SAN BERNARDINO COUNTY
Behavioral Health
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Transition of Care Standards Procedure

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Purpose

To provide procedural guidance to Department of Behavioral Health (DBH) and contract agency substance use disorder (SUD) providers regarding the process for Transition of Care Standards for Drug Medi-Cal Organized Delivery System (DMC-ODS).

Transition of Care Right

DBH SUD clients are entitled continued access to services during the following transitions:

- From State Plan Drug Medi-Cal (DMC) to DMC-ODS or
- From one DMC-ODS county to another DMC-ODS county.

These transitions are required when a client, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
SUD clients are entitled to the following:

- Access to services consistent with the access they previously had, and permitted to retain their current provider for a period of time if that provider is not in the county's DMC-ODS network;
  - Including continued services with an out of network provider when the new provider's assessment determines that in the absence of continued services, client would suffer serious detriment to their health or be at risk of hospitalization or institutionalization, and
  - Referral to appropriate providers of services that are in the network.

Criteria for Eligibility

Clients seeking to continue receiving DMC-ODS services with an out of network provider during a transition from State Plan Drug Medi-Cal (DMC) to DMC-ODS, or transition from one DMC-ODS county to another DMC-ODS county shall be approved to continue receiving those services as follows:

- DBH Substance Use Disorder and Recovery Services (SUDRS) determines through its assessment that moving a client to a new provider would result in serious detriment to the health of the client, or would produce a risk of hospitalization or institutionalization;
- SUDRS is able to independently determine that the client was receiving treatment from the out of network provider prior to the client's date of transition to the County DMC-ODS plan;
- The out of network provider is willing to accept the higher of SUDRS' contract rates or DMC rates for the applicable DMC-ODS services;

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Criteria for Eligibility, continued

- The out of network provider meets SUDRS' applicable professional standards, and no quality of care issues can be documented to the extent that the provider would be ineligible to provide services to any DMC-ODS clients;
- The provider is verified as a current DMC certified provider, and
- The out of network provider supplies SUDRS with the following relevant treatment information, consistent with state and federal privacy laws and regulations:
  - Documentation of medical necessity and a qualifying diagnosis;
  - Copy of the current treatment plan, and
  - All relevant outcomes data.

DMC-ODS services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding twelve (12) months.

Transition of Care Standards Requests

Clients, their authorized representatives, or their current provider may submit a request to SUDRS to retain their current provider through SUDRS or DBH SUD contract agencies or by calling the 24-hour Substance Use Disorder Helpline at 800-968-2636 (TTY 711) to make the request.

The request may be in person, in writing or be taken via telephone. If a client needs assistance in the completion of the Out of Network Services Request form (QM039), they can request from the DBH SUD providers or they can call the above phone number. Assistance may include providing the client with oral interpretation and auxiliary aids.

How to Submit

SUDRS clinics and contract agencies providers shall upon receipt of the form submit to the DBH mailbox: DBH-OutofNetwork@dbh.sbcounty.gov.

Upon receipt of the request, DBH's Quality Management (QM) division shall forward the request to SUDRS who will send the client written acknowledgement regarding receipt of the request within three (3) working days of the request.

Approval Process

If SUDRS and the out of network provider are able to enter into a suitable arrangement for transitioning care for a given client, SUDRS shall permit client to have access to that provider for the length of the continuity of care period, as deemed medically necessary, unless the out of network provider is only willing to provide services to the client for a shorter timeframe. In this case, SUDRS shall allow the client to have access to that provider for the shorter period of time, as established by the out of network provider.

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Approval Process, continued

Within seven (7) calendar days of approving a Transition of Care request, SUDRS shall notify the client of the following in writing:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the client's care at the end of the continuity of care period; and
- The client's right to choose a different provider from SUDRS' provider network.

Additionally, SUDRS shall submit the required DMC-ODS Provider Form to the Master Provider File unit with the Department of Health Care Services (DHCS) to ensure reimbursements for claims submitted by the out of network provider.

At any time, clients may change their provider to an in-network provider regardless of whether a continuity or care relationship has been established. When the continuity of care agreement has been established, SUDRS shall work with the provider to establish a care plan for the client.

Denial Process

SUDRS may deny a client's request to retain their current provider under the following circumstance:

- SUDRS has documented quality of care issues with the DMC provider.

If SUDRS denies a client's request to retain their current provider based on the above reason, SUDRS shall notify the client of the denial in writing, offer the client at least one in-network alternative provider that offers the same level of services as the out of network provider, and inform the client of their right to file a grievance if they disagree with the denial.

If SUDRS offered the client multiple in-network provider alternatives and the client does not make a choice, then SUDRS shall refer or assign the client to an in-network provider and notify the client of that referral or assignment in writing.

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Retroactive Approval of Out of Network Services

SUDRS shall retroactively approve a Transition of Care request and reimburse out of network providers for services that were provided if the request meets all the Transition of Care requirements described in this procedure and the services that are the subject of the request meet the following requirements:

- Services occurred after the client's enrollment into the DBH DMC-ODS, and
- Dates of services are within thirty (30) calendar days of the first service for which the provider is requesting retroactive continuity of care reimbursement.

Retroactive continuity of care reimbursement requests shall be submitted in writing within thirty (30) calendar days of the first service to which the request applies.

Transition of Care Request Completion Timeline

Each Transition of Care request shall be completed within thirty (30) calendar days from the date SUDRS received the request. Retroactive claims for services from the date of request shall be processed as described on this procedure.

A Transition of Care request is considered completed when:

- SUDRS notifies the client, in the manner outlined in this procedure, that the request has been approved; or
- The client has either selected or been assigned to an in-network provider after SUDRS notified the client that the request was denied.

Termination of Transition of Care

SUDRS shall notify the client in writing thirty (30) calendar days before the end of the Transition of Care period about the process that will occur to transition the client's care to an in-network provider at the end of the Transition of Care period. This process includes engaging with the client and affected provider(s) before the end of the Transition of Care period to ensure continuity of services through the transition to an in-network provider.

Courtesy Dosing Standards

Opioid Treatment Programs/Narcotic Treatment Programs (OTP/NTP) Programs may provide replacement narcotic therapy to short term (less than 30 days) visiting patients approved to receive services on a temporary basis as permitted by regulations, specifically California Code of Regulations (CCR), Title 9, Sections 10295 and 10210 (d).

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Courtesy Dosing Standards, continued

- When a client is going to be traveling, and is not eligible for take home dosing, the home clinic shall identify an OTP/NTP clinic near the client's area of travel by:
  - First, checking the DBH OTP/NTP Contractors list for an OTP/NTP clinic near the client's area of travel, or
  - If there is no DBH contracted OTP/NTP clinic near the client's area of travel, locate a licensed OTP/NTP clinic in the State of California Narcotic Treatment Program Directory.
- When an OTP/NTP clinic near the client's area of travel has been identified:
  1. The home clinic contacts the receiving clinic to ensure they will accept the visiting client;
  2. The home clinic completes their clinic's courtesy dosing form, which is then signed by the client's doctor and faxed to the receiving clinic;
  3. The doctor at the receiving clinic reviews the courtesy dosing form and accepts responsibility for the client by signing and dating the form;
  4. The receiving clinic faxes the courtesy dosing form back to the home clinic, and
  5. The completed courtesy dosing form is retained by the home clinic in the client's medical record.

The client will then be able to receive courtesy dosing services at the receiving clinic.

Reimbursement for Out of Network Services

The reimbursement procedures and the roles and responsibilities of DBH staff for Transition of Care requests are listed below for out of network services:

Role	Responsibility
Applicable SUDRS staff	• Contacts the out of network provider to obtain invoice and supporting documents; • Reviews and approves or requests correction of the invoice and supporting documents once received from provider, and • Provides written notification to Fiscal staff to process payment to an out of network provider.
Fiscal staff	• Processes payment upon receipt of approved documents from QM.

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Reimbursement for Out of Network Services, continued

The following are the reimbursement processes for Courtesy Dosing:

- Claims for courtesy dosing services by DBH contracted OTP/NTP clinics are paid through the contract
- Claims for courtesy dosing services by non-contracted OTP/NTP clinics are reimbursed as follows:
  - The receiving clinic submits claims for courtesy dosing services to the client's home clinic, and
  - The home clinic submits the claims to DHCS through the DBH Behavioral Health Management Information System.

DBH shall coordinate with out of network providers for payment purposes and ensure the cost to the client is no greater than it would be if the services were furnished within DBH's provider network.

Outreach and Education

SUDRS shall inform clients of their Transition of Care protections and shall include information about these protections in client information packets and handbooks. This information shall include how the client and provider initiate a Transition of Care request with SUDRS. SUDRS shall translate these documents into threshold languages and make them available in alternative formats, upon request. SUDRS shall provide training to call center and other staff who come into regular contact with clients about Transition of Care protections.

Prohibition

An out of network provider that has been approved to continue to provide care to a client as described above, shall work with SUDRS and its contracted network and shall not refer the client to another out of network provider without authorization from SUDRS. In such cases, SUDRS shall make the referral, if medically necessary, and if SUDRS does not have an appropriate provider within its network.

Reporting

SUDRS shall report every request to retain a current out of network provider, including approved and refused requests, in the quarterly Grievance and Appeals log. This submission will be sent to DHCS mailbox ODSSubmissions@dhcs.ca.gov.

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Related Policy or Procedure	DBH Standard Practice Manual and Departmental Forms: • Out of Network Services Request form (QM039) • Timely Access Policy (QM6041) • Timely Access Procedure (QM6041-1) • Network Adequacy Monitoring Policy (QM6043) • Network Adequacy Monitoring Procedure (QM6043-1) • Out of Network Access Policy (QM6044) • Out of Network Access Procedure (QM6044-1) • Continuity of Care Procedure (QM6044-2) • Service Availability Policy (QM6046)
Reference(s)	• California Code of Regulations (CCR), Title 9, Sections 10295 and 10210 (d) • California Department of Health Care Services Mental Health and Substance Use Disorder Services Information Notice No. 18-051 • DBH mailbox: DBH-OutofNetwork@dbh.sbcounty.gov • DHCS mailbox ODSSubmissions@dhcs.ca.gov • State of California Narcotic Treatment Program Directory