

# San Bernardino County Mental Health Plan (MHP)

**NEW**

## FFS Provider Orientation

### ACCESS UNIT

1-888-743-1478

909-381-2420

909-421-9272 FAX

(revised 1-1-2013)



# Provider Training Topics

- MHP background
- Network Provider Credentialing
- Beneficiaries
- Initial Contact
- Out-Of-County / Value Options
- Initial Assessment
- *Specialty* Mental Health Services- Medical Necessity
- Authorization/Re-Authorization (TAR)
- Closing of Case
- Treatment Records / Clinical Documentation
- Claims / Claims Processing
- Provider Problem Resolution and Appeal Process
- Beneficiary Problem Resolution Process
- Quality Assurance / Audits





# San Bernardino County Mental Health Plan (MHP)

- What is MHP?
  - A System of Care Which provides and manages the ***Specialty Mental Health Services*** available to County of San Bernardino Medi-Cal Beneficiaries
  - County of San Bernardino Department of Behavioral Health is the county's Medi-Cal Beneficiaries' MHP.
- What does the system of care consist of?
  - Access Unit
  - DBH Outpatient Clinics
  - DBH Contract Clinics
  - The Fee-For-Service Network Providers



# BECOMING A NETWORK PROVIDER



## Qualified Providers include:

- Licensed Psychiatrists (MD/DO)
  - Licensed Psychologists (Psy.D./Ph.D.)
  - Licensed Clinical Social Workers (LCSW)
  - Licensed Marriage, Family Therapists (LMFT)
- ❖ **NOTE:** Providers must be credentialed through San Bernardino County Department of Behavioral Health to be considered an “In-Network” Provider.

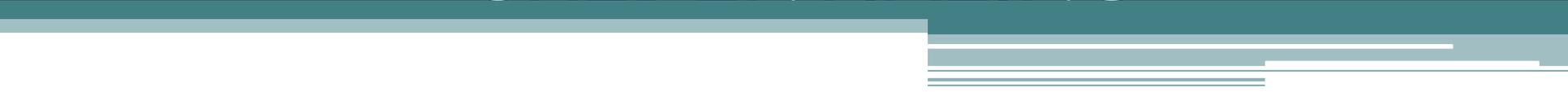
Contact Provider Relations Representative via

Telephone: (909) 873-4433 or

Email: [DBH-ACCESS@dbh.sbcounty.gov](mailto:DBH-ACCESS@dbh.sbcounty.gov)



# CREDENTIALING



# Keeping the Credential

- **Provider Relations Representative can be reached at:**
  - **Telephone: (909) 873-4433**
  - **Email: [DBH-ACCESS@dbh.sbcounty.gov](mailto:DBH-ACCESS@dbh.sbcounty.gov)**
- It is the provider's responsibility to keep his/her credentialing file updated with License, Malpractice Insurance, DEA information, and any changes related to your practice. That file is kept by the Provider Relations Representative.
  - Failure to update information will "inactivate" provider's status
  - Update Provider Information Form
    - can help with making updates easier.
- Re-credentialing takes place every 3 years



# Provider Suspensions

- If a provider is suspended or made *inactive*, then **all pending authorizations, approved reauthorizations, and existing approved authorizations for that provider are placed on hold until such time as an audit is conducted and a decision by the MHP administration is reached.**
  - This means that payment shall be suspended during the time an investigation is being completed.
- **Please note that services provided while the credential is *inactive* are not reimbursable.**
- Causes for Suspension include but are not limited to:
  - Loss of State License, DEA Certificate or Liability Policy, as applicable
  - Convictions due to illegal activity
  - Violation of ethical standards for the profession
  - Fraudulent billing/claims activity
  - Sexual involvement with beneficiary or their family members
  - Violation of the terms of the Provider Agreement for the MHP



# ANSWERING SERVICE MESSAGE

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- As an In-Network FFS Provider, your 24-hour message recording or answer service needs to include the following information:

*“If you are a San Bernardino County Medi-Cal beneficiary and need immediate assistance, call the Access Unit at 1 (888) 743-1478. If you are experiencing a life threatening emergency, please call 9-1-1”.*



# MHP BENEFICIARIES



# Who Are The Mental Health Plan Beneficiaries?

- Clients With San Bernardino County Medi-Cal Benefits
  - County Code **36** (identified on their Medi-Cal Beneficiary Identification Cards)
  - County Codes and corresponding Access Units are listed in the Provider Manual
- Medi-Cal coverage for *Specialty* Mental Health varies between counties. Limitations in coverage may apply.
  - each MHP operates differently
  - Eligibility must be checked at the end of *every* month
- Contact appropriate Medi-Cal office for questions
  - Access Unit of the Medi-Cal County of Origin



- Note: Some beneficiaries may identify themselves as having coverage from their health plans: *Molina or IEHP*.
  - Molina or IEHP are for *physical* health care.
- Check POS or the AEVS (Automatic Eligibility Verification System) at (800)456-2387.
- The State website can also verify eligibility
  - [www.medi-cal.ca.gov/Eligibility/EligResp.asp](http://www.medi-cal.ca.gov/Eligibility/EligResp.asp)



# INITIAL CONTACT



# Initial Contact Log

- When a client walks into your office or calls your office without contacting the Access Unit, an Initial Contact Log (see sample) should be filled out to show that a client contacted you first for mental health services.
  - This is a State requirement
  - **Note:** if “yes” is checked for “urgent”, a maximum response time of 2 hours is required.
- Copy of the log is sent to Access Unit on a monthly basis
  - Indicate no referrals, if none was received.
  - Logs must be available upon request.



County Of San Bernardino  
Department of Behavioral Health

INITIAL CONTACT LOG  
TELEPHONE, WALK-IN AND WRITTEN REQUESTS FOR SERVICES

NAME OF CLINIC \_\_\_\_\_

REPORTING MONTH/YEAR \_\_\_\_\_

TITLE 9 REQUIRES THAT ALL INITIAL REQUESTS FOR SERVICES MUST BE LOGGED

DATE AND TIME	** URGENT YES/ NO*	NAME OF CALLER AND RELATIONSHIP TO BENEFICIARY (Last Name, First Name)	NAME OF BENEFICIARY (Last Name, First Name)	INTERPRETER SERVICES OFFERED YES/ NO* (LANGUAGE)	*** CALLER'S RESPONSE TO OFFER OF INTERPRETER SERVICES	REASON FOR CALL	INITIAL DISPOSITION	** RESPONSE TIME TO OBTAIN URGENT SERVICES	STAFF NAME
1	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					
2	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					
3	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					
4	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					
5	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					
6	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					
7	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>					

\*\*MHP REQUIRES A MAXIMUM RESPONSE TIME OF 2 HOURS FOR ALL REQUESTS FOR URGENT SERVICES. \*\*\* ENTER 1) ACCEPTED OR 2) REFUSED

Forms are available on FFS provider website



# Beneficiary Registration

When contacted by a Medi-Cal beneficiary:

## ✓ Check eligibility

- Providers with credentials as either MD, PhD, PsyD, or DO can use the POS device or the AEVS (Automatic Eligibility Verification System) at (800)456-2387. The State website can also verify eligibility [www.medi-cal.ca.gov/Eligibility/EligResp.asp](http://www.medi-cal.ca.gov/Eligibility/EligResp.asp)
- **Please print out your verification of client eligibility and attach it to each claim for service. This will expedite payment of your claims.**

## ✓ Register beneficiary at the Access Unit

- All clients receiving services **MUST** be registered prior to the submission of an authorization request or a claim for services
- Providers must submit a [\*Beneficiary Registration Form\*](#) to register the beneficiary.
  - Please complete all items asked in the registration form to avoid delays in registration process.





## BENEFICIARY REGISTRATION SHEET



Last Name		First Name		Middle Name	
Beneficiary's Birth Name (if different from name listed above)					
Sex M <input type="checkbox"/> F <input type="checkbox"/>		Birthdate		Social Security Number	
Ethnicity (Race) (Check 2 if appropriate)			Primary Spoken Language (If Obtainable)		
White <input type="checkbox"/>	Latino <input type="checkbox"/>	Southern <input type="checkbox"/>	English <input type="checkbox"/>	Chinese <input type="checkbox"/>	Polish <input type="checkbox"/>
Black <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Asian Indian <input type="checkbox"/>	Spanish <input type="checkbox"/>	Korean <input type="checkbox"/>	Russian <input type="checkbox"/>
Native American <input type="checkbox"/>	Japanese <input type="checkbox"/>	Hawaiian <input type="checkbox"/>	Other Chinese <input type="checkbox"/>	Mandarin <input type="checkbox"/>	Portuguese <input type="checkbox"/>
Mexican American <input type="checkbox"/>	Puerto Rican <input type="checkbox"/>	Guamanian <input type="checkbox"/>	Japanese <input type="checkbox"/>	Armenian <input type="checkbox"/>	Indian <input type="checkbox"/>
Chinese <input type="checkbox"/>	Other Asian <input type="checkbox"/>	American <input type="checkbox"/>	Filipino Dialect <input type="checkbox"/>	Hawaiian <input type="checkbox"/>	Arabic <input type="checkbox"/>
Latin American <input type="checkbox"/>	Other Non-White <input type="checkbox"/>	Korean <input type="checkbox"/>	Vietnamese <input type="checkbox"/>	Mien <input type="checkbox"/>	Slovak <input type="checkbox"/>
Other Spanish <input type="checkbox"/>	Unknown <input type="checkbox"/>	Vietnamese <input type="checkbox"/>	Laotian <input type="checkbox"/>	Hmong <input type="checkbox"/>	Thai <input type="checkbox"/>
Chinese <input type="checkbox"/>	Other Southwest Asian <input type="checkbox"/>	Multiple <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Turkish <input type="checkbox"/>	Pard <input type="checkbox"/>
			Sign Language <input type="checkbox"/>	Hebrew <input type="checkbox"/>	Other Sign <input type="checkbox"/>
			Other <input type="checkbox"/>	French <input type="checkbox"/>	Unknown/not reported <input type="checkbox"/>
Home Address					
City		CA	Zip		
Mailing Address (if different than above)					
City		CA	Zip		
Home Phone			Work Phone		
Marital Status: Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Now married/remarried/living together <input type="checkbox"/> Divorced/dissolved/annulled <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					
Please indicate where the beneficiary resides. (check all that apply)					
Alone <input type="checkbox"/>	Single Room (hotel, motel) <input type="checkbox"/>	Board and Care Home <input type="checkbox"/>	Alternative to Hospitalization (<6 beds) <input type="checkbox"/>		
Family <input type="checkbox"/>	Group Quarters <input type="checkbox"/>	Small Board & Care (<7) <input type="checkbox"/>	Alternative to Hospitalization (>6 beds) <input type="checkbox"/>		
Group Home <input type="checkbox"/>	Hospital, no residence <input type="checkbox"/>	Large Board & Care (>6) <input type="checkbox"/>	SNF/ICF/Nursing home, for physical health reasons <input type="checkbox"/>		
SNF <input type="checkbox"/>	Homeless, in Transit <input type="checkbox"/>	House or Apartment <input type="checkbox"/>	Adult Res./Social Rehab <input type="checkbox"/>		
DMR <input type="checkbox"/>	Chaparral Residential <input type="checkbox"/>	SNF/ICF, for Psychiatric Reasons <input type="checkbox"/>	House or Apartment w/supervision <input type="checkbox"/>		
Charlie <input type="checkbox"/>	Chaparral Intensive <input type="checkbox"/>	House or Apartment w. support <input type="checkbox"/>	Other: <input type="checkbox"/>		
FFA <input type="checkbox"/>	Lives w/dogt Parent <input type="checkbox"/>	General Hospital <input type="checkbox"/>			
Postor Family <input type="checkbox"/>					
Please indicate the beneficiary's Legal Status:					
Voluntary <input type="checkbox"/>	72 Hour Hold for Minor <input type="checkbox"/>	Judicial Conservatorship DD <input type="checkbox"/>	Temporary Conservatorship <input type="checkbox"/>	Second 14 Day Hold <input type="checkbox"/>	
72 Hour Hold <input type="checkbox"/>	First 14 Day Hold <input type="checkbox"/>	Conservatorship of Minor DD <input type="checkbox"/>	Permanent Conservatorship <input type="checkbox"/>	Unknown <input type="checkbox"/>	
Medi-Cal Number			Education (Yrs)		
First Name of Beneficiary's Mother			Beneficiary's Place of Birth (County only if California) County: _____ State: _____ Country: _____		
Name of Primary Care Physician			Primary Care Physician Phone Number		
Is Beneficiary on Conservatorship? Yes <input type="checkbox"/> No <input type="checkbox"/>		Conservator Name			
Conservator Address			Conservator Phone Number		
Name of Provider					
Provider Phone Number			Provider Fax Number		
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Employer <input type="checkbox"/> Other					

**When completed please retain in client record and fax to (909) 421-9272**

or mail to: Access Unit, 850 E. Foothill Blvd., Rialto, CA 92376

REVISED 11/03



# OUT-OF-COUNTY MINORS



# Value Options

Administrative Services Organization (ASO)

1(800)236-0756

Value Options should be referred or contacted for the following situations:

- Minors (children up to 18 yrs old) with Other County Medi-Cal who are in out-of-family placement living in San Bernardino County.
- Minors (children up to 18 yrs old) who are in out-of-family placement, with San Bernardino County Medi-Cal, living outside of San Bernardino County.

**Note:** Not all minors qualify for services through Value Options.  
Refer to the Access Unit when in doubt.



# INITIAL ASSESSMENT

- Initial Assessment
- Medical Necessity for Specialty Mental Health Services



# Initial Assessment

- The MHP assessment is utilized for the purpose of determining the beneficiary's needs for *specialty* mental health services, i.e. meeting “Medical Necessity” for specialty mental health services.
- Providers may conduct the initial assessment without pre-authorization.
  - One (1) assessment may be billed for a new client or returning clients with over 6 months in lapse of treatment with same provider.
  - Provider must ensure registration of beneficiary by submitting a [Beneficiary Registration Form](#) prior to claim submission.



# Meeting Medical Necessity Criterion (1-4)

- 1) Diagnosed by the MHP with an included diagnosis.
- 2) Have a functional impairment as result of the diagnosis
- 3) Treatment will:
  - Significantly reduce the problem
  - Prevent significant deterioration in an important are of life-functioning
  - (For Minors) allow child to progress developmentally as individually appropriate.
- 4) The condition would NOT be responsive to physical health care based treatment.





# Included Diagnoses

- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders (Excluding Antisocial)
- Medication-Induced Movement Disorders





# Excluded Diagnoses

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communication Disorders
- Sleep Disorders
- Antisocial Personality Disorder
- Autistic Disorders
  - NOTE: other Pervasive Developmental Disorders are included
- Tic Disorders
- Delirium, Dementia, and Amnesic and other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance Related Disorders
- Sexual and Gender Identity Disorders, except Paraphilias and Gender Identity Disorders in Children which are included
- Relational Problems (V-Codes)
  - Note: Marriage therapy is not covered by Medi-Cal



# Functional Impairment Criteria

- As result of the diagnosis, the beneficiary **must have at least one (1)** of the following problems:
  - ✓ A significant difficulty in an important are of life-functioning (such as primary relationships, school behaviors or grades, job performance, housing, etc).
  - ✓ A probability of significant deterioration in an important area of life functioning.
  - ✓ For MINORS: A probability that a child will not progress developmentally as individually appropriate.



# DID NOT meet Medical Necessity?

- If beneficiary does NOT meet Medical Necessity criteria for services
  - Issue Notice of Action (NOA-A).
    - NOA-A must be hand delivered or mailed to beneficiary within 3 days of decision / assessment.
  - Submit copy of the NOA-A to Access Unit.
  - Submit Beneficiary Registration Form.
  - Submit claim for reimbursement.
  - No further Action required.



# Met Medical Necessity, But Need Refer Elsewhere?

- Met medical necessity; however, not my area of expertise or need other level of care that I can't provide.
  - Ensure appropriate referral and linkage for beneficiary by contacting Access Unit for assistance if necessary.
  - Submit Beneficiary Registration Form.
  - Submit your claim for reimbursement.
  - No further Action required.



# Met Medical Necessity, How to Continue Treatment

- Met Medical Necessity, need Treatment Authorization.
  - Submit Beneficiary Registration Form.
  - Submit Treatment Authorization Request (TAR).
    - Respond to requests for information in a timely manner.
    - Wait for authorization letter.
  - Submit your claim for reimbursement.



# AUTHORIZATION REQUEST PROCESS

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# Submitting the Authorization Request

- All Forms are available online in PDF format
- Fax the completed paperwork to the Access Unit.
- Access Unit will stamp the date received on all documents.
- The effective date for authorizations is based on the stamped date indicated on the Access Unit's receipt of the complete paperwork.
- Access Unit has 14 calendar days timeline for making authorization decisions.
  - An extension for additional 14 calendar days may be requested if necessary.





# Points to Remember



- When completing the forms:
  - Make sure to document functional impairment criteria.
  - Include a COMPLETE five-axes diagnosis using both the code *and* verbal description of diagnosis
  - Include behaviorally-specific symptoms as appropriate.
- PLEASE NOTE: the *effective date* of authorization will be the *DATE that Access Unit receives the completed request for authorization*.
  - *All required fields must be COMPLETED* in order for the request to be processed.
- Please ensure that ALL items are completed prior to submitting the request.



# Authorization Decisions

- MHP may:
  - Authorize services as requested.
    - MHP will issue authorization letter to provider.
  - Request additional information from provider.
    - MHP may request additional information to aid in authorization decisions. Prompt response to these requests will assist the process.
    - Please respond directly to the clinician reviewing the case or indicate the information is in “response” to an existing authorization request.
  - Deny or Modify services.
    - If MHP denies the authorization request, a NOA-B will be issued.

# THERAPY SERVICES



# Authorization for Therapy Services

- Authorizations are processed on 6 months cycles
  - 13 sessions is the standard frequency authorized per cycle
- Re-authorization requests can be submitted within 30 days of authorization cycle expiration date
  - i.e., authorization cycle from (1-1-13 to 5-31-13) can have a re-authorization request submitted between 5-1-13 to 5-31-13.



# Re-Authorization for Therapy Services

- If beneficiary continues to meet medical necessity for treatment after completing the initial authorization cycle, a request for re-authorization can be submitted for continuation of authorization for services.
  - Submit the TAR (checking re-authorization box) via FAX to the Access Unit.
  - Complete the TAR based on *current* information, ensuring to address “**how is treatment benefiting the beneficiary and the need for continuation of treatment**”





# PHARMACOLOGICAL MANAGEMENT



# Authorization for Pharmacological Management Services

- **FOR ADULTS**
  - Authorizations are processed on 12 month cycles
    - Standard 12 sessions authorized per cycle
- **FOR CHILDREN**
  - Authorizations are processed on 6 month cycles
    - Standard 6 sessions authorized per cycle



# CLOSING A CASE

Discharge Summary  
When to close a case?





**DISCHARGE SUMMARY**

Client Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Reason for Evaluation/Treatment: \_\_\_\_\_  
 \_\_\_\_\_

Treatment Focus and Course of Treatment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Condition at Discharge/Status of Problems Treated: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Discharge Diagnosis:

Axis I \_\_\_\_\_ Axis II \_\_\_\_\_  
 Axis III \_\_\_\_\_ Axis IV \_\_\_\_\_  
 Axis V Current GAF \_\_\_\_\_

Reason for Discharge (please check):

- |   |  |
|---|--|
| Mutual Agreement/Treatment Goals Reached <input type="checkbox"/>           | Client Withdrew: AWOL, AMA No Improvement <input type="checkbox"/> |
| Mutual Agreement/Treatment Goals Partially Reached <input type="checkbox"/> | Client Moved Out of Service Area <input type="checkbox"/>          |
| Mutual Agreement/Treatment Goals Not Reached <input type="checkbox"/>       | Discharge/Administrative Reasons <input type="checkbox"/>          |
| Client Discharged/Program Unilateral Decision <input type="checkbox"/>      | Other <input type="checkbox"/>                                     |

Discharge Recommendations/Arrangements/Appointments:

Discharge With:  No Medication  Medication \_\_\_\_\_

Discharge To:

Prognosis:  Excellent  Good  Fair/Variable  Guarded  Poor

Admission Date \_\_\_\_\_ Date of Last Service \_\_\_\_\_

Provider \_\_\_\_\_ Date \_\_\_\_\_



# When to Close a Case

- No longer meets Medical Necessity
- Client is referred to Primary Care Physician to provide maintenance therapy
- Treatment Goals Met
- AWOL, moved out of area, etc.



# CLINICAL TREATMENT RECORDS



# Treatment Clinical Records

- MHP Assessment (may use provider's own forms).
- Diagnosis Sheet
- Client Plan
- DBH Consent for Outpatient Treatment
- Advance Directive Notice
- Medication Consent Form (If Applicable)
- Progress Notes
- Medication Order Sheet (If Applicable)
- AIMS Scale (If Applicable)
- Physical Assessment Notification (If Applicable, Annually)
- Release of Information (If Applicable)
- Discharge Summary



# Treatment Records Documentation

- It is the responsibility of every MHP Provider to maintain treatment records for each Medi-Cal client served. These records are subject to periodic audit. Each form is in the manual with its description
- Documentation Standards are listed in the manual for Assessments, Client Plan, and Progress Notes
- *Progress or lack of progress needs to be addressed in the Re-Authorization requests*
  - If a psychiatric patient is stable, consider referring to the PCP for maintenance treatment.



# CLAIMS PROCESSING

- Address
- Timeline
- Requirements



# Claims Address

- Submit an ORIGINAL CMS 1500 Form to:
  - Access Unit-*Claims Department.*  
850 E. Foothill Boulevard  
Rialto, CA 92376
- CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF THE SERVICE DELIVERY DATE
- Please print out your verification of client eligibility and attach it to each claim for service. This will expedite payment of your claims.





**MEDI-CAL ELIGIBLE****CLAIMS CERTIFICATION AND PROGRAM INTEGRITY**

**HEREBY CERTIFY** under penalty of perjury to the following:

1. An assessment of the beneficiary was conducted in compliance with the requirements established in the San Bernardino County Department of Behavioral Health Provider Manual and your Provider Service Agreement with San Bernardino County Department of Behavioral Health.
2. The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.
3. The services included in the claim were actually provided to the beneficiary.
4. Medical necessity was established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service(s) provided, for the timeframe in which the service(s) were provided.
5. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the San Bernardino County Department of Behavioral Health Provider Manual and your Provider Service Agreement with San Bernardino County Department of Behavioral Health.
6. For each beneficiary with day rehabilitation, day treatment intensive or EPSDT specialty mental health services included in the claim, all requirements for payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met and any reviews for such service(s) were conducted prior to the initial authorization and any re-authorization periods as established in the Provider Manual and your Provider Service agreement with San Bernardino County Department of Behavioral Health.

\_\_\_\_\_  
Authorized Provider Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Provider



# Claims Processing (Continued)

- All claims must have either
  - the provider signature or
  - the provider may submit a “Signature Authorization Form” if they wish to assign a designee to sign the claims for them
- Providers are required to complete a Claims Certification and Program Integrity Form each time claim(s) are submitted for reimbursement. This certifies that the claim(s) are in compliance



# Claims Processing (Continued)

- If a claim is returned to the provider for correction, the correction must be completed and returned to the Access Unit within 14 days or payment may be denied
  - Claims are processed in the order they are received.
  - Payments are directly-deposited every 2 weeks.
    - EOBs are FAXed to the provider.
  - Once you have submitted a claim, allow 30 days to receive payment.
    - Inpatient services may take longer to process.
- If the TAR is denied due to Medical Necessity criteria, payment for services will be denied.



# Claims Processing (Continued)

- Medi-Cal is the payor of last resort. If the Medi-Cal beneficiary has other health coverage you are required to bill the other health coverage prior to billing Medi-Cal. Submit proof of denial of payment (EOB) from the other health coverage along with the CMS 1500 form. The date of service on the EOB must match the date of service being claimed.
- Retroactive Medi-Cal : If a client is eligible for and applies for Medi-Cal, services provided will be reimbursable IF the provider followed the MHP procedures including registering the client and requesting authorization of services, i.e. provider has operated as though the beneficiary has benefits



# Claims Processing (Continued)

What is Medi-Cal Share of Cost?

- Some beneficiaries must pay a certain amount each month toward their treatment
- POS screen shows the client's current remaining share of cost for the month
- It is the provider's responsibility to check the current share of cost, and to collect any remaining share of cost for a given month, **BEFORE** billing Medi-Cal for services



# Claims Processing (Continued)

- After each share of cost transaction, the provider must perform a SOC clearance transaction using the POS device or the AEVS system [(800) 427-1295]
- When clients have Medicare in addition to Medi-Cal, the provider should:
  - Bill Medicare FIRST
  - If claim denied, attach the EOB to the claim and submit the claim to the MHP



# Claims Inquiries

- If you receive a denial of a claim, please note the reason for the denial written on the form.
- If you have questions about the reason for denial or if you wish to appeal the denial, you may do so by following claims procedure.





San Bernardino County  
 Department of Behavioral Health  
 Access Unit  
 850 East Foothill Blvd.  
 Rialto, CA 92376  
 Fax: (909) 421-9272

Claims Inquiry Form

PROVIDER INFORMATION	
Name	
Address	
Phone #	Fax#

CLIENT INFORMATION
Date submitted:
Client Name:
Client Medi-Cal and/or Social Security#:
Date of Services:
CPT Code:
Reason for Inquire:

Requested by (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



# Provider Problem Resolution

- Complaints
- Appeal Process



# Provider Appeal Policy & Procedure

- Complaints (verbal)
- Provider Appeal Process (written)
  - Denied or modified request for payment authorization.
  - Dispute concerning the processing or payment of a claim.



# Provider Appeal Process

- Appeal must be in writing
- Must be sent to Access Unit Supervisor or Program Manager
- Must be sent within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on a request
- Program manager or designee will respond to provider within 60 calendar days of receipt of the appeal



# If Provider Appeal Granted...

- The Provider has thirty (30) calendar days from receipt of the appeal decision to submit a revised request for payment to DBH
  - Access Unit has fourteen (14) calendar days from the date of receipt of the provider's revised request to submit the documentation to the Medi-Cal fiscal intermediary



# If Provider Appeal Denied...

- If DBH does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied in full.
  - Provider has the right to appeal directly to the *State Department of Mental Health*
    - within thirty (30) calendar days from the date of the MHP's written decision of denial or
    - if the MHP fails to respond , within thirty (30) calendar days after sixty (60) calendar days from submission to the MHP.



# Beneficiary Problem Resolution

- Requirements
- Grievance
- Change of Provider
- Second Opinion
- Action Appeal
- State Fair Hearing



# Provider Responsibilities

- Maintain copies of the following in the waiting room:  
<http://www.sbcounty.gov/dbh/ConsumerInformation/ConsumerInfo.asp#>
  - Guide to Medi-Cal Mental Health Services (English/Spanish)
  - Grievance Poster (English/Spanish)
  - Grievance Forms (English/Spanish)
  - Appeal Forms (English/Spanish)
  - Request for Change of Provider (English/Spanish)
  - Request for Second Opinion (English/Spanish)
  - Envelopes Addressed to the Access Unit
  - Advance Directives Brochures
- Note that all providers are required to give clients copies of all consumer beneficiary information annually.
  - *Notice of Privacy Practices*
  - *Consent for Treatment*
  - *Advance Directive Notice at the time of the Assessment*



County of San Bernardino  
Department of Behavioral Health

**GRIEVANCE PROCESS**

You have the right to make a grievance about any aspect of your treatment at a clinic or by a Medi-Cal "Fee-for-Service" Provider (Private psychiatrist, psychologist, LCSW or LMFT). You also have the right to appeal an "Action" as taken by the County's Mental Health Plan (see below for "Action" definition).

- You may make a Grievance verbally or in writing.
- Grievance Forms and Action Appeal Forms are available in the waiting room of the clinic, or the "Fee-for-Service" Provider.
- Pre-printed envelopes are available, addressed to the *Department of Behavioral Health's Access Unit*.
- You may use an authorized representative on your behalf.
- Expedited Action Appeals may be requested if the beneficiary or the beneficiary's provider certifies that taking the time for a standard Action Appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.
- You may verbally, or in writing, file for a State Fair Hearing, after the exhaustion of an Action Appeal or Expedited Action Appeal process, whether or not, you have received a Notice of Action.

An "Action" is defined as:

1. Denial, or limiting, of an authorization of a requested service, including the type or level of service;
2. Reducing, suspending, or terminating a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failing to provide services in a timely manner, as determined by the Mental Health Plan or;
5. Failing to act within the timeframes for disposition of standard Grievances, the resolution of standard Action Appeals, or the resolution of expedited Action Appeals.

**Please note:** The County's *Problem Resolution Process*, must be exhausted, prior to the requesting of a State Fair Hearing. It is intended to resolve problems in the most prompt, efficient and effective manner possible.

If you have any questions, call the Access Unit at:

1-888-743-1478

909-381-2420

TDD: 1-888-743-1481

## Grievance Poster



# Grievance Request



# Grievance

- An expression of unhappiness about anything regarding specialty mental health services
- Beneficiaries or legal guardian / representatives may file a grievance.
- 60 days to complete
  - can request 14 days extension
- Assist with filling out grievance form- forward to Access Unit immediately.
- Access Unit will be working with clinic supervisors / program managers in attempts to resolve situation.
- Issues identified are sent to QMD
  - Founded / unfounded / customer service





County of San Bernardino  
Department of Behavioral Health

**GRIEVANCE FORM**

For Office Use Only:

Simon #

FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO THE ACCESS UNIT

288 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415-0028  
909-381-2420 • 888-743-1478 • TDD 888-743-1481 • Fax 909-421-8272

Beneficiary Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
(Please print or write clearly)

Date of Birth: \_\_\_\_\_ Gender:  M  F Preferred Language: \_\_\_\_\_

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Using Authorized Representative:  No  Yes If yes, Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Clinic or Provider: \_\_\_\_\_

Please Tell Us About Your Grievance: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How Would You Like to See Things Resolved? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Beneficiary Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Change of Provider Request



# Change of Provider

- Scenarios:
  - Beneficiary prefers to work with someone of the same culture.
  - Beneficiary prefers to work with provider of same gender, but was assigned an opposite gender provider.
  - Prefers Spanish speaking therapist versus the use of interpreter
  - Don't like the provider assigned.
  - Sometimes, no reasons given...
- The Guide to Medi-Cal Mental Health Services indicates:
  - **“You may request a change of provider at any time before or during treatment”.**



# Change of Provider

- Currently receiving specialty mental health services
- The consumer or their legal guardian / representative may request a change of provider at any time before or during treatment
- No timelines established
- The Change of Provider Form is filled out
- NOTE: if not happy, beneficiary can file Grievance however, providers are encouraged to resolve issues on the spot.





County of San Bernardino  
Department of Behavioral Health

CHANGE OF PROVIDER REQUEST FORM - SIDE 1

As a client of Department of Behavioral Health, you have the right to request a change if you are not satisfied with your current service provider. Requesting a change of provider does not put you at risk of being denied behavioral health services or having the type of services you received changed.

If you would like to request a change of provider, please fill out this form as best you can in your own words. You can get help with filling out this form from the clinic supervisor at the location where you are receiving services, from the ACCESS Unit at (888) 743-1478, or from the Patients' Rights Office at (800) 440-2391.

Once you have filled out this form, please turn it into the receptionist at the clinic where you are currently receiving services.

Date Requested \_\_\_\_\_  
Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

1. What is the name of the provider you would like to have changed?  
\_\_\_\_\_
2. Why are you asking for a change in provider?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. What type of change do you want? \_\_\_\_\_
4. Did you talk to your current provider about your request for a change?  
Yes  If yes, please complete #5      If, No  you are done.
5. What did your current provider say?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for completing this form.



County of San Bernardino  
Department of Behavioral Health

CHANGE OF PROVIDER REQUEST FORM - SIDE 2

***\*\*THIS SIDE IS FOR STAFF USE ONLY\*\****

Name of Outpatient Clinic: \_\_\_\_\_  
Clinic Response to Client Request: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approvals:

Signature _____	Clinic Supervisor	_____	Date
Signature _____	Clinic Medical Director	_____	Date

NOTE: This form should be sent to the ACCESS UNIT, 268 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415-0026 by the 5<sup>th</sup> day of the month following that in which the change was requested.



# Second Opinion Request



# Second Opinions



- When a Beneficiary seeks specialty mental health services and DID NOT meet Medical Necessity criteria; therefore, not entitled to services.
- The beneficiary or their legal guardian / representative can complete a Second Opinion Form to re-evaluate.
- There are no established timelines
- Copy of form / outcomes sent to Quality Management Division.
- NOTE: If not happy with the result of the request, beneficiary can file an Action Appeal . The “Action” they are appealing is *not meeting Medical Necessity*, even after the 2<sup>nd</sup> opinion was given.





County of San Bernardino  
Department of Behavioral Health

**REQUEST FOR SECOND OPINION**

As a Medi-Cal beneficiary, you may ask the Mental Health Plan (MHP) to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of DBH at (888) 743-1478 or write to the 268 W. Hospitality Lane Ste 400, San Bernardino, CA 92415-0920.

The MHP will provide a second opinion by a licensed mental health professional employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

Please fill out this form as best you can in your own words. If you would like help with this form, feel free to contact your therapist or physician, the Access Unit at (888) 743-1478 or the Patients' Rights Office at (800) 440-2391. Please mail or fax completed form to the Access Unit, 268 W. Hospitality Lane Ste 400, San Bernardino, CA 92415-0920, Fax (909) 421-9272.

**Note:** The beneficiary will not be subject to discrimination or any other penalty for seeking a second opinion.

Why did you originally come to the Department of Behavioral Health for help?

[Redacted text area]

Which clinic or provider did you receive services from?

[Redacted text area]

Why are you requesting a second opinion?

[Redacted text area]

Did you receive a Notice of Action letter regarding this matter?  YES  NO

Date Requested \_\_\_\_\_  
Beneficiary (Client) Signature \_\_\_\_\_ Date \_\_\_\_\_  
Beneficiary (Client) Printed Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_



DEPARTMENT OF BEHAVIORAL HEALTH

NOTICE OF ACTION  
(ASSESSMENT : NOA-A)



Date: \_\_\_\_\_

To: \_\_\_\_\_ Medi-Cal Number \_\_\_\_\_

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

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

- Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).
- Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).
- The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).
- Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of the San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 268 W. Hospitality Ln, Ste 400, San Bernardino, CA, 92415-0026.

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

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of The San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 268 W. Hospitality Ln, Ste 400, San Bernardino, CA, 92415-0026.

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of the San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 268 W. Hospitality Ln, Ste 400, San Bernardino, CA, 92415-0026 or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, you may call and talk to a representative of the San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 268 W. Hospitality Ln, Ste 400, San Bernardino, CA, 92415-0026.

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

YOUR HEARING RIGHTS

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

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

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the 1<sup>st</sup> box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing

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

State Regulations Available

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

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:  
Call toll free: 1-800-952-5253  
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representatives

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

Information Practices Act Notice (California Civil Code Section 1798, et. seq.)

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

HOW TO ASK FOR A STATE HEARING

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

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

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

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the The San Bernardino County Department of Behavioral Health.

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

Here's why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

My name: (print) \_\_\_\_\_

My Social Security Number: \_\_\_\_\_

My Address:(print) \_\_\_\_\_

My phone number: ( ) \_\_\_\_\_

My signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Notice of Action-A  
(Assessment)



# Action Appeal Request



# What are “ACTIONS”

When the MHP performs one of the following “Actions”:

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

The MHP issues a *Notice of Action*, to the beneficiary.



# Action Appeal Process

- An oral or written request for review of an action (as action is defined).
  - **NOTE:** an oral appeal must be followed up in writing
- Only Medi-Cal beneficiaries have access to this process, not providers. Beneficiaries or their legal guardian /representatives can file the request.
- 45 days (standard process) or 3 days (expedited)
- Access Unit will handle the review and decision for appeals.
- All parties notified verbally and in writing of outcome.
  
- **NOTE:** if not happy, beneficiary can file Grievance
  - After beneficiaries have exhausted all DBH processes, beneficiary may file for State Fair Hearing (within 90 days of Action Appeal decision)





County of San Bernardino  
Department of Behavioral Health

**ACTION APPEAL FORM**

FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO THE ACCESS UNIT

268 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415-0026  
909-381-2420 • 888-743-1478 • TDD 888-743-1481 • Fax 909-421-9272

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  M  F Preferred Language: \_\_\_\_\_

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Using Authorized Representative:  No  Yes if yes, Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Clinic or Provider: \_\_\_\_\_

Did you receive a Notice of Action?  Yes  No

Did you receive an action as defined as one of the following?

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

If yes, how would you like the Access Unit to review the Action?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: The  
Access Unit  
Fax Number  
is  
**(909) 421-9272**



# State Fair Hearing (SFH) Request

Department of  
**SOCIAL SERVICES**

CDSS





# What is a State Fair Hearing?

- A request for an *independent review* conducted by the California Department of Social Services.
- This *independent review* is called the State Fair Hearing (SFH).
- It is in front of an Administrative Judge ruling on whether the MHP has met or violated its contractual agreement with the State in regards to the provisions of specialty mental health services to its Medi-Cal beneficiaries.



# State Fair Hearing Request

- After **exhausting** the County's Problem resolution Processes (Appeals and Grievances)
- Only *Medi-Cal beneficiaries* can file for a SFH
- Must file within 90 days after Action Appeal decision.
- State has 90 days (standard SFH) or 3 days (expedited SFH) to complete process.
- **NOTE:** Client is eligible to continue receiving services, while waiting for the outcome of the SFH, but **MUST** request a SFH within 10 days of Action Appeal decision.



# Where to file SFH?

State Hearing Division California Department of Social Services

P.O. Box 944243

Mail Station 19-37

Sacramento, CA 94244-2430

(800)952-5253

TDD- (800)952-8349

- NOTE: beneficiaries **must have exhausted** the county's problem resolution process prior to being eligible for filing for a State Fair Hearing.





# Quality Assurance

- Compliance Program
- Quality Improvement
- Audit
- Satisfaction survey



# Compliance Program/ Quality Improvement

- The San Bernardino Mental Health Plan Compliance and Quality Improvement Program is committed to maintaining and improving the quality of the clinical care, which it provides to beneficiaries, as well as the quality of the administrative services, which it offers
- The MHP has established a quality improvement process to review and monitor the quality of care provided by credentialed MHP providers, as well as to insure their adherence to State and Federal regulations, MHP requirements and licensing and professional standards. The quality improvement monitoring activities focus on clinically significant issues which affect beneficiaries, including:



# Compliance Program/ Quality Improvement (Continued)

- Accessibility of services
- Timeliness of services
- Service delivery capacity
- Cultural sensitivity and linguistic appropriateness of services
- Beneficiary, family and provider satisfaction
- Coordination and continuity with physical healthcare
- Evaluating beneficiary grievances, appeals and requests for State Fair Hearings
- Reviewing Provider Appeals



# MHP Audits

- MHP has established qualitative and quantitative measures to monitor the services rendered by MHP providers.
- Quality of care issues may be identified through periodic audits by members of the Access, Quality Management or Compliance staff, or through quality improvement activities.
- Quality Improvement Department will review the findings and issues involved and recommend appropriate corrective actions



# Plan of Correction

- FFS Providers are required to submit a plan of correction in a timely manner when requested to do so by the Access Unit.
- Failure to correct deficiencies will result in being placed on inactive status, followed by suspension or termination of MHP provider status.
- Access Unit is responsible for preparing authorization documents for regular audits conducted by the State.
  - If irregularities are noted, an internal audit may be conducted



# MHP Provider Satisfaction Survey

- Provider Satisfaction surveys are conducted annually and will be available online during the survey periods.



# Any Questions

**Contact:**

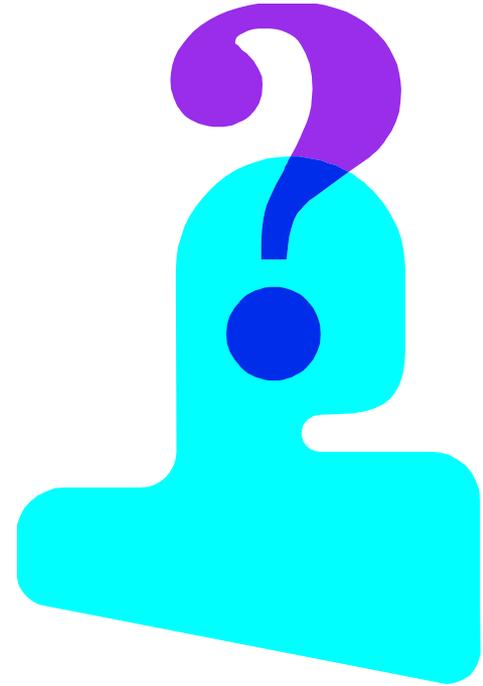
## ACCESS UNIT

When calling, please direct clerical/fiscal questions to the fiscal supervisor and clinical questions to the clinician named on your authorization-correspondence

**(888) 743-1478**

**(909) 381-2420**

**(909)421-9272- FAX**



# FFS Provider Orientation Training Acknowledgment



**FFS Provider Orientation Training Acknowledgment**

I, \_\_\_\_\_, have received and read a copy of the  
(Print name clearly)  
 County of San Bernardino Medi-Cal Fee-For-Service (FFS) Provider Manual and  
 MHP Provider Training materials. I understand its contents, and acknowledge my  
 responsibility to adhere to the policy and practices described therein.

\_\_\_\_\_  
 Provider Signature and License Number      \_\_\_\_\_  
 Date

- **Thank You** for participating in the MHP Provider Network.
- Please take a moment to complete the **FFS Provider Orientation Training Acknowledgment** Form (available on our website), and submit copy to our Provider Relations department to complete your credentialing process.