INPATIENT OPERATIONS HANDBOOK

County of San Diego
Health & Human Services Agency
Behavioral Health Services

Updated September 2012

TABLE OF CONTENTS

Page

Overview ……..5
1. General Guidelines ……6
2. Notification Procedures……..6
3. Authorization for Reimbursement of Acute Inpatient Services …….. 6-8

A. Authorization Process
B. Medi-Cal Medical Necessity Criteria

4. Authorization for Reimbursement of Continued Stay in Acute Inpatient Services ….……..8

A. Authorization Process for Continued Stay: Concurrent Review
B. Criteria for a Patient's Continued Stay

5. Authorization for Reimbursement of Administrative Days ……..……..9

A. Authorization Process for Administrative Days

6. Criteria for Administrative Days ……9-10
7. Other Authorization Issues ……..……...11
A. Electroconvulsive Therapy (ECT)
B. Referrals by the County's Emergency Psychiatric Unit (EPU)
C. Non-Acute Planned Admissions
D. Clients Under the Influence of Drugs or Alcohol: Authorization of Payment for Services

8. Admission Criteria to Edgemoor Hospital ……12-13

A. Potential Residents Criteria
B. "Not Appropriate" Admissions

9. Medication Issues ……...13
10. Claims and Billings …….……13-15

A. Treatment Authorization Request (TAR) Manual
B. Submitting TARs
C. Retro TAR
D. Processing TARs
E. Timelines
F. Eligibility
G. Medi-Cal as Secondary Insurance

11. Denials and Notice of Action …….…….…….15
12. Clinical Appeals ……..……...16-18

A. Provider Appeals
B. Expedited Review
C. Level 1 Appeal
D. Level 2 Appeal

13. Administrative Denial Appeals ……..18
14. Using the County of San Diego Mental Health Service Management Information System (CSD MHS MIS) ……..18
15. Coordination of Care ……..18-24

A. Outpatient Care Coordination
B. Transition Team
C. Discharge Planning
D. Coordination with Other Levels of Care
E Referrals to Long-Term Care Services
- General Admission Criteria
- Referral process

F Interface with Healthy San Diego Health Plans
- HMO Medi-Cal Beneficiaries
- Physical Health Services While In a Psychiatric Hospital
- Transfers from Psychiatric Hospital to Medical Hospital
- Non-Emergency Medical Transportation

G. Beneficiaries Not Enrolled In Healthy San Diego Health Plans
H. Authorization for Transfer Between Hospitals
I. Authorization Process for the Emergency Psychiatric Unit (EPU) of the San Diego Psychiatric Hospital for Receiving Hospitals
J. For Sending Hospitals

16. Beneficiary Rights ……..24-27
A. Confidentiality
B. Client Handbooks
C. Translation Service Availability
D. Client Grievances and Appeals
E. Client Right to Request a State Fair Hearing
F. Client Right to Have an Advance health Care Directive
G. Title 42 CFR Section 438.100 – Addressing Beneficiary's Rights

17. Quality Improvement ……..……27
18. Quality of Care Standards…….…….…….28-29
19. Appendices

Appendix 1 -	Medical Record Content Requirements	30
Appendix 2 -	Glossary	32-34
Appendix 3 -	Mental Health Websites	35
Appendix 4 -	Forms:	37-43
	a. Denial of Rights/Seclusions and Restraint Monthly Report	
	b. Quarterly Report on Involuntary Detentions	
	c. Convulsive Treatments Administered – Quarterly Report	
Appendix 5 -	Beneficiary and Client Problem Resolution Policy and Process	44-61
Appendix 6 -	Quality Improvement Serious Incident Report	63-70

OVERVIEW

This Inpatient Operations Handbook is designed to provide County of San Diego Behavioral Health Services (CoSDBHS) contracted Medi-Cal inpatient providers with information related to the provision of managed care services for Medi-Cal beneficiaries who are residents of San Diego County. The San Diego County Mental Health Medi-Cal Managed Care Inpatient Consolidation consists of County and contractor-operated services. Included is information on emergency services, acute inpatient services for Medi-Cal clients, and acute and long term residential services for Medi-Cal and Realignment funded clients. Please note that providers of services for the Mental Health Plan of San Diego are governed by the requirements of Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9. Website address to obtain Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9 is: http://www.dhcs.ca.gov/services/mh

Since 1997, the County of San Diego's Health and Human Services Agency, Mental Health Services, the County of San Diego Mental Health Plan (MHP), has contracted with OptumHealth (previously known as United Behavioral Health) to be the Administrative Service Organization (ASO) for the MHP. In their role as the ASO, OptumHealth provides payment authorization and utilization management for Medi-Cal inpatient services.

The OptumHealth Utilization Management (UM) staff consists of board-certified psychiatrists, licensed psychologists, Registered Nurses (RNs), Licensed Clinical Social Workers, and Marriage and Family Counselors. The OptumHealth UM staff review all requests for authorization of payment for acute inpatient admissions for adults and older adults for San Diego County Medi-Cal beneficiaries. A client's authorization for services is based on meeting the medical necessity criteria of Title 9 of the California Code of Regulations (Section 1820.205). In accordance with State requirements, a psychiatrist is involved in all decisions to deny, terminate or modify inpatient services.

The contact information for OptumHealth is:

Telephone Number: **1-800-798-2254**
Mailing Address*:* **OptumHealth**
3111 Camino del Rio North, Suite 500
San Diego, CA 92108

Email*:* **With respect to client confidentiality, please do not send by email Patient Health Information (PHI)**. Email address for most OptumHealth care managers are in the format of "first name. last name" @optum.com or may be obtained from the Care Manager directly.

Confidential Fax*:* **Utilization Management: 1-866-220-4495**
Provider Services Department: 1-877-309-4862

The **OptumHealth Provider Line at 1-800-798-2254** is available during normal business hours, Monday thru Friday from 8:00 am to 5:00 p.m. to resolve provider issues, inquiries, and/or complaints.

The contact information for **County of San Diego Behavioral Health Administration** is:

Telephone Number: **619-563-2700**

Mailing Address*:* **P0 Box 85524**
3255 Camino del Rio South
San Diego, CA 92186-5524

Confidential Fax*:* **619-236-1953**

1. GENERAL GUIDELINES

Contracted inpatient providers are required to follow all federal, State, and County regulations and policies for all San Diego County Medi-Cal beneficiaries.

Admissions should be based solely on the clinical review of the client's needs. If the client meets Title 9 Medi-Cal medical necessity criteria, inpatient services should not be delayed because of an authorization of payment decision. A copy of the Title 9 medical necessity criteria is referenced in Paragraph 4 of this handbook.

Pre-authorization is not required for emergency services, however, inpatient providers are required to notify OptumHealth of all admissions.

County of San Diego Behavioral Health Services (CoSDBHS) contracted Medi-Cal inpatient providers shall maintain Lanterman Petris Short (LPS) designation

2. NOTIFICATION PROCEDURES

Providers shall notify OptumHealth of all admissions by calling OptumHealth as soon as possible when the patient has Medi-Cal as primary coverage. For patients who have Medi-Cal as a secondary coverage it is not necessary to notify OptumHealth, unless the client has exhausted their primary insurance coverage and the primary insurance coverage is no longer available to pay for patient's care.

To notify OptumHealth of an admission contact the OptumHealth Utilization Management (UM) Unit using the following numbers:

Monday through Friday from 8:00 a.m. to 5:00 p.m.:
OptumHealth Provider Line at **1-800-798-2254**, select option #3.

All Other Hours:
OptumHealth Provider Line at **1-800-798-2254**, select option #3; or
OptumHealth Access and Crisis Line (ACL) at **1-888-724-7240 (please do not select the Crisis queue #8 as this line is for people who are experiencing a crisis or who may be suicidal)**.

In accordance with State and Federal Regulations, provider must notify OptumHealth of emergency admissions within 10 days. Failure to do so may result in denial of payment.

3. AUTHORIZATION FOR REIMBURSEMENT OF ACUTE INPATIENT SERVICES

A. **Authorization Process:** A description of the process for requesting reimbursement authorization for admission to acute inpatient services is as follows:

- Authorizations for services are provided concurrently.

  The requesting hospital contacts OptumHealth staff by calling 1-800-798-2254, option 3, to notify them that they are faxing clinical documentation to be reviewed and considered for reimbursement for acute services.

- Based on information from this medical record review, the OptumHealth staff must be able to determine if the client meets Title 9 medical necessity criteria in order to authorize reimbursement for services.

- The OptumHealth staff will continue to review clinical documentation for all additional acute and administrative days requested for reimbursement.

- For cases in which the provider indicates, or the MHP determines, that following the standard procedure could jeopardize the life of the client or their health, ability to attain, maintain, or regain maximum function, OptumHealth will make an expedited authorization decision as expeditiously as the client's health condition requires. Most standard authorization decisions are made within hours of a request, although by managed care regulation (CFR 42, 438.210 (d) (1)) the MHP has up to 14 days. In the case of an expedited auth request most requests will be determined within 1-2 hours, but in accordance with regulations, no more than 3 days.

B. Medi-Cal Medical Necessity Criteria

Title 9 of the California Code of Regulations (Section 1820.205) specifies the following medical necessity criteria for admission to inpatient services:

The client must meet one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, Text Revision, published by the American Psychiatric Association (DSM-IV-TR):

- Pervasive Developmental Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Tic Disorders
- Elimination Disorders
- Cognitive Disorders (only Dementia with delusions, hallucinations or depressed mood)
- Substance-induced Disorders only with Psychotic, Mood or Anxiety Disorder
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Intermittent Explosive Disorder
- Pyromania
- Adjustment Disorders
- Personality Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Feeding and Eating Disorders of Infancy or Early Childhood.

In addition to meeting diagnostic criteria listed in paragraph 4A above, the client **must meet both 1 and 2** below*:*

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

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

   - Represents a current danger to self or others, or significant property destruction;

- Prevents the client from providing for, or utilizing, food, clothing or shelter;
- Presents a severe risk to the client's physical health;
- Represents a recent, significant deterioration in ability to function.

(b) Requires admission for treatment and/or observation for one of the following which cannot safely be provided at a lower level of care:

- Further psychiatric evaluation
- Medication treatment
- Specialized treatment.

Note: Substance abuse disorder and developmental disorder in absence of other mental illness does not meet Title 9 medical necessity criteria for acute inpatient admission.

4. AUTHORIZATION FOR REIMBURSEMENT OF CONTINUED STAY IN ACUTE INPATIENT SERVICES

A. Authorization Process for Continued Stay: Concurrent Review

After the initial authorization, if a patient continues to require acute care the provider must request an additional authorization for continued stay. To complete the authorization process for continued stay, the requesting hospital must submit clinical documentation that demonstrates the patient continues to meet Medi-Cal Medical Necessity Criteria

- The requesting hospital contacts OptumHealth Utilization Management (UM) staff to notify them that they are faxing clinical documentation to be reviewed and considered for reimbursement for acute services.
- Based on the medical records review, OptumHealth UM staff will determine if reimbursement will be authorized and will notify provider of the number of days authorized.
- As part of the concurrent review process, UM staff will also consider information regarding the client's discharge plan with the facility.
- At any time, the OptumHealth UM staff may request additional documentation to determine medical necessity.

B. Criteria for a Patient's Continued Stay

In order for OptumHealth UM staff to authorize reimbursement for continued stay in acute inpatient services, the client must continue to meet the Medi-Cal Medical Necessity Criteria noted for admission to inpatient services (Paragraph 4, 4A and 4B*).* Continued stay in an acute psychiatric inpatient hospital will only be reimbursed when a client experiences one of the following:

- Continued presence of admission reimbursement criteria indications for psychiatric inpatient hospital services as specified in Medi-Cal Medical Necessity Criteria;
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
- Presence of new indications, which meet admission reimbursement criteria, noted in Criteria 5A and 5B,
- Need for continued medical evaluation or treatment that can only be provided if the client remains in an acute psychiatric inpatient hospital unit.

5. AUTHORIZATION FOR REIMBURSEMENT OF ADMINISTRATIVE DAYS

Administrative days are defined in Title 9 as psychiatric inpatient hospital care provided when the client's stay at the hospital must be continued beyond needed acute treatment days due to a temporary lack of placement options at appropriate, non-acute treatment facilities.

A. Authorization Process for Administrative Days

- The requesting hospital contacts OptumHealth Utilization Management (UM) staff to notify them that they are faxing clinical documentation to be reviewed and considered for reimbursement for administrative days.
- The OptumHealth UM staff conducts a concurrent review, assuring that the adult/older client is either on a waiting list for a Short Term Acute Residential Treatment (START), Skilled Nursing Facility (SNF), or IMD or that the hospital is actively seeking one of these placements.
- The OptumHealth UM staff conducts a concurrent review, assuring that the adult/older client is either on a waiting list for a Probation, Special Education Services (ERMHS), Child Welfare Services, or San Diego and Imperial County Regional Center for the Developmentally Disabled
- The expectation is that hospitals make calls to the Skilled Nursing Facilities on behalf of clients, even if they do not have funding in order to be eligible for administrative days retroactive

6. CRITERIA FOR ADMINISTRATIVE DAYS

San Diego County Mental Health policy regarding reimbursement for inpatient Administrative Days requires that clients meet the following criteria:

Client must have been approved for at least one acute inpatient day prior to request for administrative days.

- Client no longer meets criteria for Acute Inpatient Treatment, and is awaiting placement at either a:

  a) Short Term Acute Residential Treatment (START) facility, or
  b) Skilled Nursing Facility (SNF), or
  c) Casa Pacifica, (a Short Term Transitional Residential Facility); or
  d) Has been accepted by the Long Term Care Committee for placement in a facility that is paid for by the Mental Health Plan.

NOTE: This policy may be subject to change.

In addition to the above requirement, and in accordance with Title 9, in order to meet the State standards to receive reimbursement for administrative days, the provider is required to make and document at least one contact per day, with a minimum of five (5) contacts per week, with appropriate non-acute treatment facilities.

Adults and Older Adults:

a) START facilities (calls will be made to OptumHealth or the Crisis Houses daily to check on crisis bed availability, including weekends), or
b) Skilled Nursing Facilities (SNF), or
c) IMD

Children:

a) Probation,
b) San Diego County Mental Health Special Education Services (ERMHS),
c) Child Welfare Services, or
d) San Diego and Imperial County Regional Center for the Developmentally Disabled.

The County may waive the requirement of five contacts per week if there are fewer than five appropriate non-acute residential treatment facilities available as placement options for the beneficiary (IMDs, Casa Pacifica). In no case shall there be less than one contact per week. Ongoing weekly documentation shall clearly support assessment of client for continued need of long term placement. This documentation shall include but is not limited to:

- The status of the placement option
- Date of the contact
- Signature of the person making the contact

This documentation shall be sent by fax, on a weekly basis, to the Utilization Management Department, OptumHealth Public Sector, San Diego (Overview section for OptumHealth fax information).

In accordance with Title 9, in order to meet the State standards to receive reimbursement for administrative days, five (5) placement contacts per week are required from the placement agency and are to include the following required elements:

- name of facility
- date of contact
- person contacted
- immediate availability of bed
- name and signature of person making the call

This information shall be documented and referenced in the medical record

Other issues regarding Administrative Days are:

- Authorization for payment for Administrative Days for those clients awaiting long term care placement will be made when the client is accepted for placement.

- Administrative Days may not be used for clients awaiting placement in a non-treatment program such as a Board and Care facility or Independent Living Facility.

- Authorization of payment for Administrative Days starts on the day following the last acute day authorized.

- Administrative Days end when the client is discharged from the inpatient setting, when the client enters the chosen facility, or when the client no longer meets criteria for admission to the facility based on level of care guidelines and medical necessity criteria. Administrative Days will also end if the discharge plan changes to a type of facility that is not one mentioned above.

- In accordance with State regulations Administrative days are impacted if a client must be discharged to a medical/surgical unit for physical health care. Clients who have been authorized for administrative days and who are then discharged to a medical/surgical unit for physical health care, will not be approved for administrative days if they return to the acute psychiatric unit; however if the client remains on the medical/surgical unit, the client may continue to meet the criteria for administrative days under their physical health plan and could be placed on administrative days on the physicals health unit.

If a client's condition improves while they are waiting for placement at a facility, administrative days will be authorized up to the day the client no longer meets medical necessity criteria for admission to an approved type of facility as noted above.

7. OTHER AUTHORIZATION ISSUES

A. Electroconvulsive Therapy (ECT)

Inpatient ECT shall not require authorization. However, the client shall meet Title 9 medical necessity criteria for acute psychiatric inpatient treatment at admission. Inpatient providers are to maintain their own ECT Consulting Psychiatrists lists and provide their own consultants for ECT utilizing their Credentialing and Privileging guidelines. The ECT consult is Medi-Cal reimbursable and OptumHealth authorizes payment to a network provider.

Outpatient ECT shall require authorization. The psychiatrist requesting ECT shall complete the ECT Authorization Request and submit it to OptumHealth Utilization Management (UM). If indications for ECT are present, up to 14 treatments over a 6-month period may be authorized. The total of 14 treatments shall include all inpatient treatments as well as outpatient treatments within a ninety day period. ECT sessions beyond 14 shall be reviewed with the OptumHealth Medical Director.

State regulations regarding involuntary ECT - WI 5326.7 (b) – require that the County Mental Health Director appoint the second psychiatrist who provides the second opinion for the court.

It is the responsibility of each hospital to maintain a list of Board-Certified psychiatrists approved by the MH Director to provide second opinions regarding suitability of ECT in involuntary situations. Candidate names for this list must be submitted to the BHS Clinical Director (Dr. Lewis), along with CVs, and once approved on behalf of the BHS Director the names will remain active so long as that physician remains a member in entirely good standing, without practice restrictions, at the applicable hospital. Additional names may be added from time to time, by submitting them to the Clinical Director. An email receipt of approval will be considered sufficient evidence that approval has been obtained on behalf of the BHS Director.

Dr. Lewis's contact information is below:

Marshall Lewis, MD, DFAPA
Clinical Director, Behavioral Health Division
San Diego County Health & Human Services Agency
3255 Camino Del Rio South
San Diego, CA 92108
Office: 619-563-2771
Fax: 619-563-2705
Email: Marshall.Lewis@sdcounty.ca.gov

Facilities may bill the County of San Diego for facilities charges associated with Outpatient ECT.

Invoices must include:

- Client name;
- Social Security Number and Date of Birth;
- Date of authorization for ECT;
- Total number of authorized units;
- Facility authorized for the procedure; and
- Name of the psychiatrist who administers the procedure.

Invoices may be sent to:

ATTENTION: Arnel Encabo, Fiscal Analyst
San Diego County Mental Health Administration
P0 Box 85524
3255 Camino Del Rio South
San Diego, CA 92186-5524

B. Referrals by the County's Emergency Psychiatric Unit (EPU)

All clients are screened for medical necessity criteria. The receiving facility must notify OptumHealth upon the client's admission.

C. Non-Acute Planned Admissions

Providers are required to contact OptumHealth for authorization prior to planned admissions.

D. Clients Under the Influence of Drugs or Alcohol: Authorization of Payment for Services

OptumHealth clinicians shall authorize payment for one day of psychiatric inpatient hospital acute care for clients under the influence of drugs or alcohol, under the following circumstances:

- The client has a qualifying psychiatric diagnosis under Title 9 medical necessity criteria; and
- The clients' symptoms or behavior currently meet Title 9 medical necessity criteria for admission; and
- The client cannot be managed in a medical setting or at a lower level of care; and
- The client does not require a medical detoxification as determined by hospital medical staff;

OptumHealth clinicians will conduct a concurrent review within 24 hours. Payment authorization for services under this procedure will be subject to the same intensity of review on the second day as if the client were being evaluated for a new admission.

8. ADMISSION CRITERIA TO EDGEMOOR HOSPITAL

Edgemoor Hospital is a County-operated Distinct Part Skilled Nursing Facility for persons 18 years of age and older who are eligible for Skilled Nursing Care based on Title 22 and Omnibus Budget Reconciliation Act (OBRA), 1987 regulations.

A. Potential residents must meet the following criteria:

- Consideration for admission will be made only after the referring acute care hospital has completed a "good faith effort" at an alternative, appropriate placement in the community. Referral packets will be accepted and admission assessment made only after this effort has been completed.
- Referrals shall be evaluated on effectiveness of alternative placement effort, appropriateness for care in other community facilities and need for the intensity of care provided at Edgemoor Hospital.
- Bed space appropriate to the potential resident's needs must be available.
- Resident care and treatment shall be determined only by medical and nursing needs, not by source of payment.
- Possible admissions which are rejected by the Admissions Committee can be re- submitted at any time for re-consideration.

- The potential resident or his/her legal representative must consent for Edgemoor Hospital medical staff to provide medical management and coordination of care.

B. **Edgemoor Hospital generally deems "Not Appropriate" for admission of the following**:

- Persons able to receive necessary care at other facilities.
- Persons requiring acute care medical services, intensive nursing care, transfusions, and acute psychiatric care.
- Persons with a primary diagnosis of developmental disabilities or mental illness without significant skilled medical needs.
- Pregnant women.
- Persons who do not meet Medicare/Medi-Cal criteria for Skilled Nursing level of care, although they are deemed "not easily placed" by the referring facility.
- Persons with a primary diagnosis of substance abuse or persons actively receiving treatment for substance abuse.
- Persons requiring care for violence, severe agitation, suicidal or homicidal behavior.
- Persons requiring services Edgemoor Hospital is unable to provide.

9. MEDICATION ISSUES

The standard of care in the community is to send all discharging clients with either a prescription or medications in hand. The exception would be a client who is discharging to a Short Term Acute Residential Treatment (START) program, which will facilitate getting psychiatric medications for Medi-cal recipients. Indigent clients going to START programs can have medications filled through the County Pharmacy per agreement with SDCPH. Hospital physicians have the right to hold certain medications if client has recently attempted to overdose (OD) on prescribed medication or abuse medication.

Note: Issues related to medications for clients who are being discharged are being discussed at the Hospital Partner's meeting and at the Utilization Management Coordination meeting and will be included in the Adult/Older Adult Inpatient Handbook once decisions regarding requirements and recommendations have been made.

10. CLAIMS AND BILLING

A. A **Treatment Authorization Request (TAR) Manual** is distributed by the State Department of Health Care Services (DHCS) formally Department of Mental Health (DMH). The most recent version is dated February 2005. This manual is most helpful in delineating instructions regarding completing TARs. Please contact OptumHealth, San Diego County Mental Health or State DHCS for a copy of this handbook if you do not have the most recent version.

B. Submitting Treatment Authorization Requests (TARs)

The provider shall submit an original Treatment Authorization Request* (TAR) form to OptumHealth. OptumHealth reviews the TAR and forwards it to Affiliated Computer Services Inc. (ACS). ACS will deny TARs sent directly to ACS by a hospital. All TARs for San Diego County Medi-Cal residents must be approved by OptumHealth prior to submission to ACS for payment. Incomplete TARs or TARs completed with erroneous or conflicting information, will not be processed and will be returned to the hospital of origin to complete/resubmit.

*Please note that TARS require an original physician signature. TARs that are signed by a nurse for the physician or have a stamped signature will be denied by ACS. While ACS has historically accepted

these TARs, their process has changed, and the new standard is consistent with the current requirements of the TARs manual distributed by the State Department of Health Care Services.

All TARs must include the facility's National Provider Identification (NPI) Number. ACS will not accept TARs without the facility's NPI Number.

C. RETRO TARs- The hospital shall be required to send copies of the entire client chart and documentation as to why a TAR is being sent RETRO. RETRO TARS are only accepted for the following reasons

- A natural disaster
- Other circumstances beyond the hospital's control- this **does not** include negligence, misunderstanding of requirements, illness or absences, or delays by postal services.
- Eligibility was delayed by County Welfare Department
- Other coverage denied payment of a claim for service
- Communication with the field office consultant could not be established
- The beneficiary concealed Medi-cal eligibility at the time of admission

- In addition, all Retroactive TARS must be submitted within four (4) months from the date of the client's retroactive eligibility. TARS which are not submitted timely will be administratively denied.

In addition to submitting the original TAR to OptumHealth, the hospital must also submit a claim form directly to Affiliated Computer Services, Inc. (ACS) for payment of psychiatric inpatient services. Claims for Medi-Cal only clients are to be sent electronically. Medi-Medi claims are paper claims.

D. Processing TARS

Within fourteen (14) calendar days of receipt of the completed TAR from the provider, OptumHealth Utilization Management staff reconciles the information on the TAR with clinical information obtained during admission and concurrent review and submits the completed and approved TAR to ACS for payment processing via certified mail. A copy is forwarded to the provider.

The provider may appeal non-authorization by following the appeals procedure described in the Clinical Appeals section of this handbook.

E. TAR Timelines

The following timelines are Title 9 requirements for submission of TARs.

Provider must submit TAR to OPTUMHEALTH:

- Within fourteen (14) calendar days of client discharge.

Provider must submit a separate TAR to OPTUMHEALTH:

- When ninety-nine (99) calendar days of continuous service are provided to a client and if the hospital stay will exceed that period of time.

Note: TARs submitted for review after the timelines specified above must include the medical record along with an explanation of why the TAR is being submitted late. TARS submitted late (Retro TARS) without a reasonable explanation may be denied administratively.

F. Eligibility

Providers must use the state operated Point of Service (POS) verification system to check a client's current Medi-Cal eligibility to meet the State standards.

At fee-for-service-hospitals, the client's Medi-Cal number is either verified by swiping their card through a POS reader or by checking the POS web site. A POS machine strip with the verification is printed out and must be attached to the TAR.

G. Medi-Cal as Secondary Insurance

When the primary insurance is Medicare, and it is apparent that Medicare coverage will expire within *5* days, then concurrent review and TARs submission will be conducted in the same manner as if Medi-Cal was primary." Please note that although reviews will occur within 5 days of Medicare expiration, payment authorization must be based on information presented at the time Medicare coverage expires.

Should the hospital discover after discharge that a client had Medi-Cal coverage as secondary coverage, the hospital is to submit:

- A completed TAR; and
- A verification of Medi-Cal for the dates of service;
- The complete medical record; and
- A written explanation of why the TAR is being submitted late.

Forward this documentation to:
OptumHealth
Utilization Management
3111 Camino del Rio North, Suite 500
San Diego, CA 92108

OptumHealth will review the documentation for medical necessity, complete the TAR and submit it to ACS for processing. The OptumHealth Medical Director will notify the hospital in writing within 14 days of receipt of the completed record if any days of the admission are not authorized for payment.

11. DENIALS AND NOTICE OF ACTION

A. Clinical Denials

Clinical denials are based on Title 9 Medical Necessity Criteria and the medical records submitted during the Utilization Management process. It is therefore in the provider's best interest to ensure that documentation is complete and accurate so that OptumHealth staff may make a timely and appropriate authorization decision. All Denials are reviewed by a psychiatrist

B. Administrative Denials

TARS that are incomplete will be returned with a request for correction or a new TAR may be requested that provides all necessary information to allow OptumHealth to process the TAR.

TARS which show days not authorized by OPTUMHEALTH Utilization Management through initial and concurrent reviews will be denied in part or entirely, unless additional clinical information submitted with the TARS supports the medical necessity for the days requested.

C. Notice of Action (NOAs)

When OptumHealth faxes an NOA to the client in the hospital, it is the responsibility of the hospital staff assigned to the client to present the NOA to the client and explain his/her rights and options.

12. CLINICAL APPEALS

There are times when providers disagree with OptumHealth regarding a clinical determination. Providers are encouraged to communicate any issue or concern regarding clinical decisions or claims and billing procedures to OptumHealth. OPTUMHEALTH is committed to responding in an objective and timely manner. OptumHealth will attempt to resolve the issue informally through direct discussion with a provider; however, if the problem is not resolved to the satisfaction of the provider, a formal appeal process is available.

A. Provider Appeals Process

All provider problem resolution and appeals processing is governed by Title 9, Chapter 11, and Section 1850.305. Please contact the OPTUMHEALTH Provider Line at 1.800.798.2254, option # 3, if you have any questions regarding the timelines or regulation of the process.

B. Expedited Review

The MHP encourages informal resolution of disagreements regarding treatment issues through direct discussions with the OptumHealth clinician responsible for authorizing reimbursement. Please call the Provider Line at 1.800.798.2254, option #3, to discuss clinical issue resolution with a Utilization Manager. Confirmatory documentation of the clinical aspects discussed during the expedited review will be requested. Since authorization determinations are made on available documentation, progress notes, nursing notes, etc. will be requested. This discussion may result in:

- Reconsideration of the initial decision, and a negotiated resolution.
- An expedited peer-to-peer review between the OptumHealth Medical Director and the treating psychiatrist.

Request to utilize the expedited review process should be limited to those clients that are currently in the level of care under discussion. If the client has been discharged from that level of care, the provider will be directed to use the appeals process.

C. Level I Appeal

The provider may request a Level I Appeal by submitting a written request to OptumHealth for a review within ninety (90) calendar days of the date of receipt of a denial of reimbursement. The provider must include in writing all relevant data, documents or comments that support the medical necessity for the provided services. This information is to include, but is not limited to, the following:

- Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.
- Clinical records supporting the existence of medical necessity, if at issue.
- A summary of the reasons why the services should have been authorized.
- Provider's name, address and phone number.
- Signature of authorized provider representative.

This information should be sent to:

OptumHealth
QI Department, Attn: Clinical Appeals Coordinator
3111 Camino del Rio North, Suite 500
San Diego, CA 92108

An OptumHealth psychiatrist not involved with the initial denial of payment will review the information and prepare a written response to be sent back to the provider within sixty (60) days of the receipt of the appeal.

If the denial of payment is upheld, the provider may initiate a Level II appeal.

D. Level II Appeal

In the event that the denial of payment is upheld at the Level I Appeal, the provider is notified of the right to a Level II Appeal. A Level II Appeal is submitted to the State Department of Health Care Services Hearing Officer. The appeal must be filed in writing, along with supporting documentation, within thirty (30) calendar days of OptumHealth written notification of the Level I appeal decision.

The appeal and supporting documentation should be sent to:

Hearing Officer
California State Department of Health Care Services
1600 9th Street
Sacramento, CA 95814
916.654.3607

The State DHCS Hearing Officer will notify OptumHealth and the provider of its receipt of a request for appeal within seven (7) calendar days and ask for specific documentation supporting the MHPs decision to deny payment.

OptumHealth will submit the required documentation within twenty-one (21) calendar days of notification of the appeal or the State DHCS shall find the appeal in favor of the provider.

The State DHCS shall have sixty (60) days from the receipt of the MHPs documentation to notify the provider and the MHP in writing of the decision and its basis.

If the State DHCS does not respond within sixty (60) calendar days from the postmark date of the MHPs documentation, the appeal shall be deemed upheld.

As of June 30, 2003, if the State DHCS upholds the original decision to deny reimbursement, a review fee will be assessed to the provider (DM11 Letter #03-07).

If the State DHCS overturns a provider appeal, the provider is notified in writing with instructions to submit a new TAR to OptumHealth. OptumHealth has fourteen (14) calendar days from the receipt date of the provider's new TAR to authorize payment and submit to Affiliated Computer Services, Inc (ACS) for processing.

NOTE: The State DHCS does not accept Level II Appeals for administrative days.

13. ADMINISTRATIVE DENIAL APPEAL (for Retro TARs only)

Please note that the process for submitting an appeal of an Administrative denial is different than the appeal process of denials for clinical reasons. The provider has ninety (90) days to appeal an administrative decision not to authorize a retroactive request. To request a Level 1 appeal: (1) submit a written request for a review of the denial, and (2) submit in writing all relevant data, documents, or comments that support Title 9 and County of San Diego Mental Health Plan criteria for the provided services.

Mail the appeal to:
San Diego Mental Health Administration, QI Unit
3255 Camino Del Rio South
San Diego, CA 92108

A county representative not involved in the original decision will review the appeal and you will receive a written decision within thirty (30) days of receipt of the request.

14. USING THE COUNTY OF SAN DIEGO MENTAL HEALTH SERVICE MANAGEMENT INFORMATION SYSTEM (MH MIS)

To meet State and Federal reporting requirements and to facilitate coordination of client care, the County of San Diego uses the MH MIS client data recording system. MH MIS is used to register clients into the mental health system, to record service activities, and to update care coordination information. During the initial authorization process, OptumHealth enters a limited set of information from inpatient providers about adult Medi-Cal hospital admissions into the MH MIS system within one business day of the admission. Hospital staff should check MH MIS, if possible, for information about clients' Outpatient Mental Health Services, and assigned Care Coordinator or Case Manager.

Training on the MH MIS system (Anasazi) is available to hospital staff upon request. Please contact:

Steve Jones
Quality Improvement Manager
619-563-2747

15. COORDINATION OF CARE

In accordance with State and Federal regulations, and within the guidelines of San Diego County Mental Health Services policies regarding confidentiality and release of information, hospital providers are expected to coordinate care with other healthcare and mental health providers who are also serving their clients. As clarified in Department of Mental Health Information Notice #04-07, information may be released without written permission when it will be used for diagnosis and treatment purposes, on an as needed basis. This allowance is based on Civil Code Section 56.10 which states that: "A provider of healthcare or a health care services plan may disclose medical information to providers of healthcare, healthcare services plans, or other healthcare professional or facilities for purposes of diagnosis or treatment of the patient."

A. Outpatient Care Coordination

Care Coordinator or Case Manager: Clients who are already involved or have recently been involved in the Specialty Mental Health Care System, in many cases, have a Care Coordinator. A Care Coordinator, such as a clinic therapist or an intensive case manager, is the person assigned to each individual client who is responsible for ensuring that the client receives all needed services. The Care Coordinator is responsible for integrating the client's treatment and care, and assists the client in obtaining needed services both within and outside the organization. In order to coordinate care at the time of an inpatient admission, hospital staff should make an effort to obtain information regarding the client's assigned Care Coordinator. One method to accomplish this goal is to check the Management Information System, client data recording system. The goal is for the Care Coordinator to be contacted within 48 hours of admission to the inpatient setting, or as soon as possible.

The type of information the hospital staff may share with the Care Coordinator should include, but not be limited to:

- Date of admission;
- Circumstances of admission;
- Medication, and any changes in medication;
- Notification of any certification hearings or plans regarding Conservatorship;
- Discharge planning;
- Date planned discharge;
- Notification of client leaving hospital AMA .

In order to ensure that the client will receive continuity of care between providers of all services, the Care Coordinator will interact with hospital staff by participating in the following ways:

- Communicating with hospital staff about client's treatment;
- Reviewing the discharge plan with hospital staff and assisting with the discharge plan when appropriate;
- Assisting to ensure that the client is seen by a mental health care professional within 72 hours of discharge from the hospital.

In addition, it is very useful for the Care Coordinator to receive a copy of the client's discharge plan.

B. Transitional Services

1. Transition Team: Adult/Older Adult

The Transition Team (Telephone Number: 619-574-0970), operated by Telecare Corporation, under contract with the Mental Health Plan, provides a clinical review of all adult/older adult Medi-Cal recipients admitted to Medi-Cal contract hospitals. This review occurs within three working days of notification that an individual was admitted to an acute care psychiatric unit. Medi-Cal clients with a Conservator, Care Coordinator or Case Manager the Transition Team is not needed. Medi-Cal clients without such support, the Transition Team will make contact directly with the client and offer short-term case management services. Participation is voluntary.

The transition team will maintain a clinical case management record for each client who is enrolled. The goals of Transition Team services are to aid in the re-stabilization of clients in the community (following an acute psychiatric hospitalization) and to facilitate a smooth, rapid transition to requested community resources. Together, the client and Transition Team Case Manager develop an Individual Service Plan, and the Case Manager monitors the client's progress in the hospital, supports hospital discharge planning, and promotes linkage of the client with aftercare resources. The team will provide

services and supports, as necessary, to achieve the client's treatment plan goals and objectives. Transition Team services are short- term and dependent upon the requests and needs of the individual client. Upon completion of Transition Team services, clients may choose to link with care coordinators, case managers or other community providers, or choose not to participate in additional mental health services.

2. Transitional Services Program: Children's

The Herrick Center, operated by New Alternatives, Inc. under contract to the County, is a multi-disciplinary service component designed to provide intensive support and coordination of clinical services for qualifying children and adolescents. The team provides specialized case management for children and adolescents who are, or have been, hospitalized. The most intensive services are for frequent users of inpatient services who are at risk of re-hospitalization.

Clinical staff provides coordination and linkage to community resources, brokering of specialized after-care services, coordination of clinical services and intensive in-home support to facilitate the child's transition back home and to prevent re-hospitalization. The hospital shall contact the Herrick Center by calling 619-447-2432, for those clients who are in need of case management services.

C. Discharge Planning

In order to facilitate continued treatment and prevent re-admission, discharge plans shall be completed for all clients being discharged from an acute level of care. Planning for discharge shall begin on the day of admission. Discharge planning shall include:

- Attempting contact with the client's Care Coordinator within 48 hours of admission
- Coordinating with the Short-Term Transition Team if no Care Coordinator is identified
- Contacting the Regional Center for appropriate clients
- Planning for appropriate living arrangements for the client upon discharge
- Planning for discharge to the appropriate level of care, including organizational, residential, or outpatient providers
- Consideration of prior failures and successes of the client in an effort to design an effective discharge plan
- Contacting an outpatient provider and requesting an appointment for providers and programs that schedule appointments (such as children's programs) to be scheduled for the client as soon as possible, or a referral to a walk-in program, with the targeted goal that the client is seen within 3 business days of the client's discharge from the facility
- Requesting a Release of Information (ROI) from the client to facilitate coordination of care between the acute setting and the outpatient provider (an ROI is not required for coordination, diagnosis or treatment purposes; however, it is a good practice and helps the client be more actively involved in their care)
- Sending fax to the referral program with the information about the client that has been referred in order to ensure that the program is aware that the client is coming.
- Identifying plan for client to obtain medications after discharge.

OptumHealth Utilization Management staff review the discharge planning progress during the clinical record review process.

D. Coordination with Other Levels of Care

Crisis Residential Services

Upon inpatient admission, or as a step-down plan, clients can be referred to Crisis Residential Services.

Clients who do not meet, or no longer meet, the Title 9 criteria for inpatient services may be referred to a crisis residential facility if the following criteria are met:

- Be in psychiatric crisis too severe to be handled on an outpatient basis and have an Axis I diagnosis other than a substance-induced disorder. This includes individuals experiencing an acute life crisis, an acute phase of a chronic psychiatric disorder, or an acute psychiatric episode;
- Be capable of maintaining safety ;
- Be voluntarily requesting services and willing to go to the crisis residential facility;
- Not be actively violent or in need of restraints (but may have a history of violence if currently able to control impulses);
- Be free from non-psychiatric medical conditions, which would require more than outpatient medical care;
- Not have a substance abuse or substance dependence diagnosis, in absence of a mental health diagnosis;
- Be ambulatory as defined by Community Care Licensing (unless occupying room approved by Fire Department and Community Care licensing for non-ambulatory). Some facilities have waivers to admit non-ambulatory clients. “Ambulatory” is defined as the ability to exit the facility quickly without assistance from any person or device such as a cane, walker, or crutches;
- Clients over 59 who are compatible with the current population will be accepted only upon approval by Community Care Licensing. All crisis residential facilities are able to routinely get approval to admit a limited number of individuals over age 59.

E. Referrals to Long-Term Care Services and Skilled Nursing Facilities

The MHP contracts with Institutions for Mental Disease facilities (IMDs) and Skilled Nursing Facilities to meet the needs of San Diego residents who require the most intensive, secured, 24-hour setting. The MHP also manages the care of San Diego residents placed in out-of-county IMD facilities.

- **General Admission Criteria**

  - The client is diagnosed with a non-substance abuse related, non-dual diagnosis related, non-Axis III related major mental disorder on Axis I, according to the current DSM typology. Clients may also have a concurrent diagnosis on Axis II. Axis II diagnosis alone is not, however, sufficient to meet criteria;
  - The client is gravely disabled based on the Axis I diagnosis and is on conservatorship
  - Medical issues are stabilized
  - The client has a current history of being unable to adequately care for him or herself outside of a locked setting;
  - The client is in need of long term locked treatment or a skilled nursing facility in order to facilitate rehabilitation to a lesser level of care or to prevent regression to a more acute state;
  - The client is a resident of San Diego County, with San Diego Medi-Cal or has other coverage available to fund ancillary services;
  - The client is 18 years of age or older;

- The client is on a stable, clinically appropriate medication regimen;
- The client does not have a history of multiple assaultive episodes or is not currently suicidal.

- **Referral Process**

  - Referrals for long-term care placement should be made to the OptumHealth Long Term Care Coordinator at 619-641-6779. Completed Long Term Care Referral Packets can be faxed to the Long Term Care Coordinator at 888-687-2515. The Long Term Care Coordinator will review requests with the OptumHealth Medical Director who will determine the appropriateness of the referral.

F. Interface with Healthy San Diego Health Plans

Note*:* The information presented in the following section is in accordance with the Memorandum of Agreement (MOA) between County of San Diego Health and Human Services Agency Local Mental Health Plan and the Medi-Cal Managed Care Plans.

- **HMO Medi-Cal Beneficiaries**

  Over 50% of Medi-Cal beneficiaries are enrolled in one of the Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. To help facilitate communication and coordinate physical and mental health services, Healthy San Diego has prepared a Physical and Mental Health Coordination Form and Guidelines for its use. Each HMO has contracts with specific pharmacies and laboratories. Providers need to be aware of which pharmacy or laboratory is associated with the HMO serving the client for whom they are prescribing medication or lab tests in order to refer the client to the appropriate pharmacy or lab. Providers prescribing lab tests may refer the client back to his or her Primary Care Physician (PCP) for these services. The client's HMO enrollment card also may have a phone number that providers and clients can check in order to identify the contracted pharmacy or lab. See Appendices in this handbook for a chart of the Plan Partner Identification for Pharmacies.

- **Physical Health Services While In A Psychiatric Hospital**

  The client's Healthy San Diego HMO will cover and pay for the initial health history and physical assessment required upon admission to a psychiatric inpatient hospital. The client's HMO is also responsible for any additional or on-going medically necessary physical health consultations and treatments.

  The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission, and for ordering routine laboratory services. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted facility must obtain the necessary authorizations from the HMO. The client's HMO contracted providers are to provide these services, unless the contracted facility obtains prior authorization from the HMO to use a provider not contracted with the client's HMO.

- **Transfers from Psychiatric Hospital to Medical Hospital**

  Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange transfer from a psychiatric hospital to an HMO contracted hospital if it is determined that the client

requires physical health-based treatment. The OptumHealth Medical Director and the HMO Medical Director resolve any disputes regarding transfers.

- **Non-Emergency Medical Transportation**

  Healthy San Diego HMOs cover medically necessary non-emergency medical transportation services for Plan members. HMO members who call the Access and Crisis Line for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

G. Beneficiaries Not Enrolled in Healthy San Diego Health Plans

For those clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

H. Authorization for Transfer Between Hospitals

Medi-Cal patients may be transferred from one hospital to another, or from one floor to another within the same hospital, according to the following guidelines:

- Medical necessity criteria is clearly established for the client
  Referring hospital may contact Optum to request an authorization to reduce the potential for transferring a client who no longer meets medical necessity

- The referring hospital should arrange for transportation to the receiving hospital.
- The receiving hospital shall meet the following conditions:

  - Have a bed available to receive the client;
  - Have an attending physician available for the client;
  - Be willing to accept the clinical information of the referring hospital, or be willing to conduct a new assessment of the client within 24 hours of admission.

These authorization conditions apply equally for:

a) Psychiatric to psychiatric hospital transfer;
b) Medical to psychiatric hospital transfer;
c) Medical floor to psychiatric floor transfer within the same hospital.

OptumHealth clinical staff will provide authorization to the receiving hospital if the above conditions are met. Please note: When there is a transfer between hospitals, once the patient has been admitted to the second hospital that that hospital will be responsible for obtaining any further the authorizations.

I. Authorization Process for the Emergency Psychiatric Unit (EPU) of the San Diego Psychiatric Hospital for Receiving Hospitals:

When a patient has been assessed in the EPU as requiring inpatient hospitalization and is insured, the EPU staff will seek an available bed for that patient in the Lanterman-Petris-Short (LPS) unit of a participating hospital.

If the patient is a Medi-Cal recipient, the receiving hospital follows the same admission procedure they would for any requests for reimbursement for acute care as well as for subsequent days.

If the patient is a Medicare A&B recipient, the EPU will confirm this status and inform the receiving hospital.

Private insurance carriers are contacted by the receiving hospital for authorization.

J. For Sending Hospitals:

If a patient is assessed in a hospital Emergency Room as needing inpatient care and is uninsured, the facility faxes a completed San Diego County Psychiatric Hospital (SDCPH) Request for Transfer Form to SDCPH, along with other standard referral material. SDCPH acknowledges the receipt of the request within one hour, and gives a preliminary standing based on established criteria. The SDCPH staff manages and prioritizes the referrals, accepting patients who are medically stable and otherwise appropriate, as bed space allows.

16. BENEFICIARY RIGHTS

San Diego County Mental Health is committed to protecting client's rights in accordance with State and Federal Regulations and County policy. Violations of clients' rights will be responded to appropriately.

A. Confidentiality

Maintaining the confidentiality of client and family information is of vital importance, not only to meet legal mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

B. Client Handbooks

Providers are required to give each client a Client Handbook at the client's admission, or upon request. The handbook is entitled: County of San Diego – Guide to Medi-Cal Mental Health Services. The beneficiary handbooks contain a description of the services available through the MHP, a description of the required process for obtaining services, a description of the MHP problem resolution process, including the complaint resolution and grievance and appeal processes and a description of the beneficiary's right to request a State fair hearing. Guides are written by the State with updates by the MHP. They are distributed by the Strategic Planning and Administration Unit at 619-563-2788. Additional copies may be obtained by calling the Strategic Planning and Administration Unit at 619-563-2788.

All patients also must receive a copy of the State Handbook, Rights for Individuals in Mental Health Facilities. This handbook deals with rights of persons both voluntarily and involuntarily admitted, discussing the role of the Patient Rights Advocate, rights that cannot be denied, rights that can be denied with good cause, medical treatment and the right to refuse it, and informed consent for medication. The County MHS contracts with Jewish Family Service for the Patient Advocacy Program (1-800-479-2233) to assist patients with grievances and appeals. The Patient Advocacy Program distributes an informing brochure for patients called "Seclusion & Restraint: Answers to Your Questions".

C. Translation Service Availability

According to Title 9 and Title IV, Civil Rights Act of 1964, interpreter services shall be available to beneficiaries and families in threshold and non-threshold languages if requested or if the need is determined to assist in the delivery of specialty mental health services. It is not the standard of practice to rely on family members for translation services.

D. Client Grievances and Appeals

Clients may contact Jewish Family Service, the Patient Advocacy Program at 1-800-479-2233, if they are dissatisfied with any aspect of inpatient services they receive under the MHP.

It is the provider's responsibility to inform clients regarding their right to file a grievance or an appeal to express dissatisfaction with MHP services without negative consequences of any kind. Providers are required by Title 9 to post Grievance and Appeal posters (in English and the State DMH designated threshold languages which are Spanish, Vietnamese, Arabic and Tagalog for San Diego County) in a visible area to ensure clients are advised of their rights. Title 9 requires brochures are available to both clients and provider staff without the need of a verbal or written request by the client. Copies of the Grievance and Appeal posters and brochures may be obtained by contacting the CoSDBHS Strategic Planning and Administration Unit at 619-563-2788.

Clients may file an appeal of an action taken by the Mental Health Plan (MHP) such as any of the following:

- A denial or modification of services,
- A reduction, suspension or termination of a previously authorized services,
- A denial, in whole or part, of payment for a service,
- Failure to provide services in a timely manner (within 1 hour for emergency care).

If a client wishes to file an appeal, the provider should inform them that they should contact the Patient Advocacy Program at 1-800-479-2233.

If the standard resolution process for an appeal could, in the opinion of the client, the MHP, CCHEA or Patient Advocacy Program jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the client has the right to file an Expedited Appeal. Expedited Appeals may be filed for any of the reason listed above but must resolved within 3 working days.

Inpatient providers are required by Title 9 to maintain a log in which all client or family concerns or grievances are entered. Concerns may be expressed verbally or in writing. The log must include the following elements:

- Complainant's name
- Date the grievance was received
- Name of person logging the grievance
- Nature of the grievance
- Nature of the grievance resolution
- Date of resolution

The MHP may request a copy of a provider's Grievance Log at any time.

E. Client Right To Request A State Fair Hearing

Clients have the right to request a fair hearing any time before, during or within 90 days after the completion of the beneficiary problem resolution process, whether or not the client uses the problem resolution process and whether or not the client has received a Notice of Action. Providers are required to inform their clients or the clients' conservators/legal guardians of these rights.

F. Client Right To Have An Advance Health Care Directive

All new clients must be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services. This procedure applies to emancipated minors and clients 18 years and older. Generally, Advance Directives addresses how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for them. The MHP provides an informational brochure on Advance Directives, available in the threshold languages, and copies may be obtained through the MHP Strategic Planning and Administration Unit at 619-563-2788.

G. Title 42 CFR Section 438.100 – Addressing Beneficiary's Rights

1.) General rule. The State must ensure that—

(i.) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and

(ii.) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

2.) Specific rights—

(i.) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.

ii.) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to—

(a) Receive information in accordance with §438.10.

(b) Be treated with respect and with due consideration for his or her dignity and privacy.

(c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(f)(6)(xii).)

(d) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(f) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

(iii) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.

3) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

4) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

17. QUALITY IMPROVEMENT

Site reviews will be conducted tri-ennially. Requirements are based on State standards for Medi-Cal certification. On-site reviews shall occur during normal business hours with at least 72-hours prior notice; except unannounced on-site reviews and requests for information may be made in those exceptional situations where arrangement of an appointment before hand is clearly not possible or clearly inappropriate to the nature of the intended visit.

Providers are required to adhere to all applicable federal, State, and County regulations, policies and statutes, including Title 9 and DMH Letters and Notices. Relevant Letters published in 2004 included but are not limited to:

- DMH Letter 04-04, which requires hospitals to provide EPSDT and TBS notices to full scope individuals 18-21 admitted with an emergency psychiatric condition.
- DMH Information Notice 04-05, which discusses the Emily Q. v. Bonta Appeal settlement and criteria special service eligibility for those ages 21-25.

Providers are required to conduct client satisfaction surveys.

All County and contracted providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the Behavioral Health Services (BHS) Quality Improvement (QI) Unit that will review, investigate as necessary, and monitor trends. BHS-QI designated staff will communicate with program Contracting Officer's Technical Representatives (COTRs) and Mental Health Services (MHS) management staff as needed on all reported serious incidents. The provider shall also be responsible for reporting serious incidents to the appropriate authorities. (See Appendix 7).

All mental health providers are required to adhere to cultural competence standards. The QI staff will look for elements of cultural competence in program orientations, staffing, charting and/or trainings during site reviews.

Reports Required: All Lanterman-Petris-Short (LPS) facilities are required by the State DMH to submit the following quarterly reports to County Mental Health Services Quality Improvement Unit, using the State forms included in the Appendix:

- Denial of Rights/Seclusion and Restraint (MH 308)—if there are no instances of denied rights in a quarter, hospitals must submit a report saying this.
- Quarterly Report on Involuntary Detentions (MH 3825) —not required for non Lanterman-Petris-Short LPS facilities.
- Convulsive Treatment Administered—to include Outpatient ECTs.

These reports should be submitted to the QI Unit by the 15th day after the end of the quarter. Forms have been provided, both in hard copy and electronically.

Please note that because of HIPAA confidentiality requirements completed forms containing patient identifiers are not allowed to be electronically submitted. These reports can be mailed or faxed to the QI Unit confidential fax at 619-563-2795.

18. QUALITY OF CARE STANDARDS

Psychiatric inpatient providers shall be committed to providing dignified care and treatment to individuals who struggle with mental illness and substance abuse. Providers shall strive to restore the patient to optimal functioning in the shortest amount of time and in the least restrictive and most comfortable environment possible. Providers will involve the patient's natural support system and include them in their treatment planning and care. Providers shall understand that it is common for people with mental illness to experience stigma and barriers to social integration and shall be committed to eliminating stigma and to promoting the fullest recovery for each individual.

Psychiatric inpatient Providers shall abide by their respective discipline's guidelines such as those noted on the following websites.

CA Psychiatric Association	www.calpsych.org/
American Psychiatric Nurses Association- CA Chapter	www.apnaca.org
National Association of Social Workers- CA	www.naswca.org/
CA Association of Marriage and Family Therapists	www.camft.org/
California Psychological Association	www.cpapsych.org/

Inpatient Treatment for Children and Adolescents

CoSDBHS supports the use of inpatient services for children and adolescents and recommends that inpatient facilities follow quality of care guidelines such as those published by the Association of Child and Adolescent Psychiatric Nurses, and the American Academy of Child and Adolescent Psychiatry. Following are examples of quality guidelines for facilities providing child or adolescent inpatient treatment.

- Treatment program should be under the direction of a fully trained and properly qualified child and adolescent psychiatrist.
- Decisions for admitting and treating children and adolescents in an inpatient setting must be very carefully considered. This would include the diagnosis of a psychiatric disorder as defined by the most recent version of the DSM and criteria for inpatient psychiatric hospitalization such as those described in the American Academy for Child and adolescent Psychiatry's Guidelines for Treatment, Quality Assurance, and Peer Review.
- Children and adolescents and their families shall have an opportunity to explain their perception of the behaviors and symptoms that prompted the admission

- Treatment plans must be individualized based on the assessment of the patient's biological, psychological and social needs.
- The child or adolescent and their family should be encouraged to participate voluntarily in the decision for admissions, treatment and discharge planning.
- Care should be coordinated with the child or adolescent's other healthcare providers.
- Prescriptions should be based on individual characteristics, such as culture, ethnicity, gender, religious beliefs, and age.

APPENDIX 1
Medical Record Content Requirements

1. Mental status exam and psychiatric history are documented within 24 hours of admission. The history includes: previous treatment dates, providers, therapeutic interventions and responses, relevant family information, relevant results of lab tests (if applicable) and consultation reports (if applicable).
2. Initial diagnosis meets established medical criteria for acute inpatient admission:

   a. Danger to self, others or property;
   b. Unable to care for self as gravely disabled (other contributing factors need to be handled by appropriate agencies);
   c. Serious adverse reaction to treatment;
   d. Unable to receive care at lower level.

3. Diagnosis is consistent with documented symptoms;
4. Treatment plan is consistent with diagnosis;
5. Therapeutic intervention is consistent with treatment plan;
6. Discharge plan is consistent with treatment plan;
7. Consent for medication treatment form is dated and signed by client;
8. Admission Axes I, II, III, IV, V are documented;
9. Documentation of 5150 (including appropriate form) is in chart, if applicable;
10. Documentation that the client has signed a Release of Information (ROl) to his/her Primary Physician for the hospital discharge summary;
11. Cultural factors, including client's ethnicity/cultural background and primary language, are documented at admission;
12. If a readmission, how treatment plan addresses contributing problems leading to recurrence.
13. Relevant physical health conditions reported by client are prominently identified and updated as appropriate;
14. Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities, is clearly documented;
15. Documentation includes past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs;
16. Transfer to administrative days is documented;
17. Active placement efforts for clients on administrative days are documented;
18. Discharge planning for clients on administrative days is documented;
19. Provision made for translation and/or interpretive services for non-English speaking clients and/or for clients needing sign language assistance is documented;
20. Client's response to offer of an interpreter or sign language assistance is documented;
21. Discharge Axes I, II, III, IV, V are documented;
22. Final discharge plan documents referral for outpatient medication management follow-up appointment;
23. Final discharge plan for clients with Axis I diagnosis of substance abuse/chemical dependency documents recommendations for chemical dependency services;
24. Other community support/agency/outpatient service referrals are documented;
25. Current and recommended living arrangements are documented;
26. Progress notes document reaction to treatment, problems and interventions;
27. Each order and note is signed and dated;
28. Client's referral back to primary care physician is documented;
29. Client's referral back to psychiatrist and/or therapist for outpatient care is documented.

APPENDIX 2

Glossary

Beneficiary

Any person certified as eligible under the Medi-Cal Program according to Section 51001. Title 22, California Code of Regulations.

Consolidation

The term used by the state to describe shifting Medicaid dollars to the local (County) level for capitation and distribution.

Contract Hospital

A provider of psychiatric inpatient hospital services, which is certified by the State Department of Health Services, and has a contract with a specific Mental Health Plan to provide Medi-Cal psychiatric inpatient hospital services to eligible beneficiaries.

County of Beneficiary

The county is currently responsible for determining eligibility for Medi-Cal applicants or beneficiaries in accordance with Section 50120. Title 22, California Code of Regulations.

Fee For Service Medi-Cal (FFSIMC)

California's Medi-Cal program provides reimbursement on a per procedure basis for a broad array of health and limited mental health services provided to individuals who are eligible for Medi-Cal.

Fiscal Intermediary

The entity which has contracted with the State Department of Health Services to perform services for the Medi-Cal program pursuant to Section 14104.3 of the Welfare and Institutions Code.

Gatekeeper

Term for an organizational function which:

- Coordinates and assesses patient services needs.
- Monitors services rendered to assure that only needed services are provided.
- Identifies health practices and behaviors of target populations.
- Creates a fixed point of responsibility.
- Reduces service overlap and redundancy.

Hospital

An institution, including a psychiatric health facility, which meets the requirements of Section 51207, Title 22, California Code of Regulations.

Implementation Plan for Psychiatric Inpatient Hospital Services

A written description submitted to the State Department of Health Care Services (DHCS by the Mental Health Plan (MHP), and approved by the DHCS, which specifies the procedures which will be used by a prospective MHP to provide psychiatric inpatient hospital services.

Inpatient Hospital Services

See Psychiatric Inpatient Hospital Services definition.

Lanterman-Petris-Short (LPS)

Persons designated by San Diego County who may take or cause to be taken, mentally disordered person(s) into custody and place him/her in a facility designated by the County and approved by the State DHCS as a Facility for 72-hour Treatment and Evaluation.

Local Mental Health Care Plan (Plan)

The term used to denote the local managed mental health care plan administrator. The Plans will be responsible for offering an array of mental health services to all eligible Medi-Cal beneficiaries.

Managed Care

A new paradigm funding approach that combines clinical services and administrative methods in an integrated and coordinated way to provide timely access to care in a cost effective manner. Emphasis on prevention and early care reduce usage of more expensive methods of treatment.

Medi-Cal

California's Medicaid Program.

Medically Necessary

A service or treatment that is appropriate and consistent with diagnosis, and that, in accordance with accepted standards of practice in the mental health community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of care rendered.

Mental Health Carve Out

It has been determined at the state level that the local County Mental Health Departments will design and develop a managed mental health care system separate from the local County Departments of Health. However, a clear mental health and health interface for integrating service delivery must be included in the design.

Mental Health Plan (MHP)

An entity which enters into an agreement with the State DMH to provide beneficiaries with psychiatric inpatient hospital services. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

MHP Authorization for Payment

The initial process in which reimbursement for services provided by an acute psychiatric inpatient hospital to a beneficiary is authorized in writing by the MHP. In addition to the MHP authorization for payment, the claim must meet additional Medi-Cal requirements prior to payment.

Provider

A hospital, whether a Fee For Service/Medi-Cal or a Short Doyle/Medi-Cal provider, which provides psychiatric inpatient hospital services to beneficiaries.

Psychiatric Inpatient Hospital Services

Both acute psychiatric inpatient hospital services and administrative day services provided in a general acute care hospital, a free standing psychiatric hospital or a psychiatric health facility that is certified as a hospital. A free standing psychiatric hospital or psychiatric health facility that is larger than sixteen (16) beds may only be reimbursed for beneficiaries 65 years of age and over and for persons less than 21 years of age. If the person was receiving such services prior to his/her twenty-first birthday and he/she continues without interruption to require and receive such services, the eligibility for services continues to the date he/she no longer requires such services or, if earlier, his/her twenty second birthday.

Appendix 3

Mental Health Websites

The following websites can be accessed for additional information:

County of San Diego, Health & Human Services Agency:
http://www.sdcounty.ca.gov

State of California Department of Mental Health:
www.dmh.ca.gov

Medi-Cal Website:
www.medi-cal.ca.gov

OptumHealth
www.optumhealthsandiego.com

Network of Care:
www.sandiego.networkofcare.org/mh/home/index.cfm

State of California Office of Patient Advocate:
www.opa.ca.gov

State of California Department of Managed Health Care:
www.dmhc.ca.gov

National Alliance of Mentally Ill:
www.nami.org

ARC of San Diego
www.arc-sd.com

Appendix 4

The following forms are attached for your reference. Instructions and restrictions are included.

1. DENIAL OF RIGHTS/SECLUSIONS AND RESTRAINT MONTHLY REPORT
2. QUARTERLY REPORT ON INVOLUNTARY DETENTIONS
3. CONVULSIVE TREATMENTS ADMINISTERED – QUARTERLY REPORT included.

DENIAL OF RIGHTS/SECLUSION AND RESTRAINT MONTHLY REPORT
MH 307 (Rev. 12/04)
(Formerly MH 1071)

Month:

Year:

Facility:

Program/Ward:

County: San Diego

Name, Title & Telephone No. of Person Preparing Report:

Date of Report:

A. Patient's I.D.	B. No. of Days in Facility	C. Number of Days Denied Each Right or Days in Seclusion/Restraint									
		1	2	3	4	5	6	7	8	9	10
D. Total No. of Patients in 1-10											

ONLY THE FOLLOWING RIGHTS MAY BE DENIED FOR GOOD CAUSE:

1. Right to wear one's own clothes WIC 5325(a)
2. Right to keep & use one's own personal possessions WIC 5325(a)
3. Right to keep and be allowed to spend a reasonable sum of one's own money for canteen expenses and small purchases WIC5325(a)
4. Right to have access to individual storage space for one's private use WIC 5325(b)
5. Right to see visitors each day WIC 5325(c)
6. Right to have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them WIC 5325(d)
7. Right to have ready access to letter-writing material, including stamps WIC 5325(e)
8. Right to mail and receive unopened correspondence WIC 5325(e)

RESTRICTIONS IMPOSED:
(See Reverse Side)

9. Seclusion (isolation of an involuntary patient in a locked room)
10. Restraints (any physical device used to immobilize the patient because of behavioral problems)

Retention: Two Years from Date of Report

INSTRUCTIONS FOR MH 307 (Formerly MH 1071)

COLUMN A: Patient's I.D. or Hospital Number

Each patient who has been denied a right or placed in seclusion/restrain by the facility during the reporting month must be listed on this form by I.D. or hospital number.

COLUMN B: Number of Days in Facility this Month

Enter each patient's total days in the facility for the month.

COLUMN C: Number of Days Denied Each Right or Days in Seclusion/Restraint

Enter in Columns 1 through 10 the number of days each patient was denied a right or placed in seclusion/restraint.

ROW D: Totals – Number of Patients Denied Each Right

Enter in Row D, 1 through 10, the total number of patients denied each right or placed in seclusion/restraints.

(Do not count the numbers in the boxes to achieve Row D, as the number of patients, **not days**, is needed.)

RESTRICTIONS IMPOSED

Seclusion and restraints MUST be reported and documented because these actions imply the denial of other specific patients' rights, such as the right of access to the telephone.

These implied denials need not be documented in the patient's chart and should not be reported on this form.

When the exercise of a particular right is specifically requested by the patient, however, and denied by the staff while the patient is in restraint or seclusion, the denial of that right MUST be documented in the patient's record and reported on this form.

SUBMIT TO: The Quality Improvement Unit, County of San Diego Mental Health Services by the 10th of the month following the end of the quarter. An aggregated report will be submitted by the local Mental Health Director to appropriate State offices.

State of California – Health and Human Services Agency

Department of Mental Health
Statistics and Data Analysis

QUARTERLY REPORT ON INVOLUNTARY DETENTIONS
MH 3825 (Rev. 5/2007)

County Name:	
County Code:	

		Year
Quarter 1	**July 1 to Sept. 30**	__
Quarter 2	**Oct. 1 to Dec. 31**	__
Quarter 3	**Jan. 1 to March 31**	__
Quarter 4	**April 1 to June 30**	__

SUMMARY OF INVOLUNTARY DETENTIONS IN COUNTY DESIGNATED FACILITIES
(excluding State Hospitals)

Provider Code / National Provider Identifier	Facility Name	72-Hr. Eval & Treatment		14-Day Intensive Treatment	Additional 14-Day Intens.Treat (Suicidal)	30-Day Intensive Treatment	180-Day Post Certification
		Child/Adol (0-17 Yrs)	Adult (18 & Up)				

The above information is required by the California Welfare and Institutions Code (WIC) Section 5402(a). The information provided in this quarterly report will be incorporated into an annual report as required by WIC Section 5402(d). ***Please see the next page or reverse side for Reporting Instructions***. **This quarterly report should be submitted by the 30th of the month following the end of each quarter via email, fax, or U.S. Mail.** If you need assistance preparing this report, please contact Statistics and Data Analysis at **916.653.6257**.

Fax Number: **916.653.0200**
Email Address: **kenneth.lee@dmh.ca.gov** or **bryan.fisher@dmh.ca.gov**
Mailing Address: **DEPARTMENT OF MENTAL HEALTH**
STATISTICS AND DATA ANALYSIS
1600 NINTH STREET, Room 130
SACRAMENTO, CA 95814

DATE	CONTACT PERSON	PHONE NUMBER

REPORTING INSTRUCTIONS:

QUARTERLY REPORT ON INVOLUNTARY DETENTIONS (MH 3825)

SPECIAL INSTRUCTIONS: This reporting applies to all instances of involuntary treatment regardless of funding source. That is, persons who are treated involuntarily in private psychiatric facilities or whose treatment is funded by private resources must be reported along with persons whose treatment is funded through Medi-Cal or the county mental health program. **Do not count persons who are referred to another county for services. It is the responsibility of the county in which a treatment facility is located to include all of the information about the facility in its report.**

If there are no designated facilities, public or private, within your county in which at least one person was admitted involuntarily for evaluation and treatment, you must still submit this report on a quarterly basis with zero counts in each of the boxes provided. For example: In the "Facility Name" box enter "NO FACILITY", and zero fill each of the six treatment categories. In the boxes provided, enter the quarter and year of the report. Date, sign, and mail this report to the address listed on the front of this form. Please include a telephone number of the county contact for data verification purposes.

For each private or public facility reported, completely fill out each category of Involuntary Detention. Do not leave any section blank. If there are no counts for a specific category, please enter a zero count. In the boxes provided, enter the quarter and year of the report. Date, sign, and submit this report by using one of the choices on the front of this form. Please include a telephone number of the county contact for data verification purposes.

Please use one form to report each quarter.

PROVIDER CODE / NATIONAL PROVIDER IDENTIFIER: Enter the provider code or National Provider Identifier for the facility.

FACILITY NAME: Enter the names of all facilities, public or private, designated by the county to which at least one person was admitted involuntarily for 72-hour evaluation and treatment, 14-day intensive treatment, Additional 14-day intensive treatment (Suicidal), 30-day intensive treatment, or 180-day post certification during the reporting period. Exclude State Hospitals for the Mentally Disabled from the list of designated facilities. These are being reported by the State Hospitals.

> Note: A person who initially is admitted to a unit within a facility and is subsequently transferred to another unit within the same facility or to another facility for the same treatment episode while being held under the same Welfare & Institutions (WIC) section is to be counted only once. This person is to be counted in the unit or facility where each specific detention was initiated. This is to eliminate duplicate reporting.

72-HOUR EVALUATION AND TREATMENT: Enter the total count of persons admitted to the county-designated facility for 72-hour treatment and evaluation under WIC Section 5150, 5170, 5200, 5225, and 5585.56 during the report quarter. If the same person was admitted more than once during the quarter for 72-hour evaluation and treatment, count each admission. The number of persons reported should be separated into two groups, children and adolescents (0-17 years old) in one and adults (18 years & over) in the other as indicated.

14-DAY INTENSIVE TREATMENT: Enter the total count of persons certified during the report quarter for 14-day intensive treatment under WIC Section 5250.

ADDITIONAL 14-DAY INTENSIVE TREATMENT (SUICIDAL): Enter the total count of persons certified during the report quarter for an additional 14-days intensive treatment due to suicidal tendencies under WIC Section 5260. If the same person is involuntarily detained for a 14-day certification more than once during the quarter, count each certification.

30-DAY INTENSIVE TREATMENT: Enter the total count of persons certified during the report quarter for an additional period of intensive treatment of not more than 30 days under WIC Section 5270.15 for gravely disabled mentally disordered individuals who are unable to sufficiently stabilize within the 14-day period of intensive treatment.

180-DAY POST-CERTIFICATION: Enter the total count of persons certified during the report quarter for 180-days post-certification treatment under WIC Section 5303 and 5304.

State of California Health and Human Services — Department of Mental Health

ELECTROCONVULSIVE THERAPY TREATMENTS ADMINISTERED – QUARTERLY REPORT
MH 309 (Rev. 9/04)

County	Reporting Facility or Doctor		Report Date
For Quarter Ending	Number of Patients Treated By Major Source of Payment	Private: _____	3rd Party Payer: _____
		Public: _____	Other: _____

SECTION I	NUMBER OF PATIENTS RECEIVING TREATMENT																		
PATIENT DISTRIBUTION	AGE								SEX			RACE							
PATIENT TYPE	12 - 15	16 - 17	18 - 24	25 - 44	45 - 64	65+	Unknown	Totals	Male	Female	Totals	White	Black	Hispanic	Asian	Amer. Indian	Filipino	Other	Totals
Voluntary Patient - With Informed Consent																			
Voluntary Patient - Not capable of Informed Consent																			
Involuntary Patient - With Informed Consent																			
Involuntary Patient - Not Capable of Informed Consent																			
TOTALS																			
SECTION II	**TOTAL TREATMENTS GIVEN**																		
Convulsive Treatments																			
SECTION III	**COMPLICATIONS ATTRIBUTABLE TO TREATMENT**																		
Cardiac Arrest - Nonfatal																			
Memory Loss - Reported																			
Fractures																			
Apnea																			
Death - No Coroner Report																			
Death - With Coroner Report																			
TOTALS																			
SECTION IV	**EXCESSIVE TREATMENTS**																		
Patients - Excessive Treatments																			

PREPARED BY: _____
TELEPHONE NUMBER (including area code): ( ) _____

SUBMIT TO:
County Mental Health

Director

DO NOT MODIFY THIS FORM FOR SUBMITTAL TO THE DEPARTMENT OF MENTAL HEALTH

Appendix 5

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

(Rev 1/1/09)

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, whichever is later.

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, whichever is earliest.

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, <u>whichever is earliest</u>.
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 serves as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serves 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.

SERIOUS INCIDENT REPORTING

POLICY:

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the Behavioral Health Services (BHS) Quality Improvement (QI) Unit that will review, investigate as necessary, and monitor trends. BHS-QI designated staff will communicate with program Contracting Officer's Technical Representatives (COTRs) and Mental Health Services (MHS) management staff as needed on all reported serious incidents. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Client safety is the major priority of all mental health programs. When a serious incident occurs, a structured process for handling and investigating the incident must be used to determine causative factors leading up to the event in order that future similar incidents may be prevented. In addition, this process can also help to greatly reduce risk management concerns surrounding the particular event.

A Serious Incident Report is not part of the client medical record and should never be filed in the medical record. A Serious Incident Report should be kept in a separate, confidential file.

Serious incidents are categorized as follows:

- 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.).

*****Excluding Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital (SDCPH)/Emergency Psychiatric Unit (EPU), Emergency Screening Unit (ESU), and Psychiatric Emergency Response Team (PERT).

PROCEDURE(S)

Classification of a Serious Incident:

Serious incidents shall be classified into two levels:

1. **Level One** incident is the most severe and critical requiring urgent and immediate action.
2. **Level Two** incident, although serious, is less severe and follows routine reporting procedures.

Reporting of a serious incident is based on criteria and determined severity of the serious incident.

1. Criteria for a Level One Serious Incident:

Level One incident must include at least one of the following:

- The event is associated with a significant adverse deviation from the usual process for providing mental health care.
- The event resulted in a death or serious physical injury on the program's premises.
- The event has the potential for significant adverse media (press, television, radio) involvement.

In addition, when a serious incident includes:

- The death of a client by other than natural causes
- Homicide or attempted homicide by a client
- Or a near lethal suicide attempt of a client,

the same Level One specific handling and investigation procedures must be followed.

2. Criteria for a Level Two Serious Incident:

Level Two serious incidents are all those that do not meet the severity requirements of a Level One Serious Incident.

PROCEDURE(S) Continued:

1. In the event of a serious incident the client's medical record/s will immediately be located and safeguarded by the program manager or designee. Program Manager should review chart as soon as possible and until that review is complete the client medical record will be secured in a location that is not accessible by any staff member other than the program manager or designee.

2. All program staff will maintain confidentiality about client and serious incident. The serious incident should not be the subject of casual conversation among staff.

3. Program Responsibilities for Level One Serious Incident:
    a. In the event of a Level One Serious Incident, the program manager or designee shall telephonically notify the QI Serious Incident Report Line at 619-563-2781 as soon as possible but no later than within 24 hours.
    b. The program manager or designee shall also complete a QI Serious Incident Report and fax it to the QI unit within 72 hours.

4. Program Responsibilities for Level One Serious Incident Reporting on Weekends and Holidays
    a. Level One Serious Incidents are required reporting for county- operated mental health programs on weekends and holidays to the QI Unit and designated County staff.
    b. In the event of a Level One serious incident at a County operated mental health program on weekends or holidays, the designated program staff will call the QI Serious Incident Report Line at 619-563-2781to report the incident. In addition, the designated program staff will also telephonically notify the Assistant Deputy Director for either Adult/Older Adult or Children's System of Care. If staff is unable to reach this person directly, staff will leave a detailed message of the incident with a call back number in case further information is required. The MHS Deputy Director is available as a back-up contact.

5. Program Responsibilities for Level Two Serious Incident
    a. In the event of a Level Two Serious Incident, the program manager or designee shall telephonically notify the QI Serious Incident Report Line at 619 -563-2781 within 24 hours from the time of the incident, or awareness thereof.
    b. A QI Serious Incident Report shall be completed by the program manager or designee for Level Two Serious Incidents. The QI Serious Incident Report must be faxed it to the QI unit within 72 hours.

6. Program Responsibilities for all Serious Incidents:
    a. The program manager or designee shall be responsible for reporting a Level One or Level Two Serious Incident to any other appropriate licensing, governing, or regulatory authorities as necessary.
    b. Within 30 days of submitting a QI Serious Incident Report, the program manager or designee shall submit a QI Serious Incident Report of Findings. This report may be either mailed or sent via facsimile. The QI Serious Incident Report of Findings will summarize the findings of the event, identify interventions, outcomes, and/or other improvements implemented as a result of the incident.

7. QI Unit and BHS Administration Responsibilities;
    a. The QI Unit shall immediately notify County Behavioral Health Administration of a Level One Serious Incident. This notification shall be verbal and would proceed along the following communication tree: Deputy Director, Assistant Deputy Director, Director Systems of Care, Director County Operated Programs.
    At whatever initial point in the communication tree an administrator is contacted, that individual shall have the responsibility of notifying the other non-contacted

administrators as soon as reasonably possible, and also determining if County Counsel should be informed.

b. This verbal notification to Behavioral Health Administration of a Level One Serious Incident is to be followed by an electronic mail message from the QI Unit to the administrator notified. The electronic mail message should outline the known facts of the occurrence and indicate that the contents of the message constitute a "quality improvement communication". In order to safeguard the rights of confidentiality, no staff, client names, or other personal identifying information is to be cited in the electronic mail message. The administrator receiving this electronic mail message shall have the responsibility of determining if the transmittal should be forwarded to County Counsel with a copy to HHSA Director and HHSA Chief Operating Officer. County Counsel shall review and/or report all serious incidents that may be potential quality of care concern to the following as required:

- Patient Right's Advocate.
- Center for Consumer Health, Education and Advocacy (CCHEA).
- District Attorney's Office.
- Attorney General's Office.
- California Department of Mental Health (DMH).

c. The QI Unit will track and trend Serious Incident Reports and report to the Quality Review Committee (QRC) and Mental Health Administration Executive Team.

d. When received, a copy of QI Serious Incident Report shall be forwarded to the monitor of the reporting provider.

ATTACHMENT(S):

A - Quality Improvement Serious Incident Report
B - Quality Improvement Serious Incident Report of Findings

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

1. Incident Reviewed (Please check one):

☐ Death, excluding natural causes – 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:

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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: RCA Required? ☐ YES ☐ NO RCA Completed? ☐ YES ☐ NO

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.)

Continued on Page 2

2. Post Committee Recommendations/Planned Improvements:

Continued on Page 2

Report Completed By: Date:

Program Manager Signature: Date:

Contact Email: Contact Phone:

Date Faxed to County Quality Improvement:

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County of San Diego Behavioral Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT OF FINDINGS

3. 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.)

Continued from Page 2

4. Post Committee Recommendations/Planned Improvements:

Continued from Page 2