15/07 BBS

This form should be used to request authorization of payment for **Specialty Mental Health Services.**	**County of San Diego Mental Health Plan** **Specialty Mental Health Services DPR** RECEIVED by UBH:	**Form must be submitted to UBH by client's Day Program provider. UBH cannot accept this form if submitted by Specialty Mental Health Services Provider**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client InSyst #:	Date of Birth

DAY PROGRAM INFORMATION

Day Program Name: *Please print clearly*

_____Phone: :_____ Day Program RU# _____

SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION

Specialty Mental Health Program Name: *Please print clearly*

_____Phone: :_____ Program RU# _____

REQUEST FOR AUTHORIZATION of Specialty Mental Health Services delivered by Organizational County Contracted providers on the same day as Day Program Services.

*** Treatment must include coordination with the other professionals treating client. Authorization is required only for ancillary services delivered on the same day client receives Day Program Services. Ancillary Services delivered to client in an Intensive Day Program require continued authorization within 3 months. Ancillary Services delivered to client in a Day Rehab program require continued authorization within 6 months. Medication Management, Case Management, TBS, and Crisis Intervention Services do not require authorization. ***

Complete the request by writing the # of visits requested per week (or month) and the # of weeks (or months) within which the visits will occur.

Service(s)	Frequency	Service(s)	Frequency
☐ Individual Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months	☐ Group Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months
☐ Collateral Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months	☐ Collateral Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months
☐ Other Mental Health Services (describe)_____	__ visit(s) per _____week _____month for_____weeks_____months	☐ Other Mental Health Services (describe)_____	___ visit(s) per _____week _____month for_____weeks_____months

Community services/self help do not require authorization but must be coordinated comprehensively with all mental health and psychosocial rehab services.

Community services/self help (please list) _____

ADULT/OLDER ADULT Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ The client is unable to receive these services while attending the Day Rehabilitation program due to client's specific clinical needs or family/caregiver needs. (Describe needs)

_____

_____

☐ Client transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and length of interval)

_____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

_____

CHILD and YOUTH Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ Requested service(s) is not available through the day program. (Describe why service is not available through day program) _____

_____

☐ Continuity or transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and time interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

_____

_

CURRENT FUNCTIONING (enter highest level of severity in past 2 months):

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Actively _____	☐Suicidal ☐ Fire Setting ☐Homicidal ☐Psychotic			☐None
School _____	☐Expelled ☐Increased Placement Level ☐Chronic Truancy ☐Threats to Staff or Students ☐Major Property Damage	☐Failure ☐ Significant Decline ☐ Frequent Truancy/Non-Excused Absences ☐ Frequently Disruptive	☐Declining Grades ☐ Poor Attention ☐ Periodic Behavior Problems ☐ Producing Less Than Expected Level	☐Regular Attendance ☐Minimal Behavior Problems
Home _____	☐ Threats to Family Members ☐ AWOL/Running Away ☐ Severe Property Damage] Serious and Repeated Violations of Rules/Laws	☐Overnight Running Away ☐Moderate Property Damage ☐Persistent Failure to Comply with Reasonable Rules	☐Episodic Property Damage ☐Frequent Disobedience and/or Resistance	☐Occasional Disobedience
Thinking _____	☐Active Thought Disorder ☐Dissociation ☐Disorientation	☐Disorganized Communication ☐Distortion of Thinking ☐Occasional Reality Impairment (Suspicions/Obsessions)	☐Odd Beliefs ☐Unusual Perceptions ☐Eccentric	☐No disturbance in Thinking ☐Normal Concerns
Substance _____	☐Dependence, ☐Frequently Intoxicated or High (More than twice per week)	☐Abuse with Interference of Functioning	☐Recurrent Use with Minimal Interference of Functioning	☐Occasional ☐No Use ☐Full Remission
Mood _____	☐Persistent and Incapacitating	☐Intense and Abrupt Episodes ☐Marked Mood Changes ☐Blunt Affect ☐ Significantly Withdrawn / Isolative	☐Anxious ☐ Self Critical ☐ Fearful/Sad with Overt sx ☐ Low Self Esteem ☐ Easily Distressed ☐ Restricted Affect	☐Normal Reactions to Life Events ☐Expresses Emotions Appropriately
Self Harm _____	☐Active Clear Plan ☐Serious Self Harm	☐Superficial Cuts ☐Suicidal Ideation without Immediate Danger	☐Fleeting Suicidal Ideation ☐Pinching/Scratching Self	☐None
Behavior Toward Others _____	☐Serious Intent to Cause Harm ☐Seriously Assaultive ☐Serious Repeated Criminal Activity	☐Threats to others ☐Some Aggressive Behaviors ☐Inappropriate Sexual Behavior ☐ Police Involvement	☐Argumentative ☐ Occasional Tantrums ☐ Ignored/Rejected by Peers ☐ Poor Social Skills ☐ Assault History	☐Age Appropriate Behavior
Other				

End date of previous authorization: ____/_____ Start date of this authorization: _____/_____ End date of this authorization: _____/_____
MM/YYYY MM/YYYY MM/YYYY

Name of Ancillary Services

Clinician requesting authorization: (print)_____**Phone:**_____ **Date:**_____

Countersignature by Licensed Clinician:_____ **Phone:**_____ **Date:**_____

County of San Diego
Health and Human Services Agency/ Child Welfare Services/ Probation

Service Authorization Form

Interpreter Services for Clients – Access and Authorization

Instructions:

1. To request interpreter services, please complete Client Information, Service Information Section A, and Requester Information and fax to selected interpreter service provider.
2. Complete Service Information Section B after services have been provided or canceled and fax to interpreter service provider. For ongoing requests, an authorized County of San Diego representative should verify and submit the form for processing on a weekly basis.
3. Retain original form at program site for record of services provided.

Please "X" the Provider Selected:

	Service Provider:	Phone:	Fax:	Type of Interpreting:
☐	Interpreters Unlimited	(800) 726-9891	(800) 726-9822	Oral/ Spoken Language Interpretation
☐	Deaf Community Services of San Diego, Inc.	(619) 398-2488	(619) 398-2490	American Sign Language
☐	Network Interpreting Services	(800) 284-1043	(815) 425-9244	American Sign Language

Client Information:

The County of San Diego, HHSA has authorized the following interpreting services for:

_____
Please Indicate Name of Client/Participant(s)

(If any participants are under age 18, please indicate age of minor(s): _____).
Language Requested: _____
Nature of Appointment: _____

Service Information:

Section A:			Section B:			
Date:	Requested:		Actual:		Interpreter's Name: (If Services were canceled, please write "Canceled")	Verified By: (Initial and Date)
	Start Time	End Time	Start Time	End Time		

Requester Information:

Requester:

- **Name:** _____
- **Phone:** _____
- **Fax:** _____
- **E-mail:** _____

Agency Name: _____

_____

Program Name and Address: _____

_____

_____

County Department to be Invoiced: _____

Manager/ Designee Approved By:

_____
(Print Name) **(Date)**

_____
(Signature) **(Date)**

Service Site: _____

_____

_____
(If different from Program Address)

Site Contact:

- **Name:** _____
- **Phone:** _____
- **E-mail:** _____

NOTE: IT IS A HIPAA VIOLATION TO EMAIL ANY DOCUMENT CONTAINING PROTECTED HEALTH INFORMATION (PHI).

County of San Diego
Health and Human Services Agency (HHSA)

SERVICE AUTHORIZATION FORM INSTRUCTIONS

The purpose of Service Authorization Form is to request authorized scheduled interpreting services with contracted service providers and to verify that authorized scheduled interpreting services were provided **OR** cancelled and when they were cancelled.

The Service Authorization Form must be completed for each individual requiring interpreter services and authorizes services for one or more date(s) at the specified times and at a single location.

The form accompanying these Instructions dated 01/06/10 replaces all Service Authorization Forms previously in use to request interpreter services for clients/family members.

The Service Authorization Form may not be emailed with client information on it. A copy of the form may be provided to the interpreter if requested.

Note that oral interpreter services must be cancelled 24 hours in advance and American Sign Language (ASL) interpreter services must be cancelled 48 hours in advance. Please notify the client/family member of this requirement and ask them to contact your program in a timely manner if they need to cancel an appointment utilizing interpreter services. Services not cancelled timely will be charged to the County.

Instructions for Completing Section A:

- Select the Service Provider to be contacted by placing an "X" next to the Service Provider's name.
- Circle either "client" or a "family member" to indicate who is receiving the interpreter services.
- Provide the name of the person/participant(s) needing interpreter services and the date(s) the services are required. If the person is under 18 years of age provide the age only, not the date of birth.
- Complete this section by providing the nature of appointment, language requested, requested start time, and end time. Next fill out all of the requestor information including agency name, program name and address, service site of where interpreting shall take place if different than the program address, and obtain approval by a manager or designee. Multiple appointments can be requested as long as they are at the same service site.
- Provide the name of the County department to be invoiced.
- **Mental Health programs** are required to indicate if the request is from a Children's program or an Adult program.
- **FAX the Service Authorization Form with Section A completed to the service provider selected to officially request interpreter services. *** The selected service provider will call or email you to verify availability of interpreter staff.

Instructions for Completing Section B:

- If services were provided, state the date, actual start time, actual end time and the name of the interpreter. If services were cancelled, state the date and time the service request was cancelled.
- Provide initials of staff and date that were witness to services to verify information in Section B is accurate.
- **FAX the Service Authorization Form with Section B completed to the selected provider after the services have either been completed or cancelled. ***

It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client's preferred language; and interpreter services will be utilized more efficiently by everyone.

**Please note that some service providers may provide web based requesting services now or in the future. If the SAF is incorporated into their on-line services then the faxing of the form will not be necessary. Please verify this process with your service provider should there be any questions.*

Appendix D
Authorization of Reimbursement for Services

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. Or you can follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, for inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. For problems with inpatient and residential mental health services, call JFS Patient Advocacy Program at 800-479-2233. For problems with outpatient and all other mental health services, call toll free the Consumer Center for Health Education and Advocacy at 877-734-3258. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Diego County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

_____

My Phone Number: (_____) _____

My Signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____

Address: _____

_____

Phone Number: (_____) _____

County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____
_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____
_____

☐ Other:_____
_____

<u>If you don't agree with the plan's decision, you may</u>:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

CMHS OUTPATIENT REDESIGN
BRIEF TREATMENT MODEL
EFFECTIVE 1-1-10

Purpose: Establish session limited brief treatment that is efficient and effective across target populations. Clients shall receive brief treatment services that focus on the one or two most important issues identified by the client/family and conclude when those are stabilized. Clients will be able to obtain services in a timely way and have access back into the system when needed.

Initial Eligibility

Clients that meet the criteria for Title 9 medical necessity shall be eligible for 13 sessions (within a 12 month period).

- 1 Assessment Session
- 12 Treatment Sessions
- Emphasis on group and family treatment
- Adhere to CMHS SED Priority Population – others seen when space permits and priorities as follows:
  - Emergency
  - Urgent
  - AB2726
  - Routine
- Clients receiving group and/or family sessions only are eligible for an additional five (5) group or family sessions for a total of 18 sessions.
- Applies to MediCal, MHSA (indigent), and Healthy Families SED clients.
- AB2726 clients are subject to AB2726 procedures.
- Included services (count toward 13 sessions): assessment, individual, family and/or group treatment. Individual rehabilitative services are included when provided by a clinician.
- Excluded services (not counted toward 13 sessions): medication management, case management brokerage (CMBR), crisis intervention (CI), plan development, evaluation of records, report preparation, Therapeutic Behavioral Services (TBS), psychological testing (for those programs approved to do testing), and collateral (contact with significant others such as teachers, probation officers, child welfare services workers, and parent/guardians). Paraprofessional rehabilitative services (Rehab-individual, Rehab-group, Rehab-family) are excluded.
- No-show appointments count toward the 13 sessions. Cancelled appointments do not.
- The majority of clients will only be eligible for the initial 13 treatment sessions.
- At the conclusion of the 13 authorized treatment sessions, the client assignment shall be closed unless the client meets SED criteria and reauthorization is obtained.
- Medication-only cases may continue as needed and under existing procedure.

- Evidence Based Programs may be pre-authorized for the program to provide services for the time limited term of the model with written COTR documentation.

Eligibility and Utilization Management: In order to continue services beyond 13 treatment sessions, clients shall meet specific criteria and be reviewed through a Utilization Management process, conducted internally at each program by a licensed clinician.

A. <u>Utilization Management</u>

- Services may continue for one to 13 additional treatment sessions when clinically indicated as determined by UM review.
- The UM process is completed before the end of 13 sessions to determine continued eligibility and services,
- CFARS-Impairment Rating guideline of 5.
- The subsequent 13 treatment sessions must meet all three of the following criteria:
    1) Continued Medical Necessity with demonstrated benefit from services
    2) Meet SED criteria
    3) Consistent participation in services

B. <u>The UM criteria are specifically defined as follows:</u>

- Continue to meet Medical Necessity and demonstrate benefit from services (showing progress).
- Meet SED criteria:
    1) As a result of a mental disorder the child has substantial and persistent impairment in at least <u>two</u> of the following areas:
        a. Self-care and self regulation
        b. Family relationships
        c. Ability to function in the community
        d. School functioning

    AND one of the following occurs:
        e. Child is at risk for removal from home <u>due to a mental disorder.</u>
        f. Child has been removed from home <u>due to a mental disorder.</u>
        g. Mental disorder/impairment is <u>severe</u> and has been present for six months, or is highly likely to continue for more than one year without treatment.

    OR
    2) The child displays: acute psychotic features, is an imminent risk for suicide or imminent risk of violence due to a mental disorder.
- Consistent participation in services as prescribed by treating clinician.
- Current Client Functioning Impairment (CFARS)
  Guideline: Rating of 5 (Moderate to Severe) in all domains addressed through the Client Plan as it relates to the client's primary diagnosis.

Post 26 Sessions

- Must obtain prior COTR approval.
- Approximately 10% of those clients who successfully went through the initial UM will require more than 26 treatment sessions.

To continue beyond 26 treatment sessions clients shall be reviewed through a UM process and meet the following five criteria:

- Continued Medical Necessity and demonstrated benefit from services
- Meet SED criteria
- CFARS-Impairment Rating guideline of 5
- Consistent participation in services
- Meet a minimum of one continuing current Risk Factor related to child's primary diagnosis:
    1) Child has been a danger to self or other(s) in the last two weeks.
    2) Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks.
    3) Child's behaviors are so substantial and persistent that the current living situation is in jeopardy.
    4) Child exhibited bizarre behaviors in the last two weeks.
    5) Child has experienced trauma within the last two weeks. "A trauma is an exceptional experience in which powerful and dangerous events overwhelm the person's capacity to cope."

Utilization Management:

- Clinicians will clearly explain the process and limitations of services to families upon intake. Clients and families will be referred to community services upon discharge if needed.
- UM will be completed at the program level; approval will be by a licensed clinician only.
- Programs with Family Partners will include the Family Partner as part of the UM review process.
- UM forms will be utilized and will be accompanied by a new Client Plan. Client Plans will be completed within thirty (30) days of admission and prior to UM request.
- CFARS will be completed at admission and discharge and prior to each UM submission (13 sessions, 26 sessions).
- CAMS outcome measures will be administered at intake, aligned with UM cycle and prior to discharge if the previous CAMS is done over 2 months before discharge.
- Providers are required to implement a system to track UM for each client; this may be done at the Anasazi Clinician Home Page.

- Program Managers will report on the Monthly Status Report (MSR) the number of clients seen at 13, 26, and beyond 26 sessions as it compares to the total number of clients being served.
- Retroactive authorization cannot be obtained at the program level through the the UM process (COTR shall be informed when no UM is in place).
- Written exception to the UM process by evidence based program may be obtained from COTR.

INCLUDED AND EXCLUDED SERVICE CODES

Service Codes designated "included" are those that are included when counting the number of sessions provided for the 13 treatment session limit .

ID	DESCRIPTION	
5	SCREENING	excluded
9	ASSESSMENT PSYCHOSOC INTERACT	included
10	ASSESSMENT - PSYCHOSOCIAL	included
11	MEDICATION EVALUATION	excluded
12	PSYCHOLOGICAL TESTING	excluded
13	PLAN DEVELOPMENT	excluded
14	EVAL OF RECORDS FOR ASSESSMENT	excluded
15	EXTERNAL REPORT PREPARATION	excluded
20	MEDICATION SUPPORT OTHER	excluded
21	MEDICATION EDUCATION GROUP	excluded
22	MEDS - PHARMOCOLOGICAL MGMT	excluded
23	MED CHECK MD BRIEF	excluded
30	PSYCHOTHERAPY - INDIVIDUAL	included
31	PSYCHOTHERAPY - GROUP	included
32	PSYCHOTHERAPY - FAMILY	included
33	COLLATERAL	excluded
34	REHAB – INDIVIDUAL*	excluded
35	REHAB – GROUP*	excluded
36	REHAB – FAMILY*	excluded
37	REHAB EVALUATION	excluded
38	PSYCHOTHERAPY INTERACTIVE - IND	included
39	PSYCHOTHERAPY INTERACTIVE - GRP	included
40	COLLATERAL PARENT GROUP	excluded
46	THERAPEUTIC BEH SVCS - PLAN DEV	excluded
47	THERAPEUTIC BEH SVCS - DIRECT	excluded
48	THERAPEUTIC BEH SVCS - ASSESSMENT	excluded
49	THERAPEUTIC BEH SVCS - COL	excluded
50	CASE MANAGEMENT/BROKERAGE	excluded

60	OTHER SUPPORT NON-BILLABLE	excluded
63	SUBSTANCE ABUSE EDUCATION	excluded
65	COMMUNITY SERVICES	excluded
70	CRISIS INTERVENTION	excluded
90	CRISIS STABILIZATION	excluded
95	DAY TREATMENT	excluded

NOTE: rehabilitative services with * are excluded when provided by a paraprofessional and included if provided by a licensed or licensed eligible provider.

AB 2726 OUTPATIENT SERVICES REDESIGN
EFFECTIVE 3-1-10

Purpose: Provide outpatient services that are individualized, strategically planned to maximize efficiency and provide focused delivery of services, and authorized by the client's Individual Education Plan (IEP). These guidelines impact clients who are authorized for outpatient services by the County of San Diego AB 2726 assessors.

Policy
Effective 3/01/10, Special Education Services (SES) staff/assessors when recommending outpatient services will, at the initial IEP, recommend a definitive number of outpatient mental health sessions with a distinct start date and end date that coincide with the annual IEP date. Services may include individual, group and/or family therapy sessions and will be offered for a specific number of sessions until the annual review date. Collateral, case management and medication services, if appropriate, will be offered in addition to the identified treatment sessions.
AB 2726 staff shall encourage the utilization of community resources when appropriate, e.g. 12 step groups, NAMI, Families Forward, TBS, as an adjunct to the treatment process.

- The client's IEP with the specific number of outpatient treatment sessions and service period shall act as the authorization document.
- Clinicians and families will need to be strategic in planning how to utilize the allotted sessions.
- The provider's ongoing dialogue with families about focused treatment and realistic expectations of treatment sets the stage for the success of this model.
- The provider's ongoing dialogue with the contact at the client's school is imperative.
- Outpatient providers shall ensure that the client meets medical necessity and must call for an IEP meeting if client is assessed to have different mental health needs than those stipulated on the IEP, recognizing that only SES AB 2726 Assessors determine level of care.

The number of outpatient treatment sessions will be identified and authorized based on assessment of need and calculating a certain number of sessions per month. When determining the number of sessions to authorize, attention shall be given to the annual IEP date which is when mental health and the other related services will be reviewed, evaluated and renewed if necessary. Calculations are then based upon the number of months (until the next annual IEP date) rather than a non-specific offer of weekly individual sessions.

Guideline only: To determine the number of sessions to be offered, consideration shall be given to recommending one intake assessment session, and two individual, group or family therapy sessions per month until the annual IEP. In determining the number of sessions to recommend, consideration shall be given to the acuity of the illness during the

assessment process. Some clients may initially need to be seen more often and individually during an acute phase.

Additional Provider Requirements

- Outpatient provider must track the number of included treatment services that have been provided.
- No Shows are considered included services; providers will inform families of this at the onset of treatment.
- The *Client Plan* must integrate/include the IEP mental health goals and identify the number of sessions with start and end dates. The *Client Plan* format (3-1-10) allows for a notation of number of sessions authorized for AB 2726 clients.
- Clinicians can "front load" sessions initially by seeing the student or family weekly, and then reducing frequency and referring client to a group for ongoing support as indicated.
- Outcome measures are unchanged. (Youth Satisfaction Surveys twice a year, CAMS at intake, with the UR/authorization cycle, and at discharge, CFARS on assessment at intake, annually, and at discharge)
- Outpatient providers shall complete *Client Plans* within 30 days of opening of the assignment. The review date for the *Client Plan* shall coincide with the annual IEP date.

IEP Meeting Preparation and Participation

When a client has four sessions left and additional sessions are needed prior to the annual IEP, provider will contact the designated school personnel for discussion/consultation, and provide the school designee the following two forms:

1) *Quarterly Progress Mental Health IEP Report* documenting the client's progress towards the identified mental health IEP goals. The Quarterly Progress Report requires contact information and notation of the number of outpatient sessions allotted and the number remaining.
2) *Need for IEP Review* form indicating that the mental health provider is requesting additional sessions prior to the annual IEP review date.

Additional sessions shall only be requested to ensure continuity of care.

Outpatient providers shall attend IEP meetings and offer clinical recommendations as they relate to mental health services.

- Prior to IEP, provider will have negotiated with the family regarding recommendations.
- Prior to IEP, provider will have communicated with designated school personnel, discussing response to treatment and proposed recommendations for ongoing services.
- At the IEP meeting, provider will clearly state clinical recommendations and if additional mental health service sessions are warranted, identify a reasonable number of sessions to coincide with the next annual IEP date.
- Recommendations shall be individualized with a general guideline of two individual/group/family sessions per month. Groups are a preferred modality

with certain diagnoses and ages, and provide an opportunity for demonstrating progress.

- At the IEP meeting parents will be advised that if they do not attend a session and fail to cancel the session, a “no show” will be counted as part of the total number of services allocated for the client.
- Copy of the current IEP shall be maintained in the client’s medical record.

Annual IEP meetings shall be attended by the whole team, including the mental health clinician. Determination shall be made if services will be terminated or continued based upon the utilization of services, the attainment of the mental health IEP goals, and clinical recommendations.

Print Form

Service Authorization Request

For out-of-county organizational providers only.

Client's Name:	DOB:	Age:	CIN OR SSN:
_____ (First) _____ (Middle) _____ (Last)	_____	_____	_____

Requesting Agency:	Contact Person:
_____	_____

Contact Phone Number:	Contact Fax Number:
_____	_____

Submitted to (MHP):	Date Submitted:
_____	_____

◯ Initial Authorization for "Client Assessment" only.

◯ Initial Authorization (Required documents: "Client Assessment" and "Client Plan")

◯ Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

◯ Annual Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

(Please note: The MHP may request clarifying information / documentation to process your request for any of the above)

Speciality Mental Health Services Requested	Frequency of Service		Total Units Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Day Treatment Intensive	_____ Days/week		3 Months			
	◯ Half Day	◯ Full Day				
☐ Day Rehabilitation	_____ Days/week		6 Months			
	◯ Half Day	◯ Full Day				

Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care:

Service Necessity:

Child/youth requires a day rehabilitation, a structured program of rehabilitation and therapy, to:

1. ☐ Improve personal independence and functioning.
2. ☐ Maintain personal independence and functioning.
3. ☐ Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program program of therapy, which may be:

1. ☐ An alternative to hospitalization.
2. ☐ To avoid placement in a more restrictive environment
3. ☐ To maintain in a community setting.
4. ☐ Other (list): _____

Attachment-A, Refer to #01-02-225

Client Name: **Record/Identification Number:**

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Plan Development	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Individual Therapy	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Group Therapy	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Collateral Services	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Family Therapy	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Targeted Case Mgmt	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Medication Support	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Other: _____	____ per ◯ Week ◯ Month ◯ Authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

Client Name: **Record/Identification Number:**

Diagnosis

List Primary Diagnosis first.

Axis I: P: _____

_____

_____

Axis II: P: _____

_____

Axis III: P: _____

_____

Axis IV: P: _____

_____

Axis V: Current GAF: _____ Past Year GAF (if available) _____

Impairment criteria (Must have one of the following impairments as a result of the DSM diagnosis):

1. ☐ A significant impairment in an important area of life functioning.
2. ☐ A probability of significant deterioration in an important area of life functioning.
3. ☐ A probability that the client will not progress developmentally as individually appropriate.
4. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Intervention criteria (Must have 5, 6, and 7 or 7 and 8):

5. ☐ The focus of treatment is to address the condition identified in the impairment criteria.
6. ☐ The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate.
7. ☐ The condition would not be responsive to physical health care based treatment.
8. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Authorized by (Printed Name/License): _____ **Date:** _____

Signature: _____ **Authorizer's Phone Number:** _____

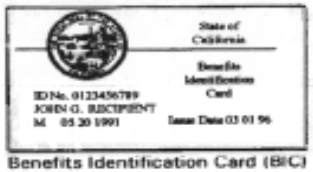
Appendix E
Interface with Physical Health Care Provider

HEALTHY SAN DIEGO

Plan Partner Identification for Pharmacies†

Step 1 - State

If patient has this (BIC) CARD:



Benefits Identification Card (BIC)

Step 1, please inquire if the patient has one of the other Plan Partner cards.
Step 2, if not, use your Point of Service (POS) Swipe Card Box for Plan Partner, Provider identification, and Member eligibility verification,
or call AEVS at 800-456-2387 or 800-786-4346. Your PIN# _____

Note: To obtain a POS device, please contact your pharmacy affiliation (Chain, PSAO).

Drug Carve-Out List

The drugs listed below should be submitted to Electronic Data System (EDS) Medi-Cal Fee-For-Service (FFS).

HIV/AIDS Drugs:

Abacavir Sulfate
Amprenavir
Atazanavir
Delavirdine Mesylate
Efavirenz
Emtricitabine
Indinavir Sulfate
Lamivudine
Lexiva
Lopinavir
Lopinavir/Ritonavir
Nelfinavir Mesylate
Nevirapine
Ritonavir
Saquinavir
Saquinavir Mesylate
Stavudine
Tenofovir Disoproxil Fumarate
Zidovudine/Lamivudine
Zidovudine/Lamivudine/Abacavir

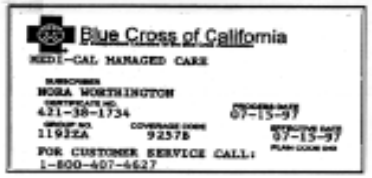
Anti-Psychotic Drugs:

Amantadine HCL
Aripiprazole
Benztropine Mesylate
*Biperiden HCL
*Biperiden Lactate
Chlorpromazine HCL
Chlorprothixene
Clozapine
Fluphenazine Decanoate
Fluphenazine Enanthate
Fluphenazine HCL
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
*Isocarboxazid
Lithium Carbonate Caps
Lithium Carbonate Tabs/CR
Lithium Citrate Syrup
*Loxapine HCL
*Loxapine Succinate
Mesoridazine Mesylate
Molindone HCL
Olanzapine
Perphenazine
*Phenelzine Sulfate
*Pimozide
Proclyclidine HCL
*Promazine HCL
Quetiapine
Risperidone
Thioridazine HCL
Thiothixene
Thiothixene HCL
*Tranylcypromine Sulfate
Trifluoperazine HCL
*Triflupromazine HCL
Trihexyphenidyl
Ziprasidone
Ziprasidone Mesylate

*Indicates medications which require a TAR (treatment authorization request)

† *Document adapted courtesy the L.A. Care Health Plan*

Step 2 - Plan Information



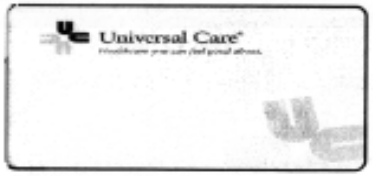
PBM:Wellpoint 800-700-2541
Eligibility: 800-962-7378
Prior Auth. Fax: 888-831-2243
CCU: 800-407-4627
Member ID: Client Identification # (CIN)

PBM:MedImpact: 800-788-2949
Eligibility: 800-854-0208
Prior Auth. Phone: 800-788-2949
Prior Auth. Fax: 800-578-9732
Member ID: Social Security #

PBM:HNPS
(Health Net Pharmaceutical Services)
Eligibility: 800-554-1444 #1
Prior Auth. Phone: 800-867-6564
Prior Auth. Fax: 800-977-8226
Member ID: Social Security #

PBM: Kaiser Pharmacy Services 800-464-4000
Eligibility: 800-464-4000
Medi-Cal Program: 619-528-5282
Member ID: Medical Record #

PBM:RxAmerica 800-770-8014
Eligibility: 800-359-2002
Prior Auth. Phone: 619-228-2400
Prior Auth. Fax: 619-228-2448
Member ID: Social Security #



PBM:MedImpact 800-788-2949
Eligibility: 800-673-4666
Prior Auth. Phone: 800-673-4666
Prior Auth. Fax: 562-981-5808
Member ID: Social Security#

HEALTHY SAN DIEGO
County of San Diego Health and Human Services Agency ■ P.O. Box 85222 San Diego ■ CA 92186-5222

SAN DIEGO REGIONAL CENTER FOR THE DEVELOPMENTALLY DISABLED

CALIFORNIA EARLY START PROGRAM

Eligibility:

- Birth to age 3 years
- Residence in San Diego or Imperial County
- No financial qualifications
- High risk for developmental disability:
  (Two or more factors that require early intervention services)
  - Small for gestational age
  - Seizures in the first week of life
  - Less than 32 weeks gestation or 1500 grams
  - Lack of oxygen at birth
  - Assisted ventilation for 48 hours or more
  - Failure to thrive

OR

Established risk for developmental disability:
- Conditions known to cause delays in development
  (e.g. Down syndrome, Prader-Willi, Spina-Bifida)
- Need not be demonstrating delays at time of referral

OR

Developmental delay in one or more of the following areas:

Cognitive	Physical
Communication	Social or Emotional
Adaptive	

Services:

Evaluation of all areas of development to determine eligibility.
Development of an Individualized Family Service Plan (IFSP).
Coordination of early intervention services which may include:

Assistive Technology	Audiology
Health Services	Medical Services (for evaluation)
Nursing Services	Nutrition Services
Occupational Therapy	Physical Therapy
Psychological Services	Service Coordination
Social Work	Special Instruction
Speech & Language Services	Transportation
Vision Services	Transition Plan at age 3 yrs
Respite	Counseling
Family Training	Home Visits

TO REFER

San Diego County (858) 496-4318 Imperial County (760) 355-8383

SAN DIEGO REGIONAL CENTER (SDRC)

Eligibility:

- Age 3 years or older
- Residence in San Diego or Imperial County
- No financial qualifications
- Developmental Disability:
  - Mental Retardation
  - Cerebral Palsy
  - Epilepsy
  - Autism
  - Other conditions similar to mental retardation

AND

- Originated prior to age 18 years

AND

- Is likely to continue indefinitely

AND

- Constitutes a substantial disability in 3 or more of the following areas:

Communication	Economic Self-Sufficiency
Learning	Self Care
Self-Direction	Mobility
Capacity for Independent Living	

Services:

Evaluation to determine eligibility
Assessment to assist with program planning
Development of the Individual Program Plan (IPP)
Case Management/Service Coordination
Coordination of developmental disability services which may include:

Residential Services	Respite
Work Program	Behavior Intervention
Transportation	Physical Therapy
Psychological Services	Medical Services
Nursing Services	

(In order to process intake, SDRC must be contacted by the parent or legal guardian of a minor, the conservator, or the unconserved adult.)

TO REFER

San Diego County (858) 576-2938 Imperial County (760) 355-8383

Programs of San Diego Imperial Counties Developmental Services, Inc.

COORDINATION OF CARE

BETWEEN PHYSICAL & BEHAVIORAL HEALTH PRACTITIONERS

SECTION A. CLIENT INFORMATION			
Name Last First Middle Initial		AKA	☐ Male ☐ Female
Street Address		Date of Birth	
City		Telephone #	
Zip		Alternate Telephone #	

SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION			
Name			
Organization OR Medical Group			
Street Address		City, State, Zip	
Telephone #		Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis	
Current Symptoms			
Current Medications			
Summary of Patient Evaluation		Current Treatment Plan	

SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION			
Name			
Organization OR Medical Group			
Street Address		City, State, Zip	
Telephone #		Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis	
Current Symptoms			
Current Medications			
Summary of Patient Evaluation		Current Treatment Plan	

To Reach a Plan Representative

Blue Cross Of California	(800) 407-4627	Health Net	(800) 675-6110	Universal Care	(800) 635-6668
Community Health Group	(800) 404-3332	Kaiser Permanente	(800) 464-4000	United Behavioral Health	(800) 479-3339
		Sharp Health Plan	(800) 359-2002		

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

FOR OFFICE USE	ID VALIDATION
SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

- o Information Contained on this form
- o Current Medication & Treatment Plan
- o Substance Dependence Assessments
- o Assessment /Evaluation Report
- o Discharge Reports/Summaries
- o Laboratory/Diagnostics Test Results
- o Medical History
- o Other _____

To Reach A Health Plan Representative Call:

Blue Cross Of California	(800) 407-4627
Community Health Group	(800) 404-3332
Health Net	(800) 675-6110
Kaiser Permanente	(800) 464-4000
Sharp Health Plan	(800) 359-2002
Universal Care	(800) 635-6668
United Behavioral Health	(800) 479-3339

Client Name { *Please type or print clearly*}

(Last) _____

(First) _____

I would like a copy of this authorization.

☐ **Yes** ☐ **No** **Initials** ☐

PLACE A COPY OF THIS FORM
IN THE CLIENT'S MEDICAL RECORD

Appendix F
Beneficiary Rights and Issue Resolution

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

1) Grievance process
2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)
3) Expedited Appeal process (available in certain limited circumstances)
4) State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5,

Section 1850.205 and 42 CFR Subpart F, Part 438.400. **The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document.** By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.
2. To protect the rights of consumers receiving mental health services, including the right to:
   - Be treated with dignity and respect,
   - Be treated with due consideration for his or her privacy,
   - Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
   - Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
   - Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
   - Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
   - Freely exercise these rights without adverse effects in the way providers treat him or her.
3. To protect the rights of consumers during grievance and appeal processes.
4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.
5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.
6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.
3. Consumers shall be informed of their right to contact the Jewish Family Service (JFS) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal

beneficiaries shall also be informed of their right to request a State Fair Hearing.

4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the JFS Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages, and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.

5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.

6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.

7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.

8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.

9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

   - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
   - Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision whether or not the client received a Notice of Action (NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)
   - Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
   - Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact JFS Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from JFS or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health

services or their administration by filing a grievance through JFS Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and Advocacy (for outpatient and all other mental health services).

IV. GRIEVANCE PROCEDURES:

At any time the consumer chooses, the consumer may contact CCHEA or JFS Patient Advocacy, as appropriate. CCHEA or JFS Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts JFS Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).
   NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition) not a grievance. See "Appeal Process" in Section V below for procedure.

2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include:
   - the client name or other identifier,
   - date the grievance was received,
   - the date it was logged, the nature of the grievance,
   - the provider name,
   - whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.

4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.

5. CCHEA or Patient Advocacy Program investigates the grievance.
   - CCHEA or JFS shall ensure that the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.
   - In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.
   - The client's confidentiality shall be safeguarded per all applicable laws.

6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's condition.

7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or JFS and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If a case should arise in which CCHEA or JFS and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or JFS shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or JFS may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.

8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
   - the date
   - the resolution

   A copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.

9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or JFS will contact the client to discuss an extension, clearly document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or JFS staff must give the client written notice of the reason for the delay. If CCHEA or JFS staff is unable to meet the timeframe described herein, the staff person shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or JFS Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.

11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or JFS. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

Grievance Plan of Correction
Quality Improvement Unit
P.O. Box 85524, Mail Stop P531G
Camino Del Rio South
San Diego, CA 92186-5524

The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or JFS's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing Date
2	Grievance Logged	1 Working Day from Grievance Filing
3	Written Acknowledgement to client	3 Working Days from Grievance Filing
4	Provider Contact	Within 3 Working Days from Client's Written Permission to Represent
5	Clinical Consultant review, if applicable	Within 60 day total timeframe
6	Grievance Disposition	60 Days from Filing Date
7	Disposition Extension (if needed)	14 Calendar Days from the 60th day
8	Provider Plan of Correction (if needed)	10 Working Days from Disposition Date
9	Request for Administrative Review	10 Working Days from receipt of the

		Grievance Disposition

V. APPEAL PROCESS—available to Medi-Cal Beneficiaries only

The appeal procedure begins when a Medi-Cal beneficiary contacts JFS Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOA was mailed, or
- within 10 days of the date the NOA was personally given to the beneficiary, or
- before the effective date of the service change, <u>whichever is later</u>.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same 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, <u>whichever is earliest</u>.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.

2. CCHEA or JFS Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.

3. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the:

   - client name or other identifier,
   - date the appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - the provider involved,
   - and whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, CCHEA or JFS will summarize in writing the content pertaining to the client.

4. CCHEA or JFS shall acknowledge, in writing, receipt of the appeal within three working days.

5. CCHEA or JFS shall contact the provider as soon as possible and within three working days of receipt of the client's written authorization to represent the client.

6. CCHEA or JFS Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.

7. CCHEA or JFS evaluates the appeal and:

   - Ensures that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - Safeguards the client's confidentiality per all applicable laws.

   In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental

health professional with the appropriate clinical expertise in treating the client's condition.

9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If CCHEA or JFS denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or JFS believes that there is sufficient merit to grant an appeal regarding an action that:

    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, CCHEA or JFS shall do the following within 30 calendar days of the date the appeal was filed:

      a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
      b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

      In some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.

12. CCHEA or JFS shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:
    - the date,
    - the resolution,
    - and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
      - the right to request a State Fair Hearing within 90 days of notice of the decision,
      - how to request a State Fair Hearing, and
      - the beneficiary's right to request services while the hearing is

pending and how to make that request for continued services.

- A copy of the appeal resolution letter will be sent to the provider and the Quality Improvement (QI) Unit at the time the letter is sent to the client.

13. Appeals must be resolved within 45 calendar days (59 calendar days if extension granted) from the date of receipt of the appeal. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.

14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.

15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOA-D to Medi-Cal beneficiaries only. A copy shall be sent to the QI Unit. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.

16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

STEP	ACTION	TIMELINE
1	Appeal Filed by client	File Date
2	Appeal Logged	1 Working Day from Appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	3 Working Days from Receipt of Appeal
5	Provider Contact	3 Working Days from Client's Written Permission to Represent
6	Clinical consultant review, if applicable	As soon as possible
7	Notify QI Unit	3 Working Days of Appeal Filing
8	Advocacy Organization recommends denying appeal	See #10 for timelines
9	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation	Within 30 calendar days from date appeal was filed
10	MHP Director makes decision on the appeal	Within 10 calendar days from receipt of appeal.
11	**Appeal Resolution**	**45 Calendar Days from Receipt of Appeal**
12	Appeal Extension (if needed)	14 Calendar Days from Extension Filing Date

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or JFS Patient Advocacy program staff, jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:
   - client name or other identifier,
   - date appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - provider involved,
   - and whether the issue concerns a child.
4. The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
6. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two working days.
7. The client or his or her representative may present evidence in person or in writing.
8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
   - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - The client's confidentiality shall be safeguarded per all applicable laws.
9. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
10. If, in the opinion of CCHEA or Patient Advocacy Program, the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
    - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.

- Transfer the appeal to the timeframe for standard appeal resolution (above), and
- Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a written notice. A copy of the letter shall be sent to QI.

11. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If CCHEA or JFS denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14.*

12. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two working days of the date the appeal was filed:
        - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
        - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.

13. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.

14. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:
    - the date,
    - the resolution,
    - and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary

- information regarding the right to request an expedited State Fair Hearing
- information on how to request continued services (aid paid pending) while the hearing is pending.

A copy of the appeal resolution letter will be sent to the provider and the QI Unit at the same time the letter is sent to the client.

15. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or JFS staff determines that there is a need for more information AND that the delay is in the client's best interest.

16. If the timeframe extension was not requested by the client, CCHEA or JFS Patient Advocacy staff must give the client written notice of the reason for the delay.

17. If CCHEA or JFS staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.

18. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

19. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

EXPEDITED APPEAL PROCESS

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in 2 calendar days in writing
3	Expedited Appeal Logged	1 Working Day from Appeal receipt
4	Written Acknowledgement of appeal to client	2 Working Days from Receipt of Appeal
5	Provider Contact	2 Working Days from Client's Written Permission to Represent
6	Notify QI Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines
8	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation.	Within 2 working days from date appeal was filed
9	MHP Director makes decision on the appeal	Within 1 working day from receipt of notification from the Advocacy Organization
10	Appeal Resolution	3 Working Days from Receipt of

		Appeal
11	Disposition Extension (if needed)	14 Calendar Days from 3rd working day.

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or JFS Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QI Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QI Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:
    - within 10 days of the date the NOA was mailed, or
    - within 10 days of the date the NOA was personally given to the beneficiary, or
    - before the effective date of the service change, <u>whichever is later</u>.
5. The beneficiary must have:

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section XII. Definitions).

6. The benefits will stay the same 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.

7. After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case is not resolved in the MHP's favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Action (NOA) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QI Unit shall review the files of CCHEA and JFS Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.

2. On a monthly basis, by the 20th of the following month, JFS Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:

   - client name or other identifier
   - date the grievance or appeal was filed,
   - date logged
   - nature of the grievance or appeal
   - provider involved,
   - and whether the issue concerns a child.

3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

4. The MHP QI Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and JFS Patient Advocacy shall report to the QI Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QI Unit also.

2. The QI Unit will investigate all such complaint clusters.

3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Appeal: A request for review of an action (as action is defined above).

Beneficiary: A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

Client:	Any individual currently receiving mental health services from the County MHS system, regardless of funding source.
Consumer Center for Health Education and Advocacy (CCHEA):	CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.
Consumer:	Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)
Grievance:	An expression of dissatisfaction about any matter other than an action (as action is defined).
Grievance and Appeal Process:	A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.
Mental Health Plan (MHP):	County of San Diego, Health & Human Services Agency, Mental Health Services.

Notice of Action (NOA):

A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.

NOA-B: (Denial of Services) Denial or modification of provider's request for Medi-cal services requiring pre-authorization. The denial is sent from the point of authorization to both provider and beneficiary, when the beneficiary did not receive the service.

NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.

NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.

NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.

Patients' Rights Advocate:

The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

JFS Patient Advocacy Program staff currently serve as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serve as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Improvement (QI) Program:

The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

State Fair Hearing:	A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.
Jewish Family Service (JFS) Patient Advocacy Program:	The Jewish Family Service Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of the Access and Crisis Line at (800) 479-3339.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan through the Access and Crisis Line at (800) 479-3339 or write to: United Behavioral Health Access and Crisis Line, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. Or you can follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, for inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____
_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____
_____

☐ Other:_____
_____

<u>If you don't agree with the plan's decision, you may</u>:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. For problems with inpatient and residential mental health services, call JFS Patient Advocacy Program at 800-479-2233. For problems with outpatient and all other mental health services, call toll free the Consumer Center for Health Education and Advocacy at 877-734-3258. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Diego County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

_____

My Phone Number: (_____) _____

My Signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____

Address: _____

_____

Phone Number: (_____) _____

Appendix G
Quality Improvement Program

CALIFORNIA DEPARTMENT OF
Mental Health

REASONS FOR RECOUPMENT
IN FY'06-07
NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1830.205(b)(1)(A-R).

   CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   CCR Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C) and 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C)—(see below):

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope MC beneficiaries under the age of 21 years, a condition, as a result of the mental disorder, that specialty mental health services can correct or ameliorate

   NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT-eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

   CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(A)

REASONS FOR RECOUPMENT
IN FY'06-07

MEDICAL NECESSITY (con't):

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:

   - Significantly diminish the impairment
   - Prevent significant deterioration in an important area of life functioning
   - Allow the child to progress developmentally as individually appropriate
   - For full-scope M/C beneficiaries under the age of 21 years, correct or ameliorate the condition

   CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(B)(1),(2), and (3)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in MHP's documentation guidelines, or, lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

   MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in MHP's documentation guidelines.

   MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

   MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving TBS, no documentation of a plan for TBS.

   DMH Letter No. 99-03, pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

   CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

    CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT
IN FY'06-07

PROGRESS NOTES (con't):

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for FFP, e.g., Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per Title 9, Chapter 11.

    CCR, Title 9, Chapter 11, Sections 1840.312(g)&(h) and 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for MC. (Dependent minor is MC eligible. Delinquent minor is only MC eligible after adjudication for release into community.)

    CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

    CCR, Title 9, Chapter 11, Section 1840.312(a),(b),(c), and (d)

14. The claim for a group activity was not properly apportioned to all clients present.

    CCR, Title 9, Chapter 11, Section 1840.316)b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

    CCR, Title 9, Chapter 11, Sections 1810.355(a)(1)(B), 1840.312(f), and 1810.247, and 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

    CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

    CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

19. No service provided: Missed appointment per DMH Letter No. 02-07.

    DMH Letter No. 02-07

REASONS FOR RECOUPMENT
IN FY'06-07

PROGRESS NOTES (con't):

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

    a) For the convenience of the family, caregivers, physician, or teacher
    b) To provide supervision or to ensure compliance with terms and conditions of probation
    c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
    d) To address conditions that are not a part of the child's/youth's mental health condition

    DMH Letter No. 99-03, page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

    DMH Letter No. 99-03, page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

    CCR, Title 9, Chapter 11, Section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
    - Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital

REASONS FOR RECOUPMENT
IN FY'06-07

MEDICAL NECESSITY (con't):

- Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, Title 9, Chapter 11, Sections 1820.205(a)(2)(B) 1 a-d, 1820.205(a)(2)(B) 2 a-c, and 1820.205(b)(1-4)

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity criteria for acute psychiatric inpatient hospital service during the current hospital stay.

    CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following: a) The status of the placement option(s), b) the dates of the contacts, and c) the signature of the person making each contact.

CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

    Code of Federal Regulations (CFR), Title 42, Subchapter C, Subpart D, Sections 456.180; *CCR, Title 9, Chapter 11,* Section 1820.210

27. The client plan was not signed by a physician.

    CFR, Title 42, Subchapter C, Subpart D, Sections 456.180; *CCR, Title 9, Chapter 11,* Section 1820.210

OTHER:

28. A claim for a day when the beneficiary was not admitted to the hospital.

    CCR, Title 9, Chapter 11, Sections 1810.238, 1820.205, and 1840.110(a)
    (b)(2)(A),(B),(C) and 1830.210(a)(3)

APPEAL PROCESS
Medi-Cal QI Recoupment Report
County of San Diego Children's Mental Health Services

The Quality Improvement Unit's 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision is as follows:

1. QI Specialist will mail the provider a formal written report outlining the results of their medical record review within 14 days of review completion.

2. Provider has 14 days from date of the cover letter attached to the written report to request a first level appeal.

3. First level appeal must be in writing, specify which recoupment(s) is being appealed, reason why, and include any supporting documentation from the medical record. Appeal should be marked "confidential" and mailed to Victoria Hilton, QI Program Manager.

4. First level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

5. Should provider disagree with first level decision, provider has 7 working days from receipt of written decision to request a second level appeal. Second level appeal must be in writing, specify which recoupment(s) is being appealed from first level decision, and reason why. Appeal should be marked "confidential" and mailed to Candace Milow, Chief, Quality Improvement.

6. Second level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

Mailing address for Children's Quality Improvement:
County of San Diego
Children's Mental Health Services
P.O. Box 85524 Mailstop: P-531Q
San Diego, CA 92186-5524

Any questions regarding this procedure may be directed to Victoria Hilton at (619) 563-2747.

Medication Monitoring Committee Minutes

Program Name:			**Meeting Date:**
Unit/Subunit:			**Place:**
☐ Quarter 1 Jul 1 – Sep 30, 20	☐ Quarter 2 Oct 1 – Dec 31, 20	☐ Quarter 3 Jan 1 – Mar 31, 20	☐ Quarter 4 Apr 1 – Jun 30, 20
Screened by: ☐ County Pharmacy ☒ MM Committee Only County Programs are checked by County Pharmacy			

Committee Members	**Print Name**	**Discipline**	**Sign Name**
Chairperson	_____	_____	_____
Members	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Description of Activities

New Business

_____ Total Number of records screened this quarter

_____ Total Number of variances identified

☐ No medication monitoring done at this site(s)*

Old Business

_____Number of outstanding variances from last MM Committee Meetings

_____ Number of variances requiring follow – up

Please note that all McFloops are due within 15 days of each quarter reporting due date (e.g. quarter one July, Aug., Sept. reports due by Oct. 15.

Please fax your Medication Monitoring Reports to:
Quality Improvement Unit
County of San Diego, CMH
Fax: (619) 584-5018
Attn: Helen Kobold/Tesra Widmayer

Q.I. Confidential Information

QUALITY IMPROVEMENT – HHSA-CHILDREN'S MHS
MEDICATION MONITORING SCREENING TOOL

Please complete all boxes on this form with legible writing or type.

Program:	**Review Date:**
Client (first name only):	**Case #:**
Treating Psychiatrist:	
Reviewer:	

PLEASE NOTE: ALL "NO" ANSWERS REQUIRE A MCFLOOP FORM.

	CRITERIA	COMPLIANCE Yes	No	NA	COMMENTS
1.	Were medication rationale and dosage consistent with standard of care in Child and Adolescent Psychiatric community?	☐	☐		
2.	If Labs were indicated, were they ordered, obtained, & acted upon?	☐	☐	☐	
3.	Were physical health conditions and treatment considered when prescribing psychiatric medication?	☐	☐	☐	
4.	For each class of meds below please indicate whether there was clearly documented rationale for prescribing <u>more</u> than 1 medication in each category:				"No" answer means that the rationale was not clearly documented <u>and</u> client is on more than 1 med. in that class. Put N/A if client doesn't take this medication.
	a. Stimulants	☐	☐	☐	
	b. Mood Stabilizer	☐	☐	☐	
	c. Antidepressants	☐	☐	☐	
	d. Antipsychotics	☐	☐	☐	
	e. Antiparkinsonian	☐	☐	☐	
5	Were Adverse Drug Reactions and/or Side Effects treated and managed effectively?	☐	☐	☐	
6.	Was informed consent obtained, as evidenced by a signed consent form or ex-parte order?	☐	☐	☐	
7.	Was the diagnosis in concordance with prescribed medication?	☐	☐	☐	
8.	Did treating M.D. document:				
	a. client's response to medication therapy?	☐	☐	☐	
	b. the presence/absence of side effects?	☐	☐	☐	
	c. the extent of client's compliance with the prescribed medication regime and relevant interventions?	☐	☐	☐	
	d. measures taken to educate client/parent in regard to medication management?	☐	☐	☐	

McFloop Form

PROGRAM:

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____
Patient Name _____
Case # _____

Summary of Recommendations/Requests for Action:

_____

Physician Reviewer Signature & Discipline **Date**

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

_____

Physician Signature & Discipline **Date**

Verification of Physician Response

( ) Approved

( ) Disapproved (Forwarded to PTSOC)

_____

Physician Reviewer Signature & Discipline **Date**

Perpetual Inventory Medication Log

Program Name:					Month:
Client Name:					
Date	Medication Name and Doseage	# of Tablets Received	# of Tablets Adm. by Client	Staff Signature	Client Signature

Medication Disposal Log

Program Name:

Date	Client	Medication/Dosage	# of Tablets	Witness Signature #1	Witness Signature #2

County of San Diego - Health and Human Services Agency

Mental Health Services

MONTHLY STATUS REPORT-NARRATIVE

due the 15th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

for instructions place cursor over the RED Markers located at the upper right corner of each heading.

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-31, 2009**
RU Number(s)		Date Submitted	**August 15, 2009**
Submitted By		Contact Phone	

2. PROGRAM DESCRIPTION:

3. ACTIVITIES AND EVENTS:

4. CO-OCCURING DISORDERS:

5. COMMUNITY OUTREACH /COLLABORATION WITH OTHER AGENCIES/EDUCATION REGARDING SERVICES:

Population Targeted	Other	**Venue**	Other

6. PROGRAMMATIC ISSUES AND ACTIONS INITIATED TO SOLVE OR MITIGATE THEM:

7. EMERGING ISSUES OR POTENTIAL PROBLEMS:

8. QUALITY IMPROVEMENT ACTIVITIES:

6. OUTCOMES DATA:

Number	Objectives	YTD Results
1	For 80% of discharged clients whose episode lasted 2 months or longer, the P-CAMS total score shall show improvement between intake and the last CAMS collected.	
2	For 80% of discharged clients whose episode lasted 2 months or longer, the Y-CAMS total score shall show improvement between intake and the last CAMS collected.	
3	For 80% of discharged clients whose episodes lasted 2 months or longer, the CFARS score shall be at least one level higher (improvement) at discharge than at admission in at least one index area.	
4	For 80% of those clients who remain in the program for 2 months or longer, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the domain rating for substance use.	
5	For 80% of clients whose episode lasts 6 months or longer, the P-CAMS total score shall show improvement between intake and the most recent P-CAMS collected.	
6	For 80% of clients whose episode lasts 6 months or longer, the Y-CAMS total score shall show improvement between intake and the most recent Y-CAMS collected.	
7	For 80% of clients whose episode lasts 6 months or longer, the most recent CFARS score shall be at least one level higher (improvement) in at least one index areas, compared to Intake.	
8	90% of clients will avoid hospitalization or re-hospitalization during the outpatient episode as measured by client and family report.	
9	At Discharge, 80% of parent CAMS will have data available for both Intake and Discharge.	
10	At Discharge, 80% of child CAMS will have data available for both Intake and Discharge.	
11	For 80% of clients open 6 months or longer, parent CAMS data will be available for both Intake and at least one additional CAMS time point.	
12	For 80% of clients open 6 months or longer, child CAMS data will be available for both Intake and at least one additional CAMS time point.	
13	At Discharge, 100% of clients with an intake after September 1, 2007 will have CFARS data available for both Intake and Discharge.	

7. SCHOOL SITE LOCATIONS

Number	School Site	School District	Hours/Week	Number of Clients
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
10	**TOTAL SCHOOL SITE DATA**			

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-31, 2009**
RU Number(s)		Date Submitted	**08/15/09**
Submitted By		Contact Phone	

2. SERVICE AND BILLING UNITS:

SERVICE FUNCTIONS	Service Units				Billing Units			
	Annual Budgeted	Report Month Actual	YTD Actual	% Elapsed	Annual Budgeted	Report Month Actual	YTD Actual	% Elapsed
MHS								
MHS-R								
MHS-TBS								
MED SUPPORT								
CRISIS INTERVENTION								
C.M. BROKERAGE								
DAY TREATMENT INTENSIVE								
DAY REHABILITATION								
OTHER(SPECIFY)								
TOTAL of budgeted units	**0**	**0**	**0**		**0**	**0**	**0**	
Estimated Productivity								**#DIV/0!**
COMMENTS								

3. STATISTICAL INFORMATION:

Report Item *(total number count as of last calendar day of report month)*	Report Month	Year to Date
Admissions		
Discharges		
Active cases		
Unduplicated clients		
Unusual Occurrences/Incident Report		
Actual FTE Direct Service Staff	**0.00**	
Average Caseload per Actual Direct Service Staff FTE - *#active cases/#direct service*	**#DIV/0!**	
Number of Referrals		

4. WAIT LIST REPORT:

Total Number on Waiting List	Average Wait time (days)	WT for Initial MD Evaluation in Days	Total Number of AB2726 Waiting

Average Wait time AB2726	Longest Wait time AB2726	Clinical Staff Vacancies
days	**days**	

Waitlist clients payor source:	**AB=**		**AB/MC=**		**Medi-Cal=**		**Healthy Families=**		**Short Doyle=**	

5. FAMILIES PARTICIPATING IN FACE-TO-FACE THERAPY AT LEAST TWO TIMES PER MONTH:

Total Number of Families	Total Number of Participating Families	Percent of Participation

Comments:	

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-31, 2009**
RU Number(s)		Date Submitted	**08/15/09**
Submitted By		Contact Phone	

2. SERVICE AND BILLING UNITS:

SERVICE FUNCTIONS	Service Units				Billing Units			
	Annual Budgeted	Report Month Actual	YTD Actual	% Elapsed	Annual Budgeted	Report Month Actual	YTD Actual	% Elapsed
MHS								
MHS-R								
MHS-TBS								
MED SUPPORT								
CRISIS INTERVENTION								
C.M. BROKERAGE								
DAY TREATMENT INTENSIVE								
DAY REHABILITATION								
OTHER(SPECIFY)								
TOTAL of budgeted units	**0**	**0**	**0**		**0**	**0**	**0**	
Actual Productivity								**#DIV/0!**
COMMENTS								

3. STATISTICAL INFORMATION:

Report Item *(total number count as of last calendar day of report month)*	Report Month	Year to Date
Admissions		
Discharges		
Active cases		
Unduplicated clients		
Unusual Occurrences/Incident Report		
Actual FTE Direct Service Staff	**0.75**	
Average Caseload per Actual Direct Service Staff FTE - *#active cases/#direct service*	**0.00**	
Number of Referrals		

4. WAIT LIST REPORT:

Total Number on Waiting List	Average Wait time (days)	WT for Initial MD Evaluation in Days	Total Number of AB2726 Waiting

Average Wait time AB2726	Longest Wait time AB2726	Clinical Staff Vacancies
days	**days**	

Waitlist clients payor source:	**AB=**		**AB/MC=**		**Medi-Cal=**		**Healthy Families=**		**Short Doyle=**	

5. FAMILIES PARTICIPATING IN FACE-TO-FACE THERAPY AT LEAST TWO TIMES PER MONTH:

Total Number of Families		Percent of Participation
	19	**#DIV/0!**

Comments:	

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-SUGGESTION & TRANSFER

1. General Information

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-31, 2009**
RU Number(s)		Date Submitted	**08/15/09**
Submitted By		Contact Phone	

2. Suggestion and Transfer Data

☑ **NONE (No Suggestion or Transfer Requests were received this reporting period.)**

Date Received or Initiated **mm/dd/yy**	Indicate if this is Client **(S)** Suggestion or **(T)** Transfer Request	Client Suggestion Code **1-15**	Transfer Request Code **1-11**	Indicate if Client Transfer Request is **(O)** Out of Program or **(N)** To New Provider within the Program	Description of Client Suggestion or Transfer Request	Date of Resolution **mm/dd/yy**	Describe Resolution or Action Taken

County of San Diego - Health and Human Services Agency
MONTHLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

Contractor Name	0	Program Type	CHILD
Program Name	0	Provider Type	CONTRACTOR
Contract Number	0	Report Period	JULY 1-31, 2009
RU Number(s)	0	Date Submitted	8/15/2009
Submitted By	0	Contact Phone	0

2. STAFFING UPDATES

☐ **NONE (No Staffing Updates were generated this reporting period.)**

3.

Position	Name	Credential	Pos Type Code	Budgtd Direct FTE	Actual Direct FTE	Budgtd Admin FTE	Actual Admin FTE	Ethnic Code	Language Proficiency Codes (Enter **ONLY 1 code per column.** IF more than 4 languages, enter additional codes in last column)					Read & Write Proficiency (Enter **ONLY 1 code per column.** IF more than 4 languages, enter additional codes in last column)					Specialty Code (Enter **ONLY 1 code per column.** IF more than 9 specialty codes, enter additional codes in last column)										Hire Date	Term Date	Cult Comp Trng Comp	Cult Comp Trng Attend	Disaster Training Complete	Disaster Training Attend

TOTALS

0.00	0.00	0.00	0.00
Budgtd Direct FTE	Actual Direct FTE	Budgtd Admin FTE	Actual Admin FTE

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

Contractor Name	**0**	Program Type	**CHILD**
Program Name	**0**	Provider Type	**CONTRACTOR**
Contract Number	**0**	Report Period	**JULY 1-31, 2009**
RU Number(s)	**0**	Date Submitted	**8/15/2009**
Submitted By	**0**	Contact Phone	**0**

2. STAFFING UPDATES

☐ **NONE (No Staffing Updates were generated this reporting period.)**

3. PERSONNEL

Position	Name	Credential	Pos Type Code	Budgtd Direct FTE	Actual Direct FTE	Budgtd Admin FTE	Actual Admin FTE	Ethnic Code	Language Proficiency Codes (Enter **ONLY 1 code per column.** IF more than 4 languages, enter additional codes in last column)					Read & Write Proficiency (Enter **ONLY 1 code per column.** IF more than 4 languages, enter additional codes in last column)					Specialty Code (Enter **ONLY 1 code per column.** IF more than 9 specialty codes, enter additional codes in last column)										Hire Date	Term Date	Cult Comp Trng Comp	Cult Comp Trng Attend	Disaster Training Complete	Disaster Training Attend

TOTALS

0.00	0.00	0.00	0.00
Budgtd Direct FTE	Actual Direct FTE	Budgtd Admin FTE	Actual Admin FTE

County of San Diego - Health and Human Services Agency

TRAINING REPORT

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-31, 2009**
RU Number(s)		Date Submitted	**08/15/09**
Submitted By		Contact Phone	

2. TRAINING REPORT

Total Hours of CCT Completed **0**

Training Course Designation	Course Topic or Description	Training Provided by **(C)** County or **(N)** NonCounty	Course Length (number of hours) **0.5** to **40.0**	Course Date Enter Actual Course Start Date **mm/dd/yy**	Number of Attendees by Function				Type of Training
					Administration or Management	Direct Services	Support Services	Volunteer or Student Workers	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
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53									

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-NOTICE OF ACTION A and B

1. General Information

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-31, 2009**
RU Number(s)		Date Submitted	**08/15/09**
Submitted By		Contact Phone	

2. Notice of Action - Assessment (NOA-A)

☐ **NONE (No Notice of Action-A was issued this report month.)**

Date	ID Number	Client Response

3. Notice of Action - Denial of Service (NOA-B)

☑ **NONE (No Notice of Action-B was issued this report month.)**

Date	ID Number	Client Response

CONFIDENTIAL

County of San Diego Behavioral Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT

To be completed and submitted via FAX to Quality Improvement Department within 72 hours of occurrence of incident

Client Name:	
Client Case Number:	DOB:
Diagnosis (Use DSM IV Codes) : Axis I (Primary) :	Axis I (Secondary) :
Provider (Program) Name:	Staff Involved:
Parent Organization (if any):	
Date of Incident:	Time of Incident:
Location where Incident Occurred: (Address/Setting)	
Date Incident was reported to Provider:	
Date and Time Incident was reported telephonically to BHS QI:	

1. Incident Reviewed (Please check at least one):

- ☐ Death, excluding natural cause, includes death by suicide
- ☐ Homicide by a client - attempted homicide by a client
- ☐ Suicide attempt resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention
- ☐ For mental health clients: use of physical restraints (prone or supine)*
- ☐ Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Injurious assault on a client <u>or</u> by a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Inappropriate staff behavior such as sexual relations with a client, financial exploitation of a client, and/or physical or verbal abuse of a client.
- ☐ Major confidentiality breach (lost or stolen laptop, large number of client files/records accessed, etc.)
- ☐ Other: _____

*Excluding Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, ESU and PERT

☐ **Notification to:** (Circle One) Parent / CWS / Probation	☐ Verbal	☐ Written

CONFIDENTIAL

Client Name:
2. Describe the Serious Incident: (Include people involved and precipitating factors. Indicate if client was admitted to acute care medical or psychiatric unit and length of stay, if known.) *(Continue on back if needed)*
3. Other Behavioral Health Services Client is currently receiving: (Outpatient, case management, medication management, day rehabilitation, residential, etc.)
4. Current prescribed medication: Name of prescribing physician:
5. Physical or medical concerns:

Report Completed By:	Title:
Print Name:	Date/Time:
Program Manager Signature:	Date/Time:
Date Faxed to County Quality Improvement:	Phone #: ( )

FAX #: (619) 563-2795
County of San Diego Behavioral Health Services Administration
Quality Improvement

Telephone #: (619) 563-2781 or
(619) 563-2747

MHS 081A (09/08)
Rev. 6/9/09

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County of San Diego Behavioral Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT OF FINDINGS

To be completed and submitted to Quality Improvement Department within thirty (30) days of occurrence of incident

Provider (Program) Name:
Name of Client:
Client Case Number:
Date of Incident:

1. Summary of Findings:

(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

2. Post Committee Recommendations/Planned Improvements:

Report Completed By:	Title:
Print Name:	Date:
Program Manager Signature:	Date:
Date Faxed to County Quality Improvement:	Phone #: ( )

FAX #: (619) 563-2795
County of San Diego Behavioral Health Services Administration
Quality Improvement

Telephone #: (619) 563-2781 or
(619) 563-2747

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: _____

(1) Summary of incident:	(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)
(2) Participants:	(List all the participants by position and title {no names} involved in the root cause analysis and action plan)
(3) Systems and Processes:	(Note systems and processes that were analyzed to determine proximate causes) List of systems and processes: Behavioral Assessment Process — Risk Assessment Process Physical Assessment Process — Registration process Medication — Control of medications, storage, access Staffing resources — Supervision Security — Equipment Facility — Client Observation Care Coordination — Staff training Communications among staff — Communications with client or family Availability of information Other:

QUALITY IMPROVEMENT ACTIVITY

(3) Note each Process to be considered for review and definition	(4) What are the steps in the process as designed? (A flow diagram is recommended)	(5) Findings	(6) Root Cause?		(7) Take Action?
			Yes	No	

(8) Action Plan		
(a) List of Action Items	(b) Risk reduction strategies	(c) Measures of Effectiveness
Action item 1:		
Action Item 2:		
Action item 3:		
Action item 4:		
Etc…as needed		

Appendix H
Cultural Competence

Culturally Competent Program Annual Self-Evaluation

CC-PAS

Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Mental Health to be used by programs to rate themselves as to their current capability for providing culturally competent services. The CC-PAS Protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). Once the CC-PAS has been completed programs should use the space at the end of the CC-PAS to develop new or revised objectives the program's Cultural Competence Plan that will support ratings with improved scores during the next rating period.

Directions for scoring for CC-PAS Protocol:

- Review each item and fill out the description as to the status for your program. Add attachments as possible to support your position.

- Determine if your program has Met, Partially Met or Not Met the stated standard using the description of the standard noted for each category.

- Tally the score in each category using the following scale:
    - 5 points for Met Standard
    - 3 points for Partially Met Standard
    - 1 point for Standard Not Met

- Determine the total score.

- If there are certain topics that your program would benefit from having technical assistance you can note that by checking:

    o ___ Technical Assistance needed.

- Keep a record of the results of the CC-PAS to use to evaluate your progress over time.

- Repeat the CC-PAS annually

- Some items may not be applicable if program is not a direct service provider.

CC-PAS Protocol:

1) The program/facility has developed a Cultural Competence Plan.
Attach a copy of the Cultural Competence Plan or describe the plan.
_____

☐ Met: Program has a written Cultural Competence Plan that addresses the specific needs of that program.
☐ Partially Met: Legal Entity has a written Cultural Competence Plan but the specific needs of that program are not identified or there is no written Cultural Competence Plan but there is some other evidence of a plan.
☐ Not met: There is no plan to achieve Cultural Competence for the program.

Note: QI Unit will supply a format that may used for developing a Cultural Competence Plan if one is needed

____ Technical Assistance needed Score = ____

2) The program/facility has assessed *the strengths* and needs for services in their community.
Describe the strengths and need for services: _____

☐ Met : The strengths and needs of the community are clearly identified in the Cultural Competence Plan. Community members, Program Advisory Groups, and other stakeholders have participated in the identification of the strengths and needs of the community.
☐ Partially Met: The strengths and needs of the community are not clearly identified in the Cultural Competence Plan but there is evidence that the program is aware of the strengths and needs of the community
☐ Not met: The program is not aware of the strengths and needs of the community

____ Technical Assistance needed Score = ____

3) The staff in the program/facility reflects the diversity within the community.
Attach a report that demonstrates the staff and compares the composition of the staff to the community or describe: _____

☐ Met: The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.
☐ Partially Met: The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.
☐ Not met: The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

____ Technical Assistance needed Score = ____

4) The program/facility has a process in place for ensuring language competence of direct services staff who identify themselves as bi-or multi –lingual.
Attach or Describe the process: _____

☐ Met: The program has a policy or written process for testing the language competence of direct services staff who identify themselves as bi- or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.
☐ Partially Met: The program has an informal process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
☐ Not met: The program does not have process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

5) The program/facility has a process in place for ensuring language competence of support services staff who identify themselves as bi or multi –lingual.
Describe the process: _____

☐ Met: The program has a policy or written process for testing the language competence of support services staff who identify themselves as bi or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.
☐ Partially Met: The program has an informal process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.
☐ Not met: The program has no process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.

____ Technical Assistance needed Score = ____

6) The program/facility supports/provides interpreter training of direct and indirect services staff.
Describe the process: _____

☐ Met: The program has evidence that demonstrates interpreter training of direct and indirect services staff
☐ Partially Met: There is informal interpreter services training of direct services staff
☐ Not met: There has been no interpreter services training of direct services staff

____ Technical Assistance needed Score = ____

7) The program/facility uses language interpreters as needed.
Describe the use of language interpreters and languages used?_____

☐ Met: The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.
☐ Partially Met : The program occasionally uses language interpreters.
☐ Not met: The program does not use language interpreters and can not demonstrate the offer of interpreters

____ Technical Assistance needed Score = ____

8) The program/facility has a process in place for assessing cultural competence of direct services/ support services staff.

Describe the process: _____

☐ Met: The program/facility has a written/formal process in place for assessing cultural competence of direct services/ support services staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members
☐ Partially Met: The program/facility has a process in place for assessing cultural competence of direct services/ support services staff
☐ Not met: The program/facility has no process in place for assessing cultural competence of direct services/ support services staff

____ Technical Assistance needed Score = ____

9) The program/facility has a process in place for direct services/ support services staff to self assess cultural competence (e.g. California Brief Multi Competence Scale- CBMCS)

Describe the process: _____

☐ Met: The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CMCBS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.
☐ Partially Met: The program encourages staff to complete the CMCBS or a similar tool.
☐ Not met: The program does not support opportunities for staff to complete the CMCBS or a similar tool and has evidence of the results of the those evaluations,

____ Technical Assistance needed Score = ____

10) The program/facility has conducted a survey amongst their clients to determine if the program is perceived as being culturally competent.

Describe the results of the survey: _____

☐ Met: The program/facility has conducted a survey amongst their clients and their family members to determine if the program is perceived as being culturally competent.
☐ Partially Met: The program/facility is using the annual State survey to determine if the program is perceived as being culturally competent
☐ Not met: The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

____ Technical Assistance needed Score = ____

11) The program/facility conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent.

Describe the results of the survey: _____

☐ Met: The program/facility has conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent
☐ Partially Met: The program/facility uses the annual State survey to determine if the program's clinical services are perceived as being culturally competent

☐ Not met: The program/facility does not use a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent

____ Technical Assistance needed Score = ____

12) The program utilizes the Culturally Competent Clinical Practice Standards.
Describe how the standards are utilized: _____

☐ Met: The program utilizes the Culturally Competent Clinical Practice Standards and trains all staff and managers at least annually.
☐ Partially Met: The program utilizes the Culturally Competent Clinical Practice Standards but has little or no training.
☐ Not met: The program does not utilize the Culturally Competent Clinical Practice Standards
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

13) The program/facility supports cultural competence training of direct services staff.
Describe the process: _____

☐ Met: The program/facility supports cultural competence training of direct services staff and 80 to 100% of staff have attended at least 4 hours of training.
☐ Partially Met : The program/facility supports cultural competence training of direct services staff and 50-79% of staff have attended at least 4 hours of training
☐ Not met: The program/facility does not support cultural competence training of direct services staff

____ Technical Assistance needed Score = ____

14) The program/facility supports cultural competence training of support services staff.
Describe the process: _____
☐ Met: The program/facility supports cultural competence training of support services staff and 80 to 100% of staff have attended at least 4 hours of training.
☐ Partially Met: The program/facility supports cultural competence training of support services staff and 50-79% of staff have attended at least 4 hours of training
☐ Not met: The program/facility does not support cultural competence training of support services staff

____ Technical Assistance needed Score = ____

15) Services provided are designed to meet the needs of the community.
Describe how the services meet the needs of the community:
_____

☐ Met: Services provided include additional hours, child care, transportation or other options that are targeted to meet the specific community needs.
☐ Partially Met: Services provided include groups that are targeted to meet the specific community needs.

☐ Not met: Services provided include do not include options that are targeted to meet the specific community needs.

____ Technical Assistance needed Score = ____

16) The program has implemented the use of any Evidence Based Practices, or best practice guidelines *appropriate for the populations served*.
Describe the practices: _____

☐ Met: The program has implemented the use of Evidence Based Practices, or best practice guidelines *appropriate for the populations served*
☐ Partially Met: The program has implemented the use of any Evidence Based Practices, or best practice guidelines
☐ Not met: The program has not implemented the use of any Evidence Based Practices, or best practice guidelines
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

17) The program collects client outcomes *appropriate for the populations served*.
Describe the client outcomes that are collected and how the information is used:
_____

☐ Met: The program collects client outcomes *appropriate for the populations served*
☐ Partially Met: The program collects client outcomes
☐ Not met: The program does not collect client outcomes.
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

18) The program conducts outreach efforts *appropriate for the populations in the community*
Describe the outreach efforts: _____

☐ Met : The program conducts effective and on-going outreach efforts *appropriate for the populations in the community*
☐ Partially Met: The program conducts occasional outreach efforts *appropriate for the populations in the community*
☐ Not met: The program does not conducts outreach efforts.

____ Technical Assistance needed Score = ____

19) The program is responsive to the variety of stressors that may impact the communities served.
Examples of responsiveness: _____

☐ Met: The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.
☐ Partially Met : The program is aware of the variety of stressors that may impact the communities served

☐ Not met: The program not aware of stressors that may have an impact on the communities served

____ Technical Assistance needed Score = ____

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.
Examples of commitment: _____

☐ Met: The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.
☐ Partially Met: The program reflects its commitment to cultural and linguistic competence in some policy and practice documents including it's mission statement, strategic plan, and budgeting practices.
☐ Not met: The program does not reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

____ Technical Assistance needed Score = ____

After completing all of the items, #'s 1- 20 above, add all the individual scores together to come up with a CC-PAS rating for the program

Total score = _____

New or revised objectives for the programs Cultural Competence Plan:
_____

_____

_____

_____

_____

_____

_____

Appendix I
Management Information System

Appendix J
Provider Contracting

DISALLOWANCE/DELETION INSTRUCTIONS

Instructions: For each reason, follow the corresponding action identified and document that on the Provider Self Reported Disallowance & Deletion Form. All services identified as disallowances on the Disallowance & Deletion Form will be disallowed from the California State Department of Mental Health Claims Database.

Reason	Disallow Billing	Delete Service	Provider Re-enter Service
Medical Necessity:			
1.Documentation does not establish an included diagnosis	X	Not Deleted	No re-entry for this reason.
2. Documentation does not establish impairment criteria	X	Not Deleted	No re-entry for this reason.
3. Documentation does not establish proposed intervention to address the impairment	X	Not Deleted	No re-entry for this reason.
4. Documentation does not establish expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	X	Not Deleted	No re-entry for this reason.
Client/Service Plan:			
5. Initial plan not completed within time period	X	Not Deleted	No re-entry for this reason.
6. Not updated within time period	X	Not Deleted	No re-entry for this reason.
7. No documentation of client participation/agreement	X	Not Deleted	No re-entry for this reason.
Progress Notes:			
8. No note for service claimed	X	County Fiscal Deletes	No re-entry for this reason.
9. Time claimed greater than time documented	X	County Fiscal Deletes	Re-enter corrected time.
10. Service provided were ineligible for FFP (Federal Financial Participation) or in setting subject to lockouts (i.e. service provided while client was in an IMD, Jail, Juvenile Hall, etc…)	X	County Fiscal Deletes	Re-enter as non-billable.
11. TBS provided in juvenile hall	X	County Fiscal Deletes	Re-enter as non-billable.
12. Service provided was solely academic, vocational, recreation, socialization	X	County Fiscal Deletes	Re-enter as non-billable.
13. Claim for group activity was not properly apportioned	X	County Fiscal Deletes	Re-enter corrected time.
14. Does not contain a signature	X	Not Deleted	No re-entry for this reason.
15. Service provided was solely transportation	X	County Fiscal Deletes	Re-enter as non-billable.
16. Service provided was solely clerical	X	County Fiscal Deletes	Re-enter as non-billable.
17. Service provided was solely payee related	X	County Fiscal Deletes	Re-enter as non-billable.
18. "No Show" billed (over zero minutes) when no treatment service provided	X	County Fiscal Deletes	Re-enter as non-billable.
Data Entry:			
19a. Data Entry Error - The wrong date of service	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19b. Data Entry Error - Wrong Service Indicator	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19c. Data Entry Error - Wrong procedure code	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19d. Data Entry Error - Wrong therapist	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19e. Data Entry Error - Wrong Time Entered	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19f. Data Entry Error - Wrong client	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19g. Data Entry Error - Wrong Unit or Sub-Unit	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19h. Data Entry Error - Wrong episode opening date	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19i. Data Entry Error - Clinet is absent	Depends on Time	County Fiscal Deletes	No re-entry for this reason.
19j. Data Entry Error - Duplicate Entry	Depends on Time	County Fiscal Deletes	No re-entry for this reason.
Other			
20. Documentation done 14 days after date of service	X	County Fiscal Deletes	Re-enter as non-billable.

County of San Diego - Health and Human Services Agency
Mental Health Services

PROVIDER SELF REPORT DISALLOWANCE & DELETION FORM (ANASAZI)

Forward form electronically to: Marie.Lopez@sdcounty.ca.gov and to: Lavonne.Lucas@sdcounty.ca.gov
For instructions please refer to attached worksheet Disallowance/Deletion Instructions

1. GENERAL INFORMATION:

Organization Name				Email Address	
Program Name				Contact Phone	
Contract Number				Date Submitted	
Unit & Sub-Unit Number		Provider ID		Review Date	
Approved & Submitted By				County Tracking Number	County Review Date

2. CERTIFICATION:

By submitting this form, the organization hereby certifies that all entries are correct and accurate, a thorough review was conducted, and a full understanding that submitted disallowance amounts will be deducted from the organizational account. Organization further certifies that it fully understands and has reviewed the County of San Diego, Health and Human Services Agency, Mental Health Services Organizational Handbook specifically dealing with Billing Disallowances-Provider Self Report.

3. DISALLOWANCE/DELETION DESCRIPTION:

Case Number	Service Code	Service Date (MM/DD/YY)	Server ID	Service Time (HH:MM)	Service Cost ($ Amount)	Service Location	Pay Source	Benefit Plan	Form Number	Reason for Disallowance/Deletion (Select from drop-down menu)	COUNTY USE ONLY: Pending (Found in Anasazi, not DCS)	COUNTY USE ONLY: Deleted (from Anasazi)	COUNTY USE ONLY: Disallowed (from ITWS Disallow Claim System)

BEHAVIORAL HEALTH SERVICES
PROPERTY INVENTORY FORM

FISCAL YEAR: _____
COUNTY CONTRACT #: _____
PROGRAM NAME _____
PROGRAM SITE ADDRESS _____
COTR NAME: _____

DATE INVENTORY TAKEN: _____
month/date/year

NEW / RECONCILIATION / REVISION
(CIRCLE ONE whichever is applicable)

SIGNATURE:_____ NAME & JOB TITLE: _____

Yellow County Property Tag/ Label Attached? (Yes/ No)	Description	Qty	Make	Model	Serial #	Acq. Date (Mo/Yr)	Original Cost/Funding Source	Date of Disposal of Fixed Assets or Minor Equipment	Date AUD253 completed

REMARKS:

Appendix K
Provider Issue Resolution

FORMAL COMPLAINT BY PROVIDER

Provider's Name	
Program Manager	
Agency	
Address	
Phone	
Fax	

FORMAL COMPLAINT BY PROVIDER **Forward copy to QI Unit**
Date:
To:
From:
Summary and date on which issue(s) was attempted to be resolved informally (if applicable):
Outline of formal complaint / concern including all relevant data and comments which support issue(s).
Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
Attach any applicable document(s).

FORMAL RESPONSE TO COMPLAINT	**Forward copy to QI Unit**
Date:	
To:	
From:	
Response to complaint / concern which includes a statement of the reason(s) for the decision that addresses	
each issue raised by the provider, and any action required by the provider to implement the decision.	
Program Monitor / Chief shall have 60 calendar days from the receipt of the written complaint to inform the	
provider in writing of the decision.	

FORMAL APPEAL BY PROVIDER	**Forward copy to QI Unit**
Date:	
To:	
From:	
Formal Provider Appeal may be submitted to the Chief, BHS Contracts Support at any time.	
Outline summary of issue(s) and support for appeal with any needed attachment(s).	
When a formal complaint process was utilized, appeal shall be submitted to the Mental Health Contracts	
Manager within 30 calendar days of formal complaint response.	

FORMAL APPEAL RESPONSE	**Forward copy to QI Unit**
Date:	
To:	
From:	
Response to complaint / concern which includes a statement of the reasons for the decision that addresses each	
issue raised by the provider, and any action required by the provider to implement the decision.	
Mental Health Contracts Manager shall have 60 calendar days from the receipt of the written appeal to inform	
the provider in writing of the decision.	

FORMAL RESPONSE TO COMPLAINT	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern, which includes a statement of the reason(s) for the decision that addresses each issue, raised by the provider, and any action required by the provider to implement the decision.	
Program Monitor/Chief shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision.	

FORMAL APPEAL BY PROVIDER	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Formal Provider Appeal may be submitted to the Mental Health Contracts Manager at any time.	
Outline summary of issue(s) and support for appeal with any needed attachment(s).	
When a formal complaint process was utilized, appeal shall be submitted to the Mental Health Contracts Manager within 30 calendar days of formal complaint response.	

FORMAL APPEAL RESPONSE	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern which includes a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.	
Mental Health Contracts Manager shall have 60 calendar days from the receipt of the written appeal to inform the provider in writing of the decision.	

Appendix L
Practice Guidelines

QUARTERLY PROGRESS MENTAL HEALTH IEP REPORT

Program: _____

Address: _____

Telephone: _____

Patient Name:	**DOB:**
Therapist:	
Reporting Period: **to**	

Progress Rating:
1-Goal not met; symptoms stayed the same or got worse
2-Goal not met completely, but some progress made (1-50% of goal achieved)
3-Goal not met completely, but substantial progress made (51-99% of goal achieved)
4-Goal met or exceeded (100% of goal achieved)

GOAL # 1:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 2:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 3:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

Scheduled Frequency of Sessions: **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐

Concerns with Attendance: No ☐ Yes ☐

Date of Contacts with School:

_____ _____

Therapist Signature **Date**

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
SAN DIEGO MENTAL HEALTH SERVICES

MENTAL HEALTH TREATMENT PLAN

Date: **Student:** **Type of Service:** **Start Date: ASAP** **Duration: 6 months**

Area of Need:

Present Level

Measurable Long-Term Goal:

Parents will be informed of progress	Periodic Review Dates	Progress Toward Goal	Sufficient Progress to Meet Goal
☒ Quarterly ☐ Trimester	1. _____	1. _____	☐Yes ☐No _____
☐ Semester ☐ Other: _____	2. _____	2. _____	☐Yes ☐No _____
How ?	3. _____	3. _____	☐Yes ☐No _____
☐ Annotated Goals/Objectives	4. _____	4. _____	☐Yes ☐No _____
☒ Other: teacher, therapist			

Benchmark/Short-Term Objective: Within 2 months:
1.

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Benchmark/Short-Term Objective: Within 4 months:
1.

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Area of Need

Present Level:

Measurable Long-Term Goal:

Parents will be informed of progress	Periodic Review Dates	Progress Toward Goal	Sufficient Progress to Meet Goal
☒ Quarterly ☐ Trimester	1. _____	1. _____	☐Yes ☐No _____
☐ Semester ☐ Other: _____	2. _____	2. _____	☐Yes ☐No _____
How ?	3. _____	3. _____	☐Yes ☐No _____
☐ Annotated Goals/Objectives	4. _____	4. _____	☐Yes ☐No _____
☒ Other: teacher, therapist			

Benchmark/Short-Term Objective: Within 2 months:

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Benchmark/Short-Term Objective: Within 4 months:

Person(s) Responsible: client, therapist

Date:
☐ **Achieved**
☐ **Reviewed**

Student Signature *Date* *Signature of Parent* *Date*

Signature of Mental Health Service Representative *Date*

MHTXPLN.tmp 09/28/99

COUNTY OF SAN DIEGO
DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES

NEED FOR IEP REVIEW

TO: _____DATE:_____

FROM: _____ TELEPHONE _____

RE: _____ DOB: _____

A. We are unable to continue our delivery of mental health assessment services to your pupil _____, for the following reason:

_____1. Parent has not signed a mental health assessment plan.

_____2. Parent has failed to come in for scheduled assessment visits.

_____3. Parent has withdrawn permission for the mental health assessment.

_____4. Other/comments _____
_____
_____
_____

B. This is to notify you of a substantial change to the IEP/Treatment Plan because:

_____1. Client has completed treatment.

_____2. Client is in need of change in mental health services level of care.

_____3. Child is not benefiting from his mental health services.

_____4. Parent no longer wishes to have treatment services identified on the IEP for the child through Short-Doyle/MHS.

_____5. Parent has had difficulty following through with the treatment plan.

_____6. Parent has moved to another district/SELPA

Other/comments_____
_____
_____
_____

cc: Chart

Appendix M
Staff Qualifications

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 06/15/10)

(Please fill-in all boxes below. See reverse side for completion instructions.)

APPLICANT'S FULL NAME (Include aliases and maiden names):

TYPE OF WAIVER REQUEST
(Please check appropriate box)

WITHIN CALIFORNIA/NOT LICENSE ELIGIBLE PSYCHOLOGIST CANDIDATE: (5 years maximum)	OUT-OF-STATE/LICENSING-EXAM-READY: (3 years maximum)		
☐	PSYCHOLOGIST CANDIDATE ☐	LCSW CANDIDATE ☐	MFT CANDIDATE ☐

DATE OF COMPLETION OF REQUIRED COURSEWORK:	EMPLOYMENT START DATE (in the position requiring the waiver):

REQUEST SUBMITTED BY: (SIGNATURE----MENTAL HEALTH DIRECTOR/DESIGNEE)

PRINTED NAME:

DATE:	COUNTY:

DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

DATE COMPLETE WAIVER APPLICATION RECEIVED:	DATE WAIVER BEGINS:
COMMENTS:	DATE WAIVER ENDS:

Approved by:

☐ Program Administrator, Program Compliance OR

☐ Chief, Medi-Cal Oversight

Signature:	Date:

This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period.

PROFESSIONAL LICENSING WAIVER REQUEST

Instructions for Completing This Form

1) *Applicant's Full Name, Include Aliases and Maiden Names:* DMH staff need this information, when applicable, to track accurately the applicant's waiver history.

2) *Type of Waiver Request*: Clearly indicate the type of waiver request. To be eligible for the Out-of-State/License-Ready category, an applicant must be both license-ready and recruited from out-of-State. When submitting an application for an Out-of-State/License-Ready waiver, the MHP must submit a letter from the appropriate licensing board which states that the applicant has sufficient experience to gain admission to the licensing examination.

3) *Employment Start Date (In the Position Requiring the Waiver):* Specify the date the applicant will start employment in the position requiring a waiver.

   In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, **it is necessary to attach a copy of the applicant's post-degree employment history.** This can take the form of a current, complete resume or recent employment application.

4) *Request Submitted By (Mental Health Director/Designee):* All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No 10-03. .

Appendix N
Data Requirements

This procedure applies only to providers approved for MAA Claiming.

Medi-Cal Administrative Activities (MAA) Procedures

MAA activities in mental health are governed by a set of procedures. These procedures are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health, and are summarized below.

The Claiming Plan

In order to participate in MAA, the County must submit a Claiming Plan to the State for approval by the last day of the quarter in which the first invoice will be submitted. Using a standardized format developed cooperatively by the State and Federal Medicaid agencies, the MAA Claiming Plan must describe in detail each of the MAA activities for which claims will be submitted, by job class. The standardized format can be found in the California Department of Mental Health MAA instruction manual.

The Claiming Plan also describes the units that will be participating in MAA, the type of supporting documentation that will be maintained, and the development and documentation of costs relating to MAA. It indicates which activities will be focused entirely on the Medi-Cal population. If the activities will be focused on a larger population, the Claiming Plan must describe the methodology that will be used to discount the claim by the percentage of Medi-Cal eligibles in the population.

The State Department of Mental Health has established procedures for amending the MAA Claiming Plan. It has also developed a Claiming Plan checklist and a checklist to use when submitting amendments to the Claiming Plan. Copies of these documents, along with a copy of the most recently approved version of the plan, are on file in the Mental Health Plan administrative offices. Claiming plans and any amendments will remain in effect from year to year. A Claiming Plan will not need to be amended, unless the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a Claiming Plan must be amended when a new outreach campaign or program is instituted, or a new claiming unit performing MAA is created.

Claiming Procedures

Claims for MAA reimbursement are submitted quarterly to the State Department of Mental Health (DMH) by HHSA. A detailed quarterly invoice is prepared for each mental health unit participating in MAA, as identified in the claiming plan. County-operated programs are one unit; each participating contractor is a separate unit. A summary invoice is also prepared that aggregates all invoices submitted by mental health. An approved claiming plan covering the period of the claim must be in place before an invoice may be paid.

The County is required to provide DMH with complete invoice and expenditure information no later than December 31, following the fiscal year for which a claim is submitted. Invoice and expenditure information must be submitted to DMH prior to or with the County's cost report for the current fiscal year. DMH may approve the claim, return it for correction and/or revision, or deny the claim. The County may request reconsideration of a denied claim in writing within 30 days of receiving the denial.

The detailed quarterly invoice captures the time spent on MAA, the Medi-Cal percentage, expenditure and revenue information on a single spreadsheet.

MAA Training

All staff participating in MAA, and completing MAA activity logs, will attend MAA training sessions on at least an annual basis. Sign-in sheets will serve as a record of the individual's attendance. Training will be scheduled and provided at the direction of Mental Health Administration.

Reporting MAA Activities

MAA activities are reported to InSyst. The reporting requirements are somewhat different than what is required for direct services. For MAA, staff must report the following each time an MAA activity is performed:

- the day the activity occurred;
- the activity code (as a proxy for the name of the activity);
- the number of minutes spent on the activity;
- the name of the employee performing the activity.

A standardized MAA Activity Log has been developed; however, programs can develop their own as long as it contains the essential MAA reporting information. When programs develop their own form, they should forward it to the MAA Coordinator to ensure it covers the basic elements. The standardized forms are included as Attachments 1 and 2. Each activity log is to be signed by the employee before he/she gives it to the clerical staff responsible for entering data into InSyst Mental Health MIS. Activity logs may cover multiple days. Completed logs should be signed by the employee, and turned in to the person responsible for entering the information into InSyst on a timely basis, but no later than the fifth working day after the end of each month.

Document Retention

The County of San Diego has adopted a record retention policy that requires these records to be retained for seven (7) years. Program managers are responsible for storing signed, original versions of all MAA activity logs, outreach materials, and all documentation that supports the MAA claimed by their staff.

Becoming an InSyst User

Information on the amount and type of MAA activity performed by individual staff is entered into InSyst. Anyone who performs MAA activities needs an InSyst User ID so these activities may be entered into InSyst. Staff who provides direct services have InSyst identification numbers. Administrative and clerical staff who perform MAA activities will need an InSyst ID number as well. These ID numbers may be secured by calling UBH.

Quality Assurance; Monitoring

The quality of the MAA program will be monitored through quarterly reports from InSyst. The Mental Health Services MAA Coordinator will disseminate these reports to program managers, notifying them of any identifiable discrepancies found. These reports will provide managers with summaries of the amount of time reported to all MAA activities, by staff name. Program managers are expected to use the monitoring reports to:

- ensure that staff is reporting their MAA time accurately, using the correct activity codes;
- ensure that all staff that should be reporting MAA is doing so;
- ensure that MAA time is being reported consistently among staff in same classification.

Managers are required to ensure that corrective action is taken on any discrepancies they find or that have been identified by the MAA coordinator. Random reviews will take place to ensure that staff is reporting MAA correctly.

The MAA Audit File

An MAA audit file will be maintained at Mental Health Administration, and includes the following:

- a copy of the most recently approved MAA claiming plan for the County and for each participating contract agency;
- copies of current SPMP forms, and verification that each SPMP's license, where applicable, is current;
- job descriptions and/or duty statements for all staff participating in MAA;
- electronic or hard copies of the raw data used to calculate each quarterly percentage of MAA activity;
- electronic or hard copies of the reports used to establish the Medi-Cal percentage for each quarterly MAA claim;
- locations (with addresses) where MAA activity logs are kept on file, and where copies of information used in outreach or eligibility assistance activities are kept;
- copies of annual training schedules, training rosters, and materials used in training.

Who Can Claim MAA: An Overview

Clinical staff

- MAA may be used for client-based activities that are not part of a direct service or that are provided to an individual who does not have an open case anywhere within the system. MAA also includes outreach activities to inform individuals or groups about the availability of Medi-Cal and mental health services.

Administrators

- MAA includes program planning and contract administration.
- MAA includes outreach activities to inform individuals or groups about the availability of mental health services.

Clerical staff, Human Service Specialist and all other staff

- MAA includes activities that assist individuals, regardless of their case status, to apply for Medi-Cal or to access services covered by Medi-Cal.
- MAA activities include the administrative support clerical staff provide around outreach, contract administration, program planning, and crisis situations.

The MAA Activity Codes

A set of MAA activity codes has been developed for local mental health programs. The activities include:

Activity Code	
401	Medi-Cal Outreach
457	Mental Health Outreach
404	Facilitating Medi-Cal Eligibility Determinations
481	Case Management of Non-Open Cases
451	Referral in Crisis Situations – Non-Open Cases
409	MAA Coordination and Claims Administration

MAA Activity Code Definitions

401 Medi-Cal Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing Medi-Cal eligibles or potential Medi-Cal eligibles about Medi-Cal services, including Short-Doyle/Medi-Cal services;

- assisting at-risk Medi-Cal eligibles or potential Medi-Cal eligibles to understand the need for mental health services covered by Medi-Cal;
- actively encouraging reluctant and difficult Medi-Cal eligibles and potential Medi-Cal eligibles to accept needed health or mental health services;
- performing information and referral activity that involves referring Medi-Cal beneficiaries;
- referring Medi-Cal eligibles to Medi-Cal eligibility workers.

457 Mental Health Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services;
- providing telephone, walk-in or drop-in services for referring persons to Medi-Cal and non-Medi-Cal mental health programs.

404 Facilitating Medi-Cal Eligibility Determinations – This code may be used by all staff in county and contract programs. Includes the following:

- screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

481 Case Management of Non-Open Cases – May be used by all staff in county and contract agencies. Includes the following:

- gathering information about an individual's health and mental health needs.
- assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up and arranging transportation to health care.

451 Referral in Crisis Situations - Non-Open Cases – May be used by all staff in county and contract programs. Includes the following:

- intervening in a crisis situation by referring to mental health services.

409 MAA Coordination and Claims Administration – This code may be used by all staff in county and contract programs. Includes the following:

- MAA Training

Appendix O
Training

Appendix P
Mental Health Services Act

Appendix Q
Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only *(Contractor Instructions)*

Appendix R
QUICK REFERENCE