Behavioral Health Services Department
Provider Manual

COUNTY OF SANTA CLARA
Behavioral Health Services

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The County of Santa Clara Behavioral Health Services Department Provider Manual covers the operations of the BHSD Provider Network.

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Chapter 1: Introduction

1.1 Introduction to BHSD

County Health System, Behavioral Health Services Department

It is the mission of the Health System to provide leadership in developing and promoting a healthy community through a planned, integrated health care delivery system that offers prevention, education, and treatment programs to all residents of Santa Clara County, regardless of ability to pay. The Health System provides a wide range of primary and specialty medical services and oversees public programs for the health and well-being of all County residents.

The BHSD's mission includes assisting individuals in the community affected by mental illness, serious emotional disturbance, and substance use disorders to achieve their hopes, dreams, and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, and most accessible environment within a coordinated system of community and self-care. Services must also be respectful to the client, their family and loved ones, and consider language, culture, ethnicity, gender, and sexual identity.

The BHSD believes without reservation that:

- All people have the right to mental health and well-being;
- All people must be treated with fairness, respect, and dignity in a culturally and linguistically competent way;
- Consumers will actively participate in their own recovery and treatment goals;
- Consumers and their families will be at the center in the development, delivery, implementation, and evaluation of their treatment;
- The system of care must have a structure and process for ensuring services access to needed services for potential and current consumers; and
- All people must have access to the highest quality and most effective integrated services.

The BHSD system is successful in helping to ensure that residents in need of public behavioral health services are:

- Physically and emotionally healthy, happy, and thriving;
- In a safe and permanent living situation;
- Part of a loving and supportive social network;
- Involved in meaningful school, work, and daily activities;
- Free from trouble or causing harm to others; and
- Safe from harm from the environment or others.

1.2 About this Provider Manual

Participating Providers[1] are responsible for adhering to the applicable requirements set

[1] A County, Individual Provider or County Contracted Provider (CCP) that has agreed to contract with the BHSD Plan to provide eligible services to Beneficiaries covered by its plan.

forth in the Participating Provider's Agreement with BHSD, applicable laws and regulations, and the Provider Manual.

This Manual serves as an administrative guide outlining BHSD's policies and procedures governing network participation. The Manual is posted on BHSD's website, https://bhsd.sccgov.org/home. Providers may email BHSDBusinessOffice@hhs.sccgov.org to request a printed copy of the Manual.

1.3 Changes to the Provider Manual

The Provider Manual may be revised from time to time to reflect changes in state regulations, BHSD processes, and updates to best practices. BHSD provides notice of changes to the Provider Manual by letter or electronic notification to the contact listed in the provider's service agreement. This notice will identify the changes that County has determined are material such that they change would affect the provider's scope of work, reimbursement mechanism, or the terms of their agreement with BHSD. This notice will be provided at least thirty (30) business days prior to the date when the change will be made to the Provider Manual. If the changes to the Provider Manual that are necessary to comply with state or federal law or regulations the notice may be less than thirty (30) business days if a shorter time for compliance is required. All contracted providers have the right to review, submit comments, and make recommendations on any proposed changes. BHSD and contracted providers will meet discuss proposed changes with the intention to reach consensus. If the Parties are unable to agree to the change within the foregoing thirty (30) business day period the Contractor may terminate the applicable service Agreement with the County pursuant to Article 2 Section 8 of that Agreement.

1.4 Quality Improvement Efforts Focus on Integrated Care

BHSD is committed to improving the quality of all its services, processes, and programs; thereby, the Quality Management (QM) Division delineates the structures and methods used to monitor and evaluate these improvements. An array of teams and committees within and affiliated within QM provide structure for the quality management and oversight responsibilities of the organization. QM is a compilation of several specific departments, committees, and individuals:

- Executive Team, Behavioral Health Quality
- Improvement Committee (BHQIC)
- System of Care (SOC)
- Learning Partnership training (LP)
- Network Management
- Clinical Practice Guidelines Committee

Collectively, these groups provide information and evaluation of current processes, identify areas for improvement, and assist with the department complying with state and federal mandates related to behavioral health services.

Chapter 2: Network Operations

2.1 Network Operations

BHSD's Contracts Administration and Business Office is responsible for procurement and administrative management of BHSD's behavioral health provider network, which include site certification and credentialing functions. BHSD has designated Valley Health Plan (VHP) as the Managed Services Organization (MSO) to perform the credentialing activities.

2.2 Contracting and Maintaining Network Participation

A "Participating Provider" is an individual practitioner, contracted agency, or County provider that has been credentialed by and has signed an Agreement with BHSD. Participating Providers agree to provide mental health and/or substance use services to Beneficiaries, accept reimbursement directly from BHSD according to the rates set forth in the budget attached to each provider's Agreement, and adhere to all other terms in the Agreement, and follow the provisions in this provider manual.

2.3 Practitioner Credentialing

Credentialing Scope

The purpose of the BHSD credentialing and re-credentialing process is to ensure that the BHSD maintains a high-quality mental health and substance use disorder service delivery network that meets all federal and state regulatory requirements. The credentialing and re-credentialing processes support this goal by validating the professional competency and conduct of the BHSD's participating practitioners (licensed, unlicensed, registered, waivered and/or certified professionals). This includes verifying licensure and board certification, (when applicable), education, and identifying any existing adverse actions, including malpractice or negligence claims, against any applicant practitioners through the applicable state and federal agencies, facility site reviews, and the National Practitioner Data Bank (NPDB). Any provider that applies to become or continue as a BHSD participating practitioner must meet the criteria established by the BHSD, all applicable government regulations, and all applicable standards of accrediting bodies. The BHSD adheres to the credentialing and re-credentialing standards promulgated by the National Committee for Quality Assurance (NCQA), and as may be amended from time to time.

All licensed, waivered, registered, and certified practitioners that provide mental health and/or substance use disorder services under contract with the BHSD are required to be credentialed. It is the practitioner's responsibility to maintain current credentials. VHP conducts re-credentialing on behalf of the BHSD at a minimum of every three years (36 months) to ensure the quality of the BHSD network. Please reference the disciplines and taxonomies for accepted credential types posted on the BHSD website and can be found on this link: [Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)]()
A practitioner's failure to maintain current credentials will result in the termination of privileges to render services and receive reimbursement for such services provided to Medi-Cal beneficiaries. Services rendered, prescribed, or ordered by a suspended or ineligible Medi-Cal practitioner are not paid or reimbursed by Medi-Cal while the suspension or ineligibility is in effect.

The BHSD must ensure that its participating practitioners are qualified to provide services in accordance with current legal, professional and technical standards and are appropriately licensed, registered, waivered and/or certified under all applicable State and Federal guidelines such as DHCS Information Notice 18-019 Provider Credentialing and Re-credentialing for MHP and DMC-ODS Counties as may be amended from time to time, and any subsequent or related notices.

Delegation to Valley Health Plan

The BHSD has delegated its credentialing and re-credentialing activities to Valley Health Plan (VHP), which is licensed as a full-service health plan under the Knox-Keene Health Care Service Plan Act of 1975 and a department within the County of Santa Clara. Integral in this delegated credentialing function is the formal process by which VHP will confirm a practitioner's credentials and qualifications through verifications conducted by a California licensing, certification, registration Board, to ensure that a practitioner has met all the education, training, and experience requirements to join the BHSD network.

Credentialing Application Requirements

A. Licensed, certified, and registered practitioners, including associate levels

All licensed, certified, and registered practitioners, including associate levels are required to submit a credentialing application through CAQH ProView

Please reference the disciplines and taxonomies for the specific provider types that are required to complete the CAQH application posted on the BHSD website, which can be found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org) Sample provider types are listed below.

- Medical Doctor (MD)
- Professionals of the Healing Arts (PHA)
- Alcohol/Drug Counselor (ADC)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Marriage/Family Therapist (MFT)
- Professional Counselor (PC)
- Certified Peer Support Specialist (PSS)

The County utilizes the Council for Affordable Quality Healthcare® (CAQH) to obtain credentialing applications for professional providers. If you have not completed a CAQH application, you can locate the registration information and access the website through https://proview.caqh.org/PR/Registration. If you already have a CAQH credentialing application and number, please log into CAQH (www.caqh.org) to attest that your credentialing application is current. In order for VHP to access your information in CAQH, select "Yes. Release my data to any organization that requests access."

If you require assistance, please feel free to contact the CAQH Provider Help Desk:
Chat: https://proview.caqh.org/PR Chat hours: Monday – Friday: 8:00 AM to 6:30 PM (Eastern)

Phone: 1(888) 599-1771 Phone hours: Monday – Friday: 8:00 AM – 8:00 PM (Eastern)

The CAQH ProView application collects the required credentialing documentation for licensed practitioners. The CAQH application is a secure web-based tool that collects and stores data related to the professional background of the licensed practitioner. Submit Credentialing Request Form once CAQH is completed and include the CAQH ID number for processing.

To begin the credentialing process, applications must be completed and submitted to VHP at: BHSDCredentialing@vhp.sccgov.org. VHP may request supplemental documentation to continue the credentialing process.

B. **Unlicensed practitioners such as paraprofessionals, mental health rehabilitation specialists, trainees and interns**

All unlicensed practitioners such as paraprofessionals, mental health rehabilitation specialists, trainees and interns are required to submit a credentialing application through the County of Santa Clara Participating Practitioner Application (CSCPPA).

Please reference the disciplines and taxonomies for the specific provider types that are required to complete the CSCPPA posted on the BHSD website and can be found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)Sample provider types are listed below.

- Paraprofessional (- or + 2 Years)
- Mental Health Rehabilitation Specialist (MHRS)
- Intern and Trainees for validation

C. County Employed Psychiatrists

For Psychiatrists employed by the County, privileging will be completed by Valley Medical Center who will then coordinate credentialing with Valley Health Plan.

<u>Minimum Qualifications for Initial Credentialing</u>

1. All licensed, certified and registered practitioners, including associate levels must submit the most updated version of the application developed by the CAQH and all applicable supplemental documents including a copy of professional liability insurance. Unlicensed practitioners must submit a completed, signed, and dated CSCPPA and all applicable supplemental documents including a copy of professional liability insurance.

2. All practitioners must complete a questionnaire attesting to the correctness and completeness of information included in the credentialing application. The attestation questionnaire includes:
    a. A minimum of five years' work history for new professional practitioners. If practitioner was licensed or completed training within the past five years, then the time frame begins at the completion of licensure or training. Employment gaps of six months or longer are researched and an explanation is required to be

documented in VHP’s permanent credentialing file by the credentialing staff. Gaps of one year or longer must be explained by the provider applicant in writing.

   b. Reasons for any inability to perform the essential functions of the position, with or without accommodation.
   c. Absence of current illegal drug use.
   d. History of loss of license, medical malpractice issues, or felony convictions.
   e. History of loss or limitation of privileges or disciplinary actions.

3. Unlicensed practitioners such as paraprofessionals, mental health rehabilitation specialists, trainees and interns must include a copy of a current Curriculum Vitae or complete work history with the County of Santa Clara Participating Practitioner Application (CSCPPA) packet.

4. Licensed practitioners must maintain a valid, current, and unrestricted license to practice and/or provide mental health and substance use disorder services in California. The license must have been obtained from the State of California from the appropriate licensing board.

5. All participating practitioners must maintain the appropriate certification.

6. Licensed practitioners must have the appropriate license for their current practice, that is free of any sanctions, and must not have had a revocation or suspension of license or clinical privileges. Practitioners with any current or past restrictions or limitations imposed upon the exercise of clinical privileges or any change in appointment of clinical privileges while serving as part of BHSD’s service delivery network, must inform VHP during the credentialing process.

7. Psychiatrists must have completed a specialty residency program, be certified by the American Board of Medical Specialties (ABMS), or other accrediting body (individually and collectively referred to as “Board”) acceptable to BHSD. Psychiatrists who are not Board certified at initial credentialing, must be Board certified by the next credentialing cycle or provide a written explanation to the Credentialing Committee regarding the lack of Board certification.

8. Psychiatrists must have a current medical staff appointment at one or more of the BHSD’s participating facilities for services to be performed at these facilities. Non-contracted psychiatrists who have an arrangement with a BHSD contracted psychiatrist to facilitate admission at one or more of the BHSD’s participating facilities are also acceptable.

9. For prescribers who are required to have a federal Drug Enforcement Agency (DEA) Certificate to perform contractual functions, the prescriber must possess a verified, current DEA number. All participating practitioners must demonstrate to the satisfaction of BHSD the capability to provide mental health and substance use disorder services that meet the standards established by BHSD.

10. All participating practitioners are responsible for organizing a structure and plan for supportive health care resources and services, advice, and supervision seven days a

week and 24 hours a day.

11. Within the five-year period preceding the date of the participating practitioner's credentialing application, the participating practitioner's medical staff appointment or clinical privileges have not been denied, revoked, or terminated by any health care facility, if applicable.

12. During the five-year period preceding the date of the practitioner's credentialing application, no more than two legal actions have been commenced and the aggregate amount of the resulting judgments and/or settlements were $100,000 or more.

13. All participating practitioners must be in good standing and must not be excluded from any State or Federal health care programs a The Office of Inspector General (OIG) has the authority to exclude practitioners from Federally funded health care programs.

14. Providers are required to notify BHSD and VHP of any of the following statuses at anytime they are participating as a BHSD provider:

    - Surrender, revocation, or suspension of a license or DEA registration;
    - Exclusion from any federal program for payment of physical or behavioral health care services;
    - Filing of any report regarding the provider to NPDB or with a state licensing or disciplinary agency;
    - Change of a provider's status that results in any restrictions or limitations; or
    - External sanction or corrective action levied against a provider by a governmental entity.

Such notice shall be sent in writing to BHSDBusinessoffice@hhs.sccgov.org and BHSDCredentialing@vhp.sccgov.org.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting the criteria for practitioner and provider participation in BHSD's network. The Credentialing Committee is also responsible for oversight and direction of the credentialing process, including provider participation, denial, and termination.

VHP's Credentialing Committee consists of the CMO, or their designee, and at least three contracted provider practitioners representing multiple behavioral specialties or practice types. The BHSD Medical Director and the Behavioral Health Utilization Program Manager are also members of the committee and designees of the CMO to review special consideration. Credentialing Committee meetings shall be held at least monthly on the third Wednesday of each month. Meetings may be rescheduled or cancelled due to unusual circumstances. Additional meetings may be scheduled as deemed necessary. Practitioners are notified in writing of the Credentialing Committee's decision within 30 calendar days or as required by California law.

Notification of Credentialing Decision to Practitioners

All applicants who have submitted a completed application for participation (initial or re-credentialing), and have been presented to the Credentialing Committee, will be notified in writing of the credentialing decision within 30 calendar days of the Credentialing Committee meeting.

Credentialing Process Timeline

The 14-calendar day turnaround time for processing a provider application for credentialing begins when an application is completed and does not need additional information. Providers who have issues that need monthly committee review will not qualify for 14-calendar day process.

Re-credentialing

In compliance with regulatory standards, VHP re-credentials practitioners at least every 36 months from the date of the initial or previous credentialing decision. The re-credentialing process incorporates reverification and identification of changes in the practitioner's license, sanctions, certifications, malpractice reports, health status, and/or performance information, such as professional conduct and competence. The re-credentialing process includes primary source verification.

In between credentialing cycles, VHP conducts ongoing or continuous monitoring activities of participating practitioners. This includes an inquiry to the appropriate and applicable regulatory agencies if/when VHP identifies newly disciplined practitioners with an expired license or negative licensure status. Additionally, VHP reviews monthly reports released by the OIG and DHCS Suspended and Ineligible List and applicable sanction databases to identify network practitioners that have been newly sanctioned or excluded from participation in any state or federal health care program. If VHP finds that a provider or practitioner has been identified by one of these sources, the provider will be termed from BHSD's service delivery network.

A Provider's Agreement may be terminated at any time if the Credentialing Committee determines that the practitioner no longer meets the minimum credentialing standards and requirements.

VHP will access CAQH to obtain an updated application to re-credential licensed professionals. Unlicensed professionals going through the re-credentialing process are required to complete and submit a signed, current CSCPPA, attestation questionnaire, and release of information page. Practitioners whose relationship with BHSD terminates or expires, and who return 30 or more calendar days after the termination/expiration date, will be required to repeat the initial credentialing process.

National Provider Identification and Taxonomy (NPI)

All practitioners are required to have an NPI. Practitioners, who do not have an NPI, will not be credentialed and will be unable to receive reimbursement for services. To apply for an NPI, go to the National Provider and Plan Enumeration System (NPPES) website. During the process of applying for an NPI, practitioners will need to submit their taxonomy code, which is associated to the license or certification they possess. To look up the taxonomy code that is related to a specific license or certification, go to Taxonomy List (Link:

https://taxonomy.nucc.org/)

Protection of Practitioner Rights

Applicants have the following rights:

1. Review information submitted to support the credentialing application, including primary source verification. A request to review must be made in advance to the Credentialing Department. However, the applicant may not review the checklist used to document the dates verifications were completed or the name of the Credentialing Specialist who completed the verifications.

2. Correct erroneous information: After completion of verification of the required elements as listed, VHP Credentialing staff will notify the applicant in writing within 10 business days of finding any discrepancy between the submitted material and information obtained through the verification process. The applicant has 15 business days to reply regarding discrepancies. Applicants may submit corrections to the Credentialing Specialist through secure e-mail to BHSDCredentialing@vhp.sccgov.org A written response of acknowledgement is sent to applicants within three business days upon receipt of corrections. Once the corrected discrepancy document is received by VHP, the document is date stamped and the staff will re-run the primary source verifications where discrepancy was noted.

3. Receive the status of the credentialing or re-credentialing application, upon request.

   a. Applicants may call the Credentialing Department at (408) 885-2221 or send a request to BHSDCredentialing@vhp.sccgov.org to receive information on the status of the application.
   b. Applicants are informed of their rights on page 4 of the County of Santa Clara Participating Practitioner Application (CSCPPA) and page 18 of the CAQH Application.
   c. When signing the release and acknowledgements page of the Credentialing application, the practitioner consents to sharing information related to credentialing and qualifications.

Practitioner Suspension/Termination Procedure
Notification is promptly made to the practitioner by the BHSD, and/or designee, via certified mail regarding suspension or termination made by the BHSD due restriction or the loss of license, privileges, exclusion from government program or probation. The notice of action will include the action being proposed, the effective date of the action, and a statement of reasons for the proposed action.

Right to Appeal
If a practitioner’s application is not approved, within 30 calendar days of the Credentialing Committee decision, a denial letter is sent to the practitioner via certified mail that includes the reason for denial of participation, and a reminder of the practitioner’s right to appeal. If a provider submits a request to appeal, and the Credentialing Committee votes to uphold the decision, the provider will be offered a fair hearing within 30 calendar days.

The BHSD will report notification of action to the appropriate Board of California, National Practitioner Data Bank, pursuant to Business and Professions Code Section 805; as well as file an 805.01 form to the Medical Board of California within 15 business days.

The appeal rights are excluded for professional who do not meet the qualifications.

Request for Hearing

Participating practitioner have 30 calendar days from the date of receipt of notification of action in which to request a hearing by the Credentialing Committee. The request must be received in writing, must be addressed to the Chief Medical Officer and/or designee, and include the rationale and supporting documentation for the hearing. The Chief Medical Officer and/or designee will coordinate all notifications, arrangements, and requests related to the hearing process. The date of the hearing will not be less than 30 calendar days and not more than 60 calendar days from the date of original notification of action to the practitioner.

The practitioner will be notified by mail of the date and time of the hearing. The hearing notification will include the following: a list of any witnesses expected to testify on behalf of the BHSD Credentialing Department at the hearing and a statement of the practitioner's rights in the hearing process.

Notification Requirements for Changes in Practitioner Status

Following the credentialing/re-credentialing process, the provider is required to notify VHP within five calendar days if any of the following circumstances arise:

- Surrender, revocation, or suspension of a license or current DEA registration;
- Exclusion of provider from any federal program for payment of physical or behavioral health care services;
- Filing of any report regarding the provider to NPDB or with a state licensing or disciplinary agency;
- Change of a provider’s status that results in any restrictions or limitations; or
- External sanction or corrective action levied against a provider by a governmental entity.

Such notice shall be sent in writing and in accordance with the “Notice” provision set forth in the provider’s Agreement to BHSD and VHP:

VHP’s Provider Credentialing Department
2480 N. 1st Street, Suite 160
San Jose CA 95131

Behavioral Health Services Department
Sherri Terao, Ed.D, Director
828 South Bascom Avenue, Suite 200
San Jose, California 95128

2.4 Professional License Waiver Request Process

DHCS requires professional license waivers (PLW) for the following practitioner types as described in BHIN 20-069: Mental Health Professional Licensure Waiver BHIN 20-069 (ca.gov) (1) unlicensed psychologists, and (2) out-of-state licensed psychologists, clinical social workers, marriage & family therapists and licensed professional clinical counselors. The waiver period would be for five years.

To apply for a waiver, complete and submit a BHSD Waiver Request Form and supporting documentation to BHSDBusinessOffice@hhs.sccgov.org for review.
If the individual satisfies the requirements to be eligible for a PLW, BHSD completes and signs the DHCS Form 1739 Mental Health Professional Licensing Waiver Request_DHCS 1739.pdf (ca.gov) for submission to DHCS for approval. Once DHCS approves, the requestor will be notified and can attach the approval to the credentialing application packets submitted to the Credentialing Team at VHP.

2.5 Paraprofessionals

A qualified paraprofessional is an unlicensed and uncertified individual who meets all the following criteria:

- Is supervised by a qualified service provider or qualified service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services for a treatment plan developed and approved by a qualified service provider.
- Meets the education and training qualifications described below:
    - PP> 2 years: An individual who provides mental health services but does not hold a license/waiver/registration as a physician, psychologist, social worker, marriage and family therapist, professional clinical counselor, registered nurse, licensed psychiatric technician, or occupational therapist, but has more than two years of mental health experience.
    - PP< 2 years: If the individual does not have a bachelor's degree in a mental health field and does not have at least two years of mental health experience.

2.6 Peer Support Specialists

Certified Medi-Cal Peer Support Specialists provide recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports and are trauma aware. These individuals would need to be 18 years of age or older, and self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer.

More information on Medi-Cal certification as a Peer Support Specialist can be found on this link: Home - CA Peer Certification

2.7 Mental Health Rehabilitation Specialists (MHRS)

Under Title 9, BHSD evaluates materials for applicants who request to be identified as MHRS. An MHRS must have the combined education and mental health experience required by state law. In all cases the experience must be: “in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.”

In order to qualify, an individual must have one of the following:

- A master’s degree in a mental health related field plus two years of clinical experience in a mental health setting;
- A bachelor’s degree plus four years of clinical experience in a mental health setting. Up to two years of graduate professional education in a mental health or related field may be substituted for the experience requirement on a year-for-year basis; or
- An associate degree and six years of clinical experience in a mental health setting. Two of the six years required work experience must be completed after being awarded the Associate’s degree

Clinical experience includes but is not limited to, the following activities: case management, counseling, psychotherapy and crisis intervention. Practicum and internship experience that is part of the requirement for the bachelor or graduate degree will not be counted as clinical experience.

Completed form and supporting documentation may be submitted to: BHSDBusinessOffice@hhs.sccgov.org If the individual satisfies the MHRS requirements, a certificate will be issued. The requestor will be notified and can attach the certificate to the credentialing application packets submitted to the Credentialing Team at VHP.

The final determination of the qualifications of a provider or practitioner to participate in BHSD’s service delivery network will remain solely within the authority of VHP acting on behalf of BHSD.

2.8 Interns and Trainees

Interns and trainees are required to be enrolled in an educational program that is designed to qualify the person for licensure. An individual that holds a Master of Social Work (MSW) requires a minimum of 1700 hours and 13 weeks of clinical supervision from a Licensed Clinical Social Worker (LCSW). The remainder may be provided by other licensed clinicians as specified by the Board of Behavioral Sciences. BHSD recommends to maximize licensed clinicians as much as possible to ensure services provided are consistent with the person’s training and experience and ensure compliance with applicable laws. Interns and trainees must possess a NPI number with a valid taxonomy.

2.9 Residents

Resident: According to the Medical Board of California, a resident is an individual who is issued a Postgraduate Training License [and] is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited postgraduate training program in California. The

resident may engage in the practice of medicine only in connection with their duties as a resident in the approved training program, including its affiliate sites, or under those conditions as are approved by the director of their program. A Postgraduate Training License is issued to an individual who has graduated from an approved medical school, passed all required examinations, has not completed 36 months of ACGME postgraduate training, and is enrolled in an approved California residency program.

2.10 BHSD System Access Request Form (SARF)

Staff that require access to myAvatar must complete and submit a BHSD SARF to the BHSD Business Office by email BHSDBusinessOffice@hhs.sccgov.org The SARF form and instructions are posted on the BHSD website and can be found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)

If any rendering provider needs access to myAvatar, the rendering provider will need to complete the credentialing process with VHP prior to submitting BHSD SARF.

2.11 PAVE

The Department of Health Care Services (DHCS) has updated the Specialty Mental Health Services (SMHS) Provider File Update (PFU) form to accommodate the Medi-Cal enrollment requirements mandated by the 21st Century Cures Act (Cures Act). The Cures Act requires eligible SMHS practitioners to enroll in the Medi-Cal program. Licensed practitioners who are eligible for enrollment must apply through the Provider Application for Validation and Enrollment (PAVE) system. Licensed practitioners must utilize the PAVE Portal to complete and submit applications, report changes to existing enrollments, and respond to requests from DHCS for continued enrollment or revalidation.

Additionally, licensed practitioners who work for entities and practitioners who provide SMHS must be reported on the PFU form before information is added to the Provider Information Management System (PIMS).

2.12 Leave of Absence (LOA)

A leave of absence is when an practitioner will take time off work for 30 days or more.
As soon as an LOA is known, Participating Provider will complete the termination form to identify the LOA, including start and end dates. The LOA will be filed for tracking purposes and identified in Avatar to prevent services billed while the provider is on LOA.

If an LOA period needs to be modified (shortened or extended), Participating Provider will submit a termination form indicating an update to the LOA start/end dates in order for the dates to be updated in Avatar.

Recredentialing after an LOA
Per NCQA, the recredentialing cycle length can be extended, if a provider's recredentialing due date falls within the time they are on leave of absence. A practitioner who returns from military assignment, maternity/medical leave or a sabbatical must have a valid license to practice before he or she resumes seeing patients.
Within 60 calendar days of when the practitioner resumes practice, practitioner

must complete the recredentialing cycle.

2.13 Medi-Cal Site Certification

Short-Doyle/Medi-Cal (SD/MC) Site Certification

Santa Clara County Behavioral Health Services (BHSD) requires all contracted and county-operated program sites that bill Medi-Cal to be certified in accordance with the standards of the DHCS SD/MC Provider Certification & Re-Certification protocol, the Mental Health Plan (MHP) contract-Exhibit A, and Title 9 1810.435 of the California Code of Regulations.

The Quality Management (QM) Provider Relations Office is responsible for coordinating with DHCS to request initial Medi-Cal program site certifications for County-owned and operated provider program sites. Afterwards, DHCS will certify all county-owned and operated provider moves and address changes. QM approves Medi-Cal certification and re-certification for all organizational and contractor sites, as well as re-certifies county-owned and operated sites every three years; these sites must be re-certified before the expiration date.

QM may accept the Host County's Approval Letter in lieu of the BHSD site certification procedure for out-of-county Organizational Providers with whom the Host County and BHSD have a contract.

SD/MC site certification requests for information and questions can be submitted by email to BHSDSiteCert@hhs.sccgov.org.

Drug Medi-Cal (DMC) Site Certification

DMC site certification is required before providers can claim any DMC reimbursement. DHCS certifies both County and Participating Provider operated sites. Drug Medi-Cal enrollment applications for each location shall be submitted to DHCS Provider Enrollment in the PAVE Enrollment System PAVE Portal. DMC site certification is effective for up to 5 years and would need to be re-certified by DHCS prior to the expiration.

SUD residential and outpatient providers licensing and certification information can be found here Licensing and Certification Division

Chapter 3: Quality Management

3.1 Quality Management Overview

The vision of County of Santa Clara Behavioral Health Services Quality Management (QM) is to ensure that all beneficiaries in need of behavioral health services receive quality, timely care that meets their needs. To ensure continuity across the network, QM provides oversight of access, availability and quality behavioral health services that are well coordinated across the continuum of care; all while adhering to requirements from our regulators, including Department of Health Care Services.

3.2 Performance Standards and Outcome Measurement

To ensure a consistent level of care within the provider network, and a consistent framework for evaluating the effectiveness of care, BHSD has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level of care they provide to beneficiaries which include the following:

Provider Type: MH Providers, SUTS Providers, Both (MH and SUTS), Hospital, Residential, NTP	Category	Topic	Goal
Both	Penetration Rate	SCC Adult Residents served (at least one paid claim in reporting visit) per quarter; broken down by Medi-Cal and Uninsured.	At the end of FY serve at least 3% more Medi-Cal clients from prior FY baseline; report cumulative results quarterly
Both	Penetration Rate	SCC Youth (0-20) Residents served (at least one paid claim in reporting visit) per quarter; broken down by Medi-Cal and Uninsured.	At the end of FY serve at least 3% more Medi-Cal clients from prior FY baseline; report cumulative results quarterly

Both	Timely Access	Initial Request to First offered appt (Date of 1st offered appointment - Date referral received by agency)	Access standard: 10 business days. Depending on FY 23 performance, maintain timely access or increase by a minimum of 1 day.
Both	Timely Access	Initial Request to offered psychiatry (Date of 1st offered appointment - Date referral received by agency)	Access standard: 15 business days. Depending on FY 23 performance, maintain timely access or increase by a minimum of 1 day.
Residential	Timely Access	Date of admission - Date referral received by Residential Provider	Access standard: 10 business days. Depending on FY 23 performance, maintain timely access or increase by a minimum of 1 day.
MH	Timely Access	Post-psychiatric Hospitalization Follow-up (Date of outpatient appointment - date of hospital discharge)	Provide post-psychiatric hospitalization follow-up appointment within 7 days of discharge.
Hospitals	Quality, Readmission	Post-psychiatric Hospitalization Readmission Rate	Reduce the number of beneficiaries receiving inpatient hospital services who are readmitted within 30 days to 9%.

NTP	Timely Access	Initial Request to First offered appt (Date of 1st offered appointment - Date referral received by agency)	Access standard: 3 business days. Depending on FY 23 performance, maintain timely access or increase by a minimum of 1 day.
All (except hospital)	Quality, Language	All beneficiaries are served in their preferred language either with bilingual staff or utilizing translation services. (# of non-English speaking beneficiary referrals submitted to provider denied - # of non-English speaking beneficiary referrals submitted to provider)	Standard = 100% of non-English referrals will be served
All (except hospital)	Quality, Care Coordination	Assess volume of care coordination provided by the network to identify opportunities to increase care coordination. (# of beneficiaries who have at least one care coordination claim/ # of beneficiaries engaged in care)	FY24, report only for baseline

The measurements will be updated no more than annually, and performance will be reviewed and discussed at provider meetings. Provider will need to submit required data no later than 30 calendar days after the end of the quarter. For any metrics with an identified outcome, provider will work to identify interventions that are approved by BHSD to achieve the stated goal.

3.3 Timely Access Standards

Appointments

To comply with network adequacy standards set forth in 42 C.F.R. §438.68 Network

Adequacy Standards and Welfare and Institutions Code (W&I) Section 14197; all providers must have a system in place for tracking and measuring the timeliness of care and treatment. To ensure these standards are being met BHSD developed a standardized tool for Contract Agencies and County Clinics to complete and submit on a monthly basis. Each month BHSD will review and analyze each provider's data to measure compliance with meeting the timeliness goals. Failure to meet timely access standards may result in a CAP.

Below are the standards set forth by DHCS for the Mental Health Plan (MHP) and Drug Medi-Cal-Organized Delivery System (DMC-ODS).

Timely Access Standards Mental Health Plan	
Modality Type	**Standard**
Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services	Offered an appointment within 10 business days of request for services
Psychiatric Services	Non-urgent: Offered an appointment within 15 business days of request for services Urgent: 48 hours without prior authorization
The above standards are applicable, unless as provided in CCR §1300.67.2.2(c)(5)(G) and (H) DHCS defines urgent as: When the beneficiary's condition is such that they faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the beneficiary's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.[1] [1] 28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2)	

Timely Access Standards **DMC-ODS**	
Modality Type	**Standard**
Outpatient Services – Substance Use Disorder Services	Offered an appointment within 10 business days of request for services
Residential	Offered an appointment within 10 business days of request for services

Narcotic Treatment Program[1]	Within 3 business days of request
[1] For NTP patients, the NTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations so we default to the federal regulations. (For example, with take home medication, time in treatment requirements are applicable to buprenorphine patients if in the NTP program.) 28 CCR § 1300.67.2.2, subd. (b)(7)	

3.4 Referral and Intake Process

All Providers, Contracted Agencies and County Clinics shall serve clients as determined by County policies, procedures, directives, and guidelines promulgated by BHSD. Contractor shall accept all referrals that are generated through the BHSD Call Center or direct referrals from beneficiaries or providers.

When beneficiaries call the BHSD Call Center, the beneficiary will be screened for eligibility for Specialty Mental Health and Substance Use Treatment services. If the beneficiary meets the criteria per the CalAIM screening tool, and after the insurance verification, then the BHSD Call Center will send the referral to a Participating Provider within 15 miles or 30 minutes on public transportation from the beneficiary's home address. Once the referral is received, the Participating Provider will call the beneficiary to offer an appointment. The appointment offered must be for a time and date within 10 business days of the beneficiary's referral. If the beneficiary does not meet criteria, then the BHSD Call Center will offer community resources and offer a referral to Santa Clara Family Health Plan or Anthem for mild-moderate services, as applicable.

If Participating Providers are anticipating a change in capacity to accept referrals that would result in a program closure, refer to section 3.6 Closing a Program to Referrals.

3.5 Clinical Standards and Evidence Based Practices

Adherence to Clinical Standards and use of Evidence-Based Practices (EBP) are critical to ensure quality and continuity of care across BHSDs provider network. These cover various aspects of care for our beneficiaries. Ensuring a comprehensive, evidence-based guidelines support equitable care for all. The County of Santa Clara Behavioral Health Services supports and encourages the use of Evidence-Based Practices (EBP) in the treatment of persons in care to support resiliency, recovery, and wellness. All providers shall be familiar with and utilize the County of Santa Clara Clinical Practice Guidelines, which can be found on the BHSD website that is being updated. Link will be available soon.

3.6 Data Collection

274 Monthly Submission

Providers are required submit 274 data to meet the requirements for the MHP and DMC-ODS monthly 274 network adequacy reporting. The process and schedule are described below. This requirement is active for MHP providers and will begin for DMC-ODS providers as of February 2024.

Date	Process
15th of every month file, if holiday file will be prepared business day before	Providers will log in to their web app account to access their respective agency folder in One Drive and download their prior month's file to review and update.
23rd of every month	Providers will send email to BHSDBusinessOffice@hhs.sccgov.org to notify that provider data is ready for review.
26th of every month	BHSD will notify the provider of errors in their files.
29th of every month	Providers will log in to their web app account to correct errors and notify BHSD when updates are completed.

The specific instructions can be found on the BHSD website on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)

Temporary Closure of a Program to Referrals

If a Participating Provider is unable to accept referrals, the Participating Provider is required to report the closure to the Plan. To report a temporary closure, the Participating Provider must complete the Network Change Request Form which can be found on this link:
https://www.surveymonkey.com/r/BHSDNETWORKCHANGEREQUEST

The form will request an explanation for the closure that's resulting in a capacity change and identify the number of network providers who are not accepting new Medi-Cal beneficiaries.

The Network Change Request Form will contain detailed information about the change in capacity, including the reason for the change, the impacted service areas, and the expected impact on covered individuals' access to care.

The following fields must be completed on first page of the Network Change Request form:

- Brief description of what is needed
- Legal Entity name
- Date of request

- Contact name
- Contact role
- Contact phone
- Contact email

Then select Network Adequacy Change Notification – Temporary Closure. Selection of Temporary Closure will redirect to an additional page which also must be completed. If the NCR is incomplete, Provider Relations will not forward the request to impacted parties until the participating provider answers the required information by email or NCR resubmission. Completed forms are sent to BHSD Divisions, including UM and the Call Center on day of receipt if submitted before 4:00 p.m. on a business day. Participating Providers are advised to submit the NCR at least 24 hours in advance of change, if possible, to ensure BHSD has reasonable time to take action on the request. The following required fields must be completed on the Temporary Closure section of the NCR:

- Estimated Closure Date
- Anticipated re-opening date
- Reasoning for temporary closure (Note despite temporary closure you are responsible for maintaining workday and/or after-hours beneficiary communication)
- Impacted BHSD Contract Monitor(s) if known
- Impacted Program Type. Examples - F&C TBS, F&C EOPC, ADULT FSP, AOA EOPD, AOA New Refugee SVCS, OA Elders Storytel, AOA CALWORKS OPD, KATIE A
- Impacted age groups
- Impacted Location(s) (physical address)
- Current Medi-Cal Capacity of program temporarily closing (# of medi-cal beneficiaries being served):
- Number of pending discharges:
- Number of beneficiaries that **MUST** be referred back.

  Example: you have 6 client referrals that you need to send back to BHSD, in this example, enter 6. THEN complete and send in the Participating Provider Tracking Table with the 6 referrals using the form linked below.

Provider Relations may not know which specific programs operate out of specific locations, age groups served by location, or that there are multiple locations where the same programs are operating. The more detail that is provided about the specific impacted program(s), age group and locations, will help facilitate timely communication.

It is important to report changes in capacity to BHSD in a timely manner to avoid potential compliance issues and ensure that beneficiaries continue to have access to the care they need.

1. Participating Providers will submit the Network Change Request Form along with additional documentation that may support the justification for closure. Additional documentation may be requested by the BHSD Provider Relations office. Anticipated closures would need to be reported by the 23rd of the month prior to the closure.
2. Participating Provider Directors or managers must sign off on Network Change Request before submission to the Provider Relations office.
3. Participating Provider will notify BHSD of the anticipated date the program is able to accept new referrals. If an extension is needed, Participating Providers must submit another Network Change Request.
4. Participating Providers will provide capacity on the monthly 274 network adequacy data submission by the 23rd of each month.
5. Participating Providers will discharge beneficiaries in a timely manner to ensure availability of services to new beneficiaries. Participating Providers must submit beneficiary's discharge paperwork no later than 30 calendar days from last billable service.

Program closures lasting one month or more may be subject adjustments to current or future contacts.

Permanent Provider Closure

This process applies to both individual programs closing as well as overall contracted entities.

Participating Providers are required to report permanent program closures to the Plan. To report a permanent program closure, the Participating Provider must complete the Network Change Request Form within ninety (90) days of the closure.

1. Participating Providers will submit the Network Change Request Form to the BHSD Provider Relations office who will notify the Call Center to ensure future referrals and referrals in progress are re-directed to other programs.

2. Participating Providers will partner with BHSD Contract Monitors to coordinate transition of affected clients to alternative programs by providing a list of clients (Program Closure Client Tracking Table) to be closed and/or transferred within 10 days of the notice of closure.

3. Participating Providers will submit member letters, and in some cases, Notice of Adverse Beneficiary Determinations and supporting materials to

inform impacted members of program closing that are:

- Part of the closure.
- Being transferred due to closure.
- Closing without a new provider (this is a NOABD)

4. Participating Providers will return any County equipment and inventory items belonging to BHSD. If the program and Participating Provider agency are closing, Participating Providers will make arrangements to store any medical records whether paper or electronic in order to meet the requirements under HIPAA.

Client Satisfaction Survey

All participating providers for Behavioral Health Services are required to meet minimum standards for meeting survey requirements set by Department of Health Care Services (DHCS). BHSD will provide requirements for each type of consumer satisfaction surveys. All instructions and timelines will be provided to participating providers by the Quality Improvement Division upon receiving notification from DHCS.

All participating providers are required to participate in administration of surveys once a year for each type of survey that applies to their population of beneficiaries.

- Consumer Perception Surveys (CPS) for beneficiaries receiving mental health services to meet DHCS requirements,
- Treatment Perception Surveys (TPS) for beneficiaries receiving substance use services to meet the DMC-ODS requirements.

Service Verification

All participating providers for Behavioral Health Services are required to meet Medi-Cal service verification requirements set forth in Title 42 C.F.R. § 438.608 Program Integrity requirements and in annual review protocols for specialty mental health services by DHCS.

The purpose of service verification process is to establish a method to verify that services reimbursed by California's Medicaid program (Medi-Cal) were actually provided to beneficiaries.

To meet monitoring requirements BHSD has established the following minimum requirements for all participating providers:

- Establish and maintain a policy and procedure that outlines Service Verification process.
- Conduct a verification of services twice a year for all Medi-Cal beneficiaries at each clinic.

    - Note: Service Verification for SCC County Clinics will be done in collaboration with BHSD's Quality Improvement team

- The methodology in which this is done is up to each CCP agency and SCC County Clinic (participating provider). The requirements for this service verification period are as follows:
    - The minimum number of beneficiaries who will have their services verified is 2% of clinic population or 5 beneficiaries, whichever is greater.
    - All beneficiaries who are selected must be 18 or over.
    - All beneficiaries must be Medi-Cal recipients.
    - At minimum the latest five services must be verified
- All documentation regarding service verification must be maintained and available upon request for BHSD Annual Administrative Review.

3.7 Utilization Management

BHSD's Utilization Management (UM) program is administered by licensed, experienced clinicians, who are specifically trained in UM techniques and in BHSD's standards and protocols. All BHSD employees with responsibility for making UM decisions have been made aware that:

- All UM decisions are based on the member meeting medical necessity (medically necessary) based on DHCS regulations.
- Financial incentives based on an individual UM clinician's number of adverse determinations/adverse actions or denials of payment are prohibited.
- UM decision makers do not receive financial incentives for decisions that result in underutilization.

Authorization

County of Santa Clara Behavioral Health Utilization Management program will ensure beneficiaries have appropriate access to the correct level of care. For services that require an authorization, authorizations are given based on medical necessity. If a beneficiary no longer meets medical necessity, it is up to the provider to support a transition to a lower or higher level of care and inform the utilization management team of the change. In adherence with DHCS Information Notice 22-016 the following pre-authorizations, re-authorization, and concurrent review is required.

Pre-authorizations and re-authorizations are required for:

- SUTS Residential Services

- Intensive Home-Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

For Pre-Authorization and Re-Authorization all require the Authorization Request Form. This form is located on the BHSD website and can be found on this link: BHSD Forms - Behavioral Health Services - County of Santa Clara (sccgov.org)

Concurrent Review and authorization is required for:

- SMH Crisis Residential Treatment Services (CRTS)
- SMH Adult Residential Treatment Services (ARTS)
- Inpatient Psychiatric Hospital Services

BHSD will be maximizing the authorization form for other contracted services such as our Eating Disorder, Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS).

BHSD will maintain telephone access 24-hours a day, 7-days a week for providers to request expedited authorization of an outpatient service requiring prior authorization. The telephone access number for the Call Center is (800) 704-0900.

Medical Necessity
Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition. For medical necessity for both SUTS and Mental Health, providers are to adhere to the criteria outlined by DHCS in BHIN 21-073 Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

Level of Care Criteria
BHSD shall perform utilization review (UR) for the determination of clinical appropriateness, level of care (LOC) and/or medical necessity to authorize payment for behavioral health services in the areas of mental health and substance use disorders. For additional information on level of care criteria, providers are to adhere to the criteria and information as outlined by DHCS in BHIN 21-071 (ca.gov) Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services.

3.8 Accessibility Standards

STANDARDS:

Service	**Timely Access Standards** (from request to appointment)	**Time & Distance Standards** (from Beneficiary's place of residence)
Telephone Wait Times		
Customer Service Phone Call to County and Certified Contracting Providers	No longer than ten (10) minutes wait during normal business hours.	n/a
Screening Call Back Times from Gateway/Call Center	No more than 30 minutes from request.	n/a
Emergent and Urgent Appointments		
Emergent	Non-life-threatening Emergency care within six (6) hours of request.	15 miles or 30 minutes
Urgent	48 hours of request non-prior authorization. 96 hours of request for prior authorization.	15 miles or 30 minutes
Opioid Treatment Programs	Within three (3) business days.	15 miles or 30 minutes
Post Stabilization	Within five (5) business days of discharge from hospital, Emergency psychiatric services, or crisis residential program.	15 miles or 30 minutes
Non-Urgent Appointments		
Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services	Within ten (10) business days from request to appointment.	15 miles or 30 minutes
Outpatient Substance Use Disorder Services, other than opioid treatment programs	Within ten (10) business days from request to appointment.	15 miles or 30 minutes

Psychiatry	Within 15 business days from request to appointment.	15 miles or 30 minutes

3.9 Care Coordination

Given the multiple healthcare delivery systems and resources that a person in care can be served in, there is a need for care coordination to successfully transition between providers and care settings. We should think about care as occurring across a continuum with an understanding that people's needs change over time. Given that individual needs can also be addressed concurrently by providers in different agencies or systems, coordination of care is a necessary element of your service provision. The goal of care coordination is to meet the person's needs through proactive and deliberate activities that include the person in care and to organize or coordinate with other service providers to facilitate the appropriate delivery of services across providers, treatment settings, and healthcare systems. It is likely that the coordination of services may include other treatment team members to help carry out activities, with each provider identifying what roles and activities they are taking on that support the person in care's overarching wellness.

Each agency is expected to obtain any necessary release of information in order to provide the care coordination needed to best serve the beneficiary. When a beneficiary discharges, it is expected that each level of care insures there is a plan of action for the next level of care. A phone number is not sufficient for care coordination. Care coordination would include a plan, including phone numbers, a warm hand off to the next level of care, and not closing until the new level of care has opened the beneficiary for services. If an unexpected discharge occurs, for instance someone is discharged from residential services prior to completion, then the care coordination would happen after the unexpected discharge. Plans should begin at entry into a program, even if they change, to provide as much support for unexpected discharges as well. Clinical Practice Guidelines will contain more details of how to plan for discharge and provide appropriate care coordination between levels of care.

3.10 Documentation

For Specialty Mental Health Services, please refer to the CalMHSA Documentation Guide CalAIM Documentation Guides - California Mental Health Services Authority (calmhsa.org)
and trainings California Mental Health Services Authority | CalAIM (calmhsa.org) and County of Santa Clara Mental Health Companion Guide for guidelines and criteria.

For Substance Use Disorder Treatment Services, please refer to the CalMHSA Documentation Guide CalAIM Documentation Guides - California Mental Health Services Authority (calmhsa.org)
and trainings California Mental Health Services Authority | CalAIM (calmhsa.org) and the County of Santa Clara Substance Use Treatment Services Companion Guide for guidelines and criteria.

As the plan, BHSD outlines the standards and expectations for documentation. Providers are tasked with implementation of these standards in a manner and workflow that best suits their agency and/or clinic needs while also providing the best care in accordance with best practices for beneficiaries.

In addition, Providers are to follow any criteria for documentation required by licensing, certification, best practices, or grants that pertain to their agency and the beneficiaries they serve.

3.11 Language Access

All non-English, monolingual, hearing impaired, and Limited English Proficient (LEP) Medi-Cal beneficiaries must have access to no-cost linguistic services for all service inquiries, and at all visits. Linguistic services may be provided by bilingual staff that are assessed for proficient language capacity. When bilingual staff is not available, interpreter services must be provided by telephone language line, or TDD/TTY service. Beneficiaries have a right to the following language services:

- No-cost linguistic services (through bilingual staff or interpreters) during face-to-face or telephonic contact.
- Receive fully translated documents in threshold and concentration languages such as grievance letters, welcome packets, and services information. SFHP’s Medi-Cal threshold languages include English, Chinese (spoken: Cantonese and Mandarin; written: Traditional), Spanish, Vietnamese, and Farsi.
- Receive informing documents in alternative formats such as Braille or large sized print upon request. Receive referrals to culturally and linguistically appropriate community services. File grievances or complaints if linguistic needs are not met.

Participating Providers can access language services to support service delivery to Medi-Cal beneficiaries. Over the Phone Interpretation (OPI) through a third-party vendor(s) is available to Participating Provider sites. These sites are assigned PIN numbers to access these language services and provided dialing instructions and tips.

All other interpreter services and cost are the responsibility of the Contract Agency or County Clinic and programs. Questions and requests for further information should be directed to the Program Manager at: BHSD_DEI@hhs.sccgov.org

Chapter 4: Encounter Data, Billing, and Claims

4.1 Claims Overview

This section presents information needed to submit claims to BHSD. BHSD requires providers to rely on electronic submission, either through EDI or myAvatar in order to achieve the highest success rate of first-submission claims.

Participating Providers, or their practitioners, are responsible for submitting required data and claims through Provider Connect Enterprise or Provider Connect (PCNX) using standard code sets published by the BHSD. Participating Providers will assume financial responsibility for claims that are inaccurate, untimely, invalid or lack supporting documentation. Participating Provider will not balance bill Beneficiary for any covered Medi-Cal benefit outside of Share of Cost obligations.

BHSD wants to ensure that all providers understand and are aware of the guidelines that BHSD has in place for submitting a claim. BHSD or Designee will make training documentation available to Participating Providers on the BHSD website link here: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org).

4.2 Adjudication Rules

There are many reasons why a claim may be pended or denied. The list below although not exhaustive, contains some of the key reasons:

a. The date of service needs to be within the authorization begin and end dates or the service will be denied.
b. Date of Service is Prior to Santa Clara BHSD Medi-Cal Eligibility Effective Date
c. In the Maximum Number of Calendar Days Prior to 'Date Claims Received' Date of Service is Permitted field, define the number of calendar days a service can be included in a batch before a batch is created (Date Claims Received field, Batch Creation form).
    - Drug Medi-Cal is set to “120”
    - MHP is set to “305”
d. In the Maximum Number of Calendar Days Prior to Date Claims Received Date of Service is Permitted for Replacement Claims, enter the number of calendar days a service would be denied
    - Drug Medi-Cal is set to “305”
    - MHP is set to “400”
e. Third Party Guarantor Does Not Exist
f. Maximum Units Per Calendar Day Exceeded.
g. Specified Diagnosis on Authorization is not a Medi-Cal Covered Diagnosis
h. Invalid Place of Service

i. Specified Duration is not valid for Procedure Code
j. Duplicate Service Parameters
k. Adjudication rule will be evaluated for all services that contain third party payments but are not fully covered by the identified authorization.
l. Participating Provider program does not match the contracting provider program for the selected authorization.

These rules apply to Drug Medi-Cal, Mental Health Plan and County of Santa Clara claims.

Basic Claims Process Workflow

1. Verify Santa Clara BHSD Medi-Cal Eligibility. Confirm beneficiary eligibility on a monthly basis.
2. Complete payer financial information to determine beneficiary ability to pay, share of cost obligation or other health care coverage at admit and annually thereafter for beneficiaries still receiving treatment.
3. Conduct an assessment or updated assessment, notes, and prepare treatment plans, treatment plan updates and discharge information within federal, state, and contractual mandated timelines for your program type.
4. Document that medical necessity was established by a Licensed Practitioner of the Healing Arts (LPHA) for the services provided for the timeframe in which the services were provided.
5. Finalize service documentation within required timelines and maintain a beneficiary record with notes and service documentation that accurately reflects claims data entered into the BHSD Health Information System.
6. Adhere to Medi-Cal documentation standards regardless of payor.
7. Enter Specialty Mental Health Client Service Information (CSI) and/or California Outcomes Measurement System (CalOMS) data at admission, annual update, and discharge.
8. Review, clarify and amend any claims that were returned because they did not meet compliance.

4.3 Electronic Signature

Providers must adhere to the electronic signature requirements in accordance with DMH Letter 08-10 DMH Letter Electronic Signature and Electronically Signed Records and ADP Bulletin 10-01 ADP Bulletin 10-01 (ca.gov)

Contract Providers are required to:

- Have a policy for this electronic signature process; including identifying staff that are required to have electronic signatures, the process to

distribute the link to their staff to sign the document, and ensure it's completed on an annual basis.
- Keep copies of all forms, for a minimum of 10 years and made available for audit by BHSD and other oversight entities.

The form is posted on the BHSD website Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)

County Clinic Staff are required to:

- Understand and follow BHSD Policy #PRR-007 Electronic Signatures in Electronic Health Record Systems.
- Sign their annual attestation via the annual Health Learning.
- Retain completed forms in the employee files for audit purposes for 10 years and managers must track if the attestations hasn't been signed.

4.4 Electronic Billing Requirements

Providers must adhere to the following:

1. Ensure secure information exchanges and technologies employed by their agency for quality improvement, care coordination and claims submission methods meet HIPAA security and confidentiality requirements outlined in 45 CFR parts 160 and 164, and 42 CFR Part 2.
2. Is responsible for submitting any and all data and claims information that is required to obtain payment utilizing 837 files (for those connecting via Provider Connect Enterprise; (PCE) or manually via Provider Connect (PCNX) (myAvatar portal) using standard code sets published by the BHSD and within the timeframes specified by the BHSD and the state:
    a. To receive timely reimbursement, Participating Providers should submit claims within the timeframes set forth in the County's Claims Submission Schedule.
    b. Participating Providers must submit claims for Specialty Mental Health Medi-Cal services no later than 305 calendar days from the date of service.
    c. Participating Providers must submit claims for Drug Medi-Cal services no later than 120 calendar days from the date of service.
3. Will assume financial responsibility for claims that are inaccurate, untimely, invalid or lack supporting documentation or if any claims are denied or disallowed.
4. For PCE and PCNX, load all data regarding beneficiary record requirement into the BHSD health information system within seven (7) business days from the date services were rendered such as Beneficiary registration, financial eligibility, diagnosis, and discharge.

5. Work with identified staff to accurately enter data, to complete, clarify or addend claims returned.
6. Submit a void or void & replace via 837 or portal within sixty (60) calendar days of identification of payments more than amounts specified for reimbursement of Medi-Cal services.

4.5 Provider Connect Enterprise and Provider Connect (PCNX)

CCPs that implement Provider Connect Enterprise (PCE) will be able to utilize the Application Programming Interface (API) to send information over to the County. In addition, they will be able to submit claims through 837 files. There are a few documents in Provider Connect NX (PCNX), a CCP accessible web portal that connects to the County's myAvatar, that won't be able to come through the API. These documents need to be manually entered directly into PCNX. CCPs will be able to reference the PCE Companion Guide, 837/835 Companion Guide, and PCNX training materials online.

CCPs that implement PCNX have two possible implementation options: A) PCNX with 837 submission and B) PCNX with manual billing. In both of these scenarios CCPs will need to manually enter documentation into PCNX from the client's Admissions through the client's discharge. CCPs will be able to reference the PCNX training materials online.

4.6 Coding

When submitting claims through myAvatar, users will be prompted to include appropriate codes in order to complete the submission, and drop-down menus appear for most required codes. The training materials for this would be used to assist the billing provider how to enter the claims for submission.

- PCE and some PCNX users will have an 837 generated.
- The CCPS who bill manually will use PCNX to enter claims into myAvatar through the "Fast Service Entry" form.

CCPs will be able to reference the 837/835 Companion Guide materials found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org).

Standard Code Sets

Refer to CPT Code Crosswalk which is posted on the BHSD EHR website: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)\

ICD-10 Compliance

International Classification of Diseases, 10th Edition, referred to as ICD-10 coding, was implemented industry-wide October 1, 2015, replacing ICD-9, the current set of diagnosis and procedure codes. This transition to ICD-10 affects everyone covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE: All claims submitted with dates of service on and after October 1, 2015, must only include ICD-10 codes. Claims submitted without the appropriate ICD 10 codes will result in denials.

Refer to the CalAIM Diagnosis guide " County of Santa Clara CalAim CPT Code Set" posted on the BHSD website which can be found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)

4.7 Correcting Claims

Corrected Claims must be submitted electronically with the appropriate fields on the 837P. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or the correct Resubmission Code for an 837P and include the original claim number. Corrected claims are considered new Claims for processing purposes.

4.8 Timely Filing Standards

Original Claims

- For Medi-Cal claims, the primary claim must be received within 305 calendar days from the date of services for Mental Health claims and 120 calendar days from the date of service for DMC-ODS claims.
- If claims are received outside of the billing time limit, these claims will be denied for exceeding billing time limits.

Claim Resubmissions/Replacement Claims

- For resubmission, the Participating Provider's replacement claim must be received within 400 calendar days from the date of services for Mental Health claims and 120 calendar days from the adjudication date for DMC-ODS claims.

4.9 Where to Send Invoices

All invoices should be sent to the BHSD Finance's email address monthly, in arrears, in the format directed by County. The subject line of the email should have the following information: Invoice-Agency-Month-Invoice Type.

Finance Email Address: BHSD-Finance BHSD-Invoices@hhs.sccgov.org
Example of Subject Line of Email: Invoice-Momentum-March-Client Support

Billing types are:

1. Direct Service: Services that have the potential to earn Medi-Cal if the client has Medi-Cal as their payor. There are two types of clients receiving Direct Services; sponsored, and unsponsored. A sponsored client has Medi-Cal coverage and an unsponsored client does not have Medi-Cal coverage.
2. Indirect Service: Invoices may be submitted for Indirect Services that are authorized in the Participating Provider's Agreement with the County. Indirect Services are Non-Medi-Cal Eligible services, whether the client has Medi-Cal or not. Indirect Services include:
   a. Outreach Services
   b. Dedicated Beds
   c. Any other Indirect Services authorized in the Agreement
3. Cost-Based Services: Invoices may be submitted for Cost-Based Services that are authorized in the Participating Provider's Agreement with the County. Cost-Based Services may include client housing expenditure, client housing operating expenditures, client flexible support expenditures, and other cost-based services authorized in the contract. Claims for client flex/housing support expenses will be invoiced using the cost-based invoice or client flex/housing invoice when allowed. Supporting documentation such as invoices, checks, receipts, and so forth are to be retained by the agency for purpose of verification and reconciliation. In addition, a check/receipt register is to be provided for each invoice submitted.
4. Cost-Based Programs: If authorized in the Participating Provider's Agreement with the County, cost-based invoices may be submitted for any Cost-Based Program expenses in excess of Direct Services, Indirect Services, and Cost-Based Services. An invoice itemizing labor, operating, and other costs must be provided. Total expenses less payments made from monthly Direct Services, Indirect Services, and Cost-Based Services Invoices will be paid up to the Maximum Financial Obligation (MFO) of the program. Supporting documentation such as payroll records, invoices, receipts, a trail balance, G&A overhead schedule, overhead schedule, and any other records necessary to support costs listed on the invoice should be submitted and copies retained for verification and reconciliation purposes.
5. Start-Up Expenses: If authorized in the Participating Provider's Agreement with the County, claims for start-up and related expenses must be billed using the cost-based/cost reimbursement invoice. Supporting documentation for start-up expenses should be submitted and copies retained for verification and reconciliation purposes.

4.10 Compensation

1. BHSD will compensate County Contracted Provider as detailed in each Agreement's Exhibit B for SD/MHSA and DMC-ODS Agreements. The BHSD will use the MFO to

first match Federal Financial Participation for services to Medi-Cal beneficiaries and any remaining funds will pay for services to non-Medi-Cal Beneficiaries as defined in BHSD's policies, procedures, directives, and guidelines.

2. County and County Contracted Provider's compensation will be reduced by any penalties imposed by the Federal and/or State government(s) for the overestimation of costs.
3. County Contracted Providers will be paid for claims approved by the County and reimbursed by the State. Providers assume financial responsibility for rejected services, and must successfully replace or resubmit invalid, rejected, or void claims in order to receive reimbursement for them.
4. County Contracted Provider must reimburse County for payments made for claims denied by the State, unless the denial was due to error attributable solely to County. Reimbursement will be made through an offset against a subsequent invoice or by direct payment by Contractor to County.
5. County Contracted Providers should correct claims denied by the State and submit replacement claims as soon as possible and no later than the following deadlines: for SUTS replacement claims, 305 days from the date of service; for mental health claims, 400 days from the date of service. County Contracted Providers will be paid for replacement claims that are approved by the County and, for Medi-Cal-eligible claims, reimbursed by the State.
6. If a provider submits a charge that is greater than the rate table amount in the Exhibit B, the County will only pay the agreed Exhibit B amount (not the larger amount). If a beneficiary also has other health care coverage, such as Medicare or private insurance, the County will pay the agreed Exhibit B amount minus any amount paid by the other health care coverage.
7. Payment shall be subject to any restrictions, limitations, and/or conditions imposed by County, state, or federal funding sources that may in any way affect the fiscal provisions of, or funding.

4.11 Reimbursement Policies

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that the provider will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis.

Eligibility and benefit information are not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on many factors, such as compliance with clinical and administrative protocols, coding guidelines, date(s) of services rendered, and type of services.

Below are some examples for disallowance or non-reimbursement. These examples are not a comprehensive or exhaustive list.

1. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.
2. The provided services were not within the scope of practice of the person delivering the service.
3. There was no documentation date in the medical record.
4. Services provided by non-qualified individuals.
5. Providers are on the exclusion or sanction State or Federal list(s).

BHSD complies with Department of Health Care Services' regulations for Coordination of Benefits (COB). State law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party. Medi-Cal members with Other Health Care (OHC) coverage must utilize their OHC for covered services prior to utilizing their Medi-Cal benefits. As a result, BHSD may deny the submitted claims or services in situations where providers have not sought reimbursement for covered services that are covered services for which a third party is liable.

4.12 Overpayment

If BHSD determines that it has overpaid a claim, BHSD will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of services(s) and a clear explanation of the basis upon which BHSD believes the amount paid on the claim was in excess of the amount due.

4.13 Recoupment and Withholding Compensation

BHSD reserves the right to recoup or withhold amounts from future compensation due to providers equal to the amount of any overpayment, denial, and/or disallowance for billed services and/or other payments due to the BHSD.

4.14 Prohibition of Billing Beneficiaries and Requirement to Spend Down Medi-Cal Share of Cost

Providers are not permitted to bill Beneficiaries under any circumstances for covered services rendered, excluding Medi-Cal share of cost and co-payments when appropriate.

State law requires certain Medi-Cal beneficiaries to pay a Share of Cost (SOC) before they are eligible to receive Medi-Cal benefits. When this requirement applies, the State will deny claims submitted for services provided to beneficiaries who have not met their SOC. To avoid denials by the State (and reimbursement of County payments pursuant to Section 4.10), Providers should access the Medi-Cal eligibility verification system to determine whether beneficiaries must pay a SOC and, when required, take steps to clear beneficiaries' SOC. Information about determining and clearing SOC can be found at the following links:

- [Medi-Cal Provider Manual Part 1 – Medi-Cal Program and Eligibility, Share of Cost]
- [Workbook_Share of Cost (SOC) (soc_bb) (ca.gov)]

4.15 Provider Dispute Resolution for Claims

BHSD Participating Providers have access to Provider Problem Resolution and Appeals processes to address authorization or claims issues, complaints, or other concerns.

4.16 Advance Payment

Advance payment request approval is at the sole discretion of County. Providers may submit advance payment requests in writing on agency letterhead. The request should specify the fiscal year and division for which the request is made (e.g., FY 2024 Children, Youth & Family Agreement); the advance payment amount requested; and the reason for the advance payment request. In addition, the request must include the following supporting documents:

(1) A proposed monthly payback schedule. The proposed payback schedule should provide for repayment of the requested advance payment amount before the end of the fiscal year through equal monthly payments, to be made through deductions from monthly invoices. The last monthly payment may be adjusted by a small amount if necessary to account for rounding and to achieve full repayment. (For example, a proposed payback schedule for a $100,000 advance could reflect eight payments of $11,111 and a ninth payment of $11,112.)

(2) Evidence (documentation) that all officials, employees, and agents handling or having access to funds received or disbursed under the provider's Agreement with the County, or authorized to sign or countersign checks, are covered by a BLANKET FIDELITY BOND in an amount of AT LEAST fifteen percent (15%) of the maximum financial obligation of the Agreement under which the request is made, as defined in the Exhibit B Summary Page of the Agreement.

The advance payment request, proposed monthly payback schedule, and blanket fidelity bond information must be sent via email to BHSD Finance at BHSD-Invoices@hhs.sccgov.org.

Chapter 5: Provider Beneficiary and Appeals Process

5.1 Complaints and Grievances

Grievance: A grievance is an expression of the person in care's unhappiness or dissatisfaction with the behavioral health plan (Mental Health and DMC-ODS). Any person who receives behavioral health services through the behavioral health care plans may file a grievance. There is no deadline to file a Grievance, but it is best to do it soon after the issue arises in order to provide more specific and detailed information. A person in care may file a grievance in writing, calling, or by coordinating an in person visit with the Utilization Management (UM) department (800) 704-0900, Option #5 or by calling (408) 793-5894 (TTY/TDD: (800) 855-7100 or 711). Grievances can also be submitted in writing to: Behavioral Health Utilization Management, P.O. Box 28504, San Jose, CA 95159. The person in care will receive a written confirmation of filing a grievance and the behavioral health plan will make a decision within 90-calendar days from the date the grievance was filed.

Grievances are categorized by issue which include but depending upon further updates from DHCS may not be limited to:

a) Related to Customer Service
b) Related to Case Management
c) Access to Care
d) Quality of Care
e) County (Plan) communication
f) Payment/Billing issues
g) Suspected Fraud
h) Abuse, Neglect or Exploitation
i) Lack of timely response
j) Denial of Expedited Appeal
k) Filed for other reasons

Providers must participate in annual training on Plan, state and federal Grievance (including Exempt Grievances) Resolution Process requirements, timelines, and reporting, and adhere to those standards. The process and reporting requirements for Discrimination related grievances must also be followed.

Grievance process exemptions, grievances, and discrimination grievances will be reviewed on average monthly by a group of leadership, division directors and other representatives as a means to identify system gaps and patterns that are problematic in

order to develop corrective action for system improvement.

5.2 Appeals Process

An appeal is a request for a review of a problem you have with the Behavioral Health Plan regarding a denial or changes in your services as mentioned in the NOABD section. Persons in care who have Medi-Cal and disagree with the decision or action taken by the mental health plan can request an Appeal. There are two types of appeals. A Standard and an Expedited Appeal.

Standard Appeal: A person in care may file an appeal in writing, on the phone, or in person. If filing by phone, the person MUST follow up with a written appeal as well however the date of the phone call is considered the filing date. If filing verbally in person, the person MUST follow up with a written appeal. The behavioral health plan will send the person a written confirmation that an appeal was received and is being processed. The behavioral health plan may take up to 30 calendar days to review a standard Appeal. The person in care must file an appeal within 60 calendar days from the date the action or decision was taken. This usually means the date on the NOABD.

Expedited Appeal: This type of appeal process is similar to the Standard Appeal, but an Expedited Appeal must meet certain requirements below:

- The person in care may request an Expedited Appeal verbally and does NOT have to put your request in writing.
- If the person in care thinks that waiting up to 30 calendar days for a standard Appeal decision will jeopardize their life, health, or ability to attain, maintain, or regain maximum function.
- If the behavioral health plan agrees that the person's appeal meets the requirements for an Expedited Appeal, then the behavioral health plan will resolve the expedited appeal within 72 hours from the date the expedited appeal as received.
- The behavioral health plan will notify the person and all affected parties orally and in writing of the decision of the expedited appeal.
- If the behavioral health plan decides that the appeal does not qualify for an expedited appeal, then the behavioral health plan will notify the person right away (verbally) and in writing within two (2) calendar days from the date the appeal was received.

To file a Standard or Expedited Appeal, the person in care may call the Utilization Management (UM) department (800) 704-0900, Option #5, by calling (408) 793-5894 (TTY/TDD: (800) 855-7100 or 711) or coordinate an in-person visit by calling any of the aforementioned phone numbers.

State Fair Hearing Process: A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure the person receives the behavioral health services to which they are entitled under the Medi-Cal program. The person in care may request a Fair Hearing if they are a Medi-Cal recipient. The person

in care has 120 calendar days to ask for a hearing from the day the behavioral health plan personally issued the Notice of Adverse Benefit Determination, or the day after the postmark date of the NOABD if it was mailed, or if an appeal was filed, 120 calendar days after the postmark date of an appeal. The person in care must follow these steps to request a State Fair Hearing:

1. Fill out the form provided with the Notice of Adverse Benefit Determination (NOABD)
2. Keep a copy for records
3. Send the completed form to: State Hearing Division California Department of Social Services P.O. Box 944243, Mall Station 19-37, Sacramento, CA 94244
4. Or call 1(800) 952-5253 (TTY/TDD: 1 (800) 952-8349)

Patient's Rights Advocate Persons in care and/or support persons may contact the Law Foundation of Silicon Valley (formerly known as the Mental Health Advocacy Project) at any time at (408) 293-4790 or Fax: (408) 293-0106 to assist with grievances, appeals, and state fair hearings. In-person assistance can be obtained by visiting the Law Foundation of Silicon Valley at 4 North Second Street, Suite 1300, San Jose, CA 95113. Online support can be obtained by going to the following website: https://www.lawfoundation.org.

5.3 Clinical Appeals Process

The clinical appeal process is available following the completion of a provider's audit/clinical record review. The instructions on what can be appealed, how to complete an appeal request including any necessary forms, along with the relevant timelines for such are typically included with the instructions that are given at the onset of a provider's audit/clinical record review.

5.4 Notice of Adverse Benefit Determination (NOABD)

Notice of Adverse Benefit Determination A Notice of Adverse Benefit Determination (NOABD) must be given to a person in care whenever services are denied, changed, or terminated. A NOABD is entered when it is determined that a person is not eligible for services or there has been alteration in the services provided. Before completing a NOABD, practitioner should consult with a supervisor.

What is a Notice of Adverse Benefit Determination (NOABD) and what is its purpose?
A Medi-Cal NOAB is a written notice that gives Medi-Cal applicants and persons in care an explanation of their eligibility for Medi-Cal coverage or benefits. NOABs include the eligibility decision and effective date of coverage, as well as any changes made in the person in care's eligibility status or level of benefits. The NOAB also includes information about hearing rights and how to appeal the decision if the person in care disagree with the eligibility determination. All NOABDs are available on BHSD's website.

Below are the types of NOABDs available:

A. Services Denied – Used when there has been a determination that the individual does not meet “medical necessity” criteria and is being referred to a lower level of care to address behavioral health concerns.

B. Provider Authorization Request Denied – Used when the Behavioral Health Plan denies a request for authorization by a Provider.

C. Provider Authorization Request Modified – Used when the Behavioral Health Plan denies a request for authorization from a Provider as requested, but instead approves a different level of care.

D. Termination of Previously Authorized Services – Used when the previously authorized services are no longer authorized (must be issued at least 10- calendar days prior to date of expiration of authorization).

E. Request for additional information – Used when a provider has submitted a request for authorization of service but there is insufficient information to make a decision on the request. The Behavioral Health Plan has asked for and awaiting additional information from the provider AND the 14-calendar day authorization period has expired.

F. Request for Authorization Late Notice – Used when the Behavioral Health Plan does not provide services within the expected time frames:

- 15 calendar days for psychiatry
- 10 calendar days for outpatient mental health or substance use treatment
- 5 calendar days for opioid treatment programs
- 24 hours for substance use treatment residential programs

G. Payment Denial – Used to deny payment for services which have already been delivered to the individual.

H. Dispute Financial Liability Denial – Used to notify the individual when their financial liability dispute has been denied.

I. Grievance Late Notice – Used by Behavioral Health Quality Improvement team to notify the individual when a resolution for their grievance has not been or was not resolved with the 45-calendar standard.

J. Appeal Late Notice – Used by Behavioral Health Quality Improvement team to notify the individual when a review of their appeal has been or was not resolved within the 30-day standard.

K. Timely Access Notice – Used by a provider to notify the individual when services have not been provided within a specified number of working days.

Chapter 6: Communicating with BHSD

6.1 Communications with BHSD

BHSD's website, www.BHSD.sccgov.org, contains answers to frequently asked questions, BHSD clinical practice guidelines, and links to numerous resources and important news for providers. General inquiries can be sent to BHSDBusinessoffice@hhs.sccgov.org

6.2 Provider Directory

BHSD maintains a database of provider information as reported to us by providers. The accuracy of this database is critical to BHSD and the plan's operations, for such essential functions as:

1. Reporting to the State for mandatory reporting requirements.
2. Periodic reporting and updating printed provider directories
3. Identifying and referring members to providers who are appropriate and to available services to meet their individual needs and preferences.
4. Network monitoring to ensure Beneficiary access to a full continuum of services across the entire geographic service area.
5. Network monitoring to ensure compliance with quality and performance standards, including appointment access standards.

Provider-reported hours of operation and availability to accept new members are included in BHSD's provider database, along with specialties, licensure, language capabilities, addresses and contact information. This information is visible to members on our website and is the primary information source for BHSD staff when assisting members with referrals. In addition to contractual and regulatory requirements pertaining to appointment access, up-to-date practice information is equally critical to ensuring appropriate referrals to available appointments.

6.3 Network Change Request Form

Contractor must immediately provide written notice to County of a change in ownership, organizational status, licensure, changes in contract, key contacts, program location or move, re-certification, added hours of operation, mergers, modes of service, or ability of

Contractor to provide the quantity or quality of contracted services in a timely fashion by completing and submitting the Network Request Change Form that can be found on this link https://www.surveymonkey.com/r/BHSDNETWORKCHANGEREQUEST

The Network Change Request Form serves as a centralized reporting place which serves several purposes including:

Track	Impacted Area	Types of Change
A	**Agency Contact Information and Updates**	New Legal Entity Name
		New CCP Email Address/Website
		Ownership Change
		Key Contacts – annual and updates
		Medical Director
B	**Site Certification, 274 and Electronic Health Records**	New location
		New program
		Add/Change of Modes
		Partial Move
		Renovation
C	**Network Adequacy**	Temporary Closure= Hold Referrals
		Program Closure
		Legal Entity Closure

Instructions for completing the Network Change Request Form can be found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)

On an annual basis, Participating Providers must complete a Census Form to accurately map and report the provider network, identify facilities that are accessible to beneficiaries with disabilities, and update key Participating Provider contacts.

6.4 Reporting HIPAA Violations

All HIPAA violations are to be submitted to the County of Santa Clara Health System's Ethics, Privacy, and Compliance Office within 24 hours of the discovery by phone at (408) 885-3794 or in writing via email to ComplianceOfficer@hhs.sccgov.org . To make an anonymous report, call (855) 888-1550 or on the web by connecting with Web Link: www.mycompliancereport.com (use Access Code: SCVH).

6.5 Reporting Fraud, Waste, and Abuse and Catastrophic Events

Provider will notify County by telephone of any potential violations of any provision of the Provider Agreement and unusual incidents within twenty-four (24) hours of the occurred incident. In addition, written notice must be sent to the Director of BHSD within seventy-two (72) hours from the occurred incident. This notification applies to the

following:

1. Catastrophic events that prevent provider to meet the regulatory deadlines.
2. Reporting fraud, waste, and abuse

6.6 Incident Report Submission

When an incident occurs, all providers will attend first to the mental wellbeing of the beneficiary first and notify their supervisor. For a Critical Incident or a Sentinel Event providers will complete the Critical Incident Sentinel Event Report. For a Quality of Care Concern, all sites, both county operated and contracted, are required to report concerns through submission of a Quality-of-Care Concern log sent quarterly. The Quality of Care Log requires a signature of the director or designee at the time of submission.

Critical Incidents are expected to be reported within two (2) calendar days, and Sentinel Events are reported immediately following the event (within 24 hours). Providers are required to report quality of care concerns by completing and submitting a Quality of Care Concern/Incident Report in a secure encrypted email to qualityofcareconcern@hhs.sccgov.org.

Please see the following links for the forms.

AGI-003A-Critical-Incident-Sentinel-Event-Report-(5).pdf (sccgov.org)

AGI-003B-Quarterly-Quality-of-Care-Log(1).xlsx (live.com)

A Critical Incident is reported within 2 days (48 hours) and includes:
Violent Behavior
☐ Verbally or physically threatening behavior by a client (includes mandatory reports of threatened violence)
☐ Physical assault by a client on staff NOT requiring emergency medical intervention
☐ Physical assault between clients NOT requiring emergency medical intervention
☐ Damage to program property by client
☐ Violent behavior or thoughts resulting in a psychiatric hold
☐ Other violent behavior (e.g., visitors, witness community violence)

Client Suicide Attempt
☐ NOT requiring emergency medical intervention

Medication Issue
☐ Client required emergency care, hospitalization, or transfer to medical unit as a result of medication issue.

Injury, Accident, or Acute Medical Problem

☐ Staff injury, accident, or acute medical problem NOT requiring emergency medical intervention (Significant Injury, requiring possible medical attention in the immediate future)
☐ Client injury, accident, or acute medical problem NOT requiring emergency medical intervention (Significant Injury, requiring possible medical attention in the immediate future)
☐ Unauthorized/Unexcused Client Absence from 24-hour Care Settings (AKA AWOL)
☐ Other

A Sentinel Event is reported immediately (within 24 hours) and includes:
Violent Behavior
☐ Physical assault by a client on staff requiring emergency medical intervention
☐ Physical assault between clients requiring emergency medical intervention
☐ Homicide

Sexual Assault/Misconduct (all considered sentinel)
☐ Sexual assault/misconduct involving client by staff
☐ Sexual assault/misconduct involving client by another client

Client Suicide Attempt
☐ Requiring emergency medical intervention

Medication Issue
☐ Client required emergency care, hospitalization, or transfer to medical unit as a result of medication issue.

☐ Acts constituting a violation of professional code of ethics or of any County of Santa Clara policy governing professional conduct

Client Death (all considered sentinel)
☐ Expected medical problem ☐ Unexpected medical problem ☐ Accidental/fatal injury ☐ Homicide ☐ Suicide ☐ Alcohol/drug overdose ☐ Unknown

Service Disruption Resulting in Temporary or Prolonged Program Closure Due To (all considered sentinel)
☐ Client behavior ☐ Fire ☐ Water/flood ☐ Terror threat ☐ Crime scene
☐ Earthquake ☐ Unusual odors/vapors ☐ Violence ☐ Infestation
☐ Disease outbreak ☐ Other

Injury, Accident, or Acute Medical Problem
☐ Staff injury, accident, or acute medical problem requiring emergency medical intervention

☐ Client injury, accident, or acute medical problem requiring emergency medical intervention
☐ Client or staff needle stick

A Quality of Care Concern is reported quarterly (5th day of the month after the prior quarter) using the Quality of Care Log and includes:

Any event or condition that has had or may have an adverse effect on the health or safety of our program beneficiaries, guests, staff, or members of the general public. Quality of care concerns may include reports from workforce members, public or beneficiaries, mandatory abuse reporting, audit findings, utilization reviews, critical incidents, or sentinel events.

Quality of Care Logs and Critical Incident_Sentinel Event Reports are to be sent securely to the QualityofCareConcern@hhs.sccgov.org email. The log and report can be found on these links:

AGI-003A-Critical-Incident-Sentinel-Event-Report-(5).pdf (sccgov.org)
AGI-003B-Quarterly-Quality-of-Care-Log(1).xlsx (live.com)

If a incident review is requested to discuss the circumstances surrounding the critical incident or sentinel event a team will convene to identify any systemic issues, agency practices, or areas of need which may be able to be addressed to support improvements to our process.

6.7 Annual Attestation

Providers are required to complete the "Provider Ownership Interest and/or Managing Control Disclosure Statement" form. The purpose of this form is to determine if a contracted provider and/or network provider has ownership and controlling interests, disclosures related to business transactions, or disclosures related to persons convicted of crimes for the contractor ("Agency"). The form can be found on this link: Electronic Health Records - Behavioral Health Services - County of Santa Clara (sccgov.org)

1. Disclosure of 5% or More Ownership Interest

   a. Individual with an ownership or control interest means a person that:
      i. Has an ownership interest of 5% for more in the Agency;
      ii. Has an indirect ownership interest equal to 5% in the Agency;
      iii. Has a combination of direct and indirect ownership interest equal to 5% or more in the Agency;
      iv. Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least 5% of the value of the property or assets of the Agency

v. Is an officer or director of an applicant or provider that is organized as a corporation within the Agency;
vi. Is a partner in an applicant or provider that is organized as a partnership of the Agency.

b. Ownership interest means the possession of equity in the capital, the stock, or the profits of the applicant or provider.

c. To determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the applicant or provider's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and shall be reported pursuant to Section 51000.35(a). Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

2. Disclosures Related to Business Transactions

   a. The ownership of any sub-Contractor with whom Contractor's transactions total more than $25,000 during the 12-month period ending on the date of the request.

   b. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)

3. Disclosures Related to Persons Convicted of Crimes:

   a. The identity of any person who has an ownership or control interest in the provider or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)

4. On annual basis, Agencies must email the completed forms for all its providers to the BHSDBusinessOffice@hhs.sccgov.org upon execution of contract and within 35 calendar days of any changes.

Chapter 7: DMC-ODS Program Requirements

7.1 Trainings

The required trainings for DMC-ODS participating providers are described below:

ASAM Training

This training is required prior to providing services.
Participating providers conducting assessments will need complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care." A third module entitled "Introduction to The ASAM Criteria" is recommended for all support staff participating in DMC-ODS.

Department Training

Thes trainings are for new participating providers and includes an annual update training:

1. Departmental Best Practices (must be taken by all new employees). Current staff may attend as a refresher.
2. DMC-ODS Training. Contractor staff shall be trained on the requirements of the Intergovernmental Agreement (IA) Title 9, Title 22 regulations and DMC requirements annually. Participating providers will need to complete annual DMC-ODS update training.

Prison Rape Elimination Act (PREA) Training

This training is for participating providers serving beneficiaries in locked facilities. This training is required every two years and is a federally mandated training required for all staff who have face to face contact with incarcerated adults and juveniles.

CalOMS Training

CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for substance use disorder (SUD) treatment services. This training is for clinical and administrative staff and will be offered monthly.

Mandatory trainings		
Training title	**Target staff**	**Frequency**
ASAM E-modules	All	Once upon hire
ALOC (authorization)	Clinical	Once and as needed to keep up with updates

Treatment Planning/Stage of Change	Clinical	Once and as needed
CalOMS (provided monthly)	Clinical and admin	Once and as needed to keep up with updates
Clinical Practice Guidelines	Clinical and management	Once and as updated
DMC-ODS training	Clinical and management	Annually or as provided
Confidentiality/42 CFR Part 2	Clinical, Admin, Management	Once annually
Compliance	Clinical, Admin, Management	Once annually
CLAS (Cultural & Linguistically Appropriate Standards)	Clinical, Admin, Management	Once annually
Prevention of Sexual Harassment	Clinical, Admin, Management	Once every 2 years
Law and Ethics	Clinical, Admin, Management	Once every 2 years
Communicable Diseases: (Hep C, TB, HIV, AIDS)	Clinical, Admin, Management	Once every 2 years
Case management & care coordination	Clinical and management	At least once annually
Evidence-based practices	Clinical and management	At least once annually
ASAM workshops	Clinical	At least once annually

7.2 Substance Use Treatment Services (SUTS): Residential

Participating providers in SUTS residential programs will need to follow these guidelines:

1. Intakes must take place 7 days/week and include evening hours.
2. Missed initial intake appointments must be rescheduled by the program.
3. An empty bed must be filled within 24 hours of a discharge (unless there are no referrals).

4. During the initial phase of treatment clients/beneficiaries must be eligible for family visitation.
5. Programs must make every effort to arrange for storing and making available personal snack food of clients/beneficiaries.
6. On family visiting days, families must be allowed to bring food to share with clients/beneficiaries.
7. Programs must offer family educational component, minimum one time per month.
8. Programs must keep group sign in sheets.
9. Residential treatment is a component of the continuum of care focusing on stabilization. Once a client/beneficiary has stabilized, they have completed this phase of treatment, and should be referred to the next appropriate level of care based on ASAM criteria. Discharge planning and follow up referrals are required for all clients, including those discharged involuntarily.

7.3 Adolescent Substance Use Disorder (SUD) Best Practices Guide

SUTS Youth providers will need to follow the Adolescent SUD Best Practices Guide developed by DHCS incorporating scientific research and clinical practice from both the SUD treatment files and children's service systems. The guidance is based on the American Society of Addiction Medicine (ASAM) Criteria for determining the appropriate intensity and length of treatment for adolescents with SUDs. The guide can be found on this link: Adolescent Best Practices Guide OCTOBER 2020 (ca.gov)

7.4 Perinatal Practice Guidelines

Perinatal providers will need to follow the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The guide can be found on this link: PPG FY 18-19 FINAL (ca.gov) Perinatal NTP will also follow Title 9 Perinatal requirements.

Chapter 8: Court System Requirements

8.1 Adult Client Status Report (CSR)

All programs are required to submit a CSR upon intake to BHSD, and as requested for court dates, informal reviews, and at critical incidents and any level of care changes due to behavioral issues. BHSD providers shall submit a CSR form to the Court and the Supervising agency (i.e., Pretrial, Probation, Parole) five (5) days in advance of the court date or as soon as possible. BHTC staff will notify Case Managers of the participant's upcoming court dates.

The following is the expected workflow regarding CSRs for Contract Agencies:

1. CSRs must be sent to BHTSRD61@hhs.sccgov.org
2. CSRs must be sent as encrypted when sent to community and justice partners via e-mail.
3. CSRs must be sent monthly to the following: Court, Parole Agents, Pre-Trial Service Officers, and Probation Officers.
4. CSRs must be sent five business days prior to a client's court date, as per court guidelines. a. Note: It is the treatment providers' responsibility to know when a client's court date is. The CSR Clerk or BHTC Manager will also provide the court calendar approximately 1 week in advance via email.
5. CSRs must be sent out when clients are admitted, discharged, or go AWOL in addition to the monthly reports required prior to clients' court dates. a. Note: When a client is discharged from the program, a CSR must be sent to community and justice partners within five business days.
6. Once CSRs are received the by Behavioral Health Treatment Court Staff, a confirmation email should reach Contract Agencies.

CSRs must include the following:

1. Details regarding client participation in treatment program:
    a. Client Strengths: What is the client doing well? What, if any, improvements has the client made to the quality of their life and/or pursuit of increased independent functioning?
    b. Adherence to mental health treatment and groups: Is the client compliant with program expectations for individual and group therapy?
    c. Medications: Is the client abiding by the medication policy? Are they taking the appropriate medications at the appropriate times?
    d. Meetings with Case Managers, Pretrial/Probation/Parole, and Psychiatrists: Is the client attending their meetings with their assigned case

managers/pretrial/probation/parole and psychiatrists? How many have they attended since the last court date? How many have they missed?

e. Making good use of leisure time (if applicable): Is the client working on productive use of time (obtaining a job, community service, school)?
f. U/A and Breathalyzer Results (if applicable): Has the client tested positive for any illicit substances? When asked to provide a random sample, did the client behave appropriately?
g. Current Needs: What do you want the court to specifically address with the client?

CSRs may also include the following, if applicable:

1. Responding to Reasonable Staff Requests: Does the client respond appropriately to reasonable staff requests? If not, how many times has this issue arisen and how has the issue been addressed by staff?
2. Behavioral Issue[s] Examples: a. The resident did not follow simple staff requests; the resident engaged in staff splitting behavior by asking different members of staff the same question with the aim of obtaining a different answer; the resident was reminded on the following dates that cleanliness is a required part of the community living expectations: DD/MM/YYYY, DD/MM/YYYY, etc.
3. Residential Discharge Detail Examples:
    a. Example 1: The client was discharged from the [PROVIDER] on DD/MM/YYYY due to a violation of his/her behavioral contract. The resident continues to engage in staff splitting behaviors as evidenced by the client continuing to ask different members of staff the same question with the aim of obtaining a different answer.
    b. Example 2: The client was discharged from the [PROVIDER/HOUSING PLACEMENT] on DD/MM/YYYY due to a violation of his/her behavioral contract. After being placed on a behavioral contract on DD/MM/YYY, the client did not take medications, missed all mandatory meal checks-in (breakfast and dinner) and continued to be in violation of the following community living expectations and rules of which the client consented to following at intake. (In this example, the rules and violations would then be listed.)

How do we find out when the clients' next court date is?

- Review the Calendars of your clients sent by the BHSD CSR Clerk.
- Attend Court with client and hear next scheduled date.
- Obtain date from the client and their Minute Order
- Check the Santa Clara County Superior Court Portal: https://portal.scscourt.org/search (You will use the Party Search tab and enter the person's name.)
- For In-Custody clients, the next court date can be found using: https://eservices.sccgov.org/ovr/findinmate/find

Chapter 9: Compliance

9.1 Release of Information (ROI)

Federal and State Privacy regulations protected health information (PHI) cannot be disclosed without a complete and valid release of information (ROI) singed by the client/guardian. There are some exceptions under HIPAA that allow providers to share information for treatment purposes without an ROI present. Consult your privacy and compliance departments for further information on exceptions.

9.2 Communication of Beneficiary and Provider Information

Providers are reminded that protected health information (PHI) can only be communicated via email if it is encrypted and secured, or through BHSD's myAvatar. PHI can also be communicated by telephone or secure fax if the recipient of the information is confirmed, I.e., confirming fax number, validating a minimum of two identifiers from the individual (DOB, Address, Name, email address on file, etc.).

Providers are required to develop policies and procedures to ensure the confidentiality of behavioral health and substance use information. Comprehensive policies must include initial and annual in-service education of staff/contractors, identification of staff allowed to access and limits of access, procedure to limit access to trained staff, protocol for secure storage, procedure for handling requests for behavioral health and substance use information, periodic reviews to validate staff access, and protocols to protect patients from discrimination.

In the event of a PHI breach, providers (County and Contracted) are required to have written policies and procedures in place to report such incidents to BHSD. Providers are required to report violations of PHI breaches to their local compliance officers and notify the County of Santa Clara Health System's Ethics, Privacy, and Compliance Office (CSCHSEPCO) within 24 hours of the discovery by phone at (408) 885-3794 or in writing via email to ComplianceOfficer@hhs.sccgov.org . To make an anonymous report, call (855) 888-1550 or on the web by connecting with Web Link: www.mycompliancereport.com (use Company Access ID Code: SCVH).

Chapter 10: Auditing

10.1 State Audits

Providers who render services to Medi-Cal are subject to audits by our state partners, state and federal entities have the authority to directly review any provider sites. BHSD is available to support our provider partners through the process, including resolution and submission of corrective action plans and evidence. If a Participating Provider is selected by DHCS for an audit, that Participating Provider must inform the County of Santa Clara Quality Assurance Team within 72 hours of receiving the notification by forwarding the DHCS letter to QA@HHS.SCCGOV.ORG.

10.2 Clinical Audits

Compliance and Quality Assurance audits within a Medi-Cal context are focused on ensuring that there is no fraud, waste, and/or abuse within the service provision and claiming system. Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote compliance. Additionally, providers should never copy and paste notes into a person's medical record. Not only does this practice do a disservice to the individual's documented course of treatment; it is an unethical practice. Each note must clearly document the specific service provided.

Please ensure documentation is completed within the appropriate program under which you are providing the service. Generally, this means the program for which you, the practitioner, are assigned to in order to avoid issues with the submission of billing for services. Please note that County staff are not permitted to write progress notes in a contracted Provider episode and vice-versa; contracted Provider staff are not permitted to write progress notes in a County episode. Doing so will have financial impact to the programs.

10.3 Site Visits

BHSD may conduct site visits to review compliance with State and Federal requirements related to health and safety of the facility and required postings.

10.4 Corrective Action Plans

As a Participating Provider you are obligated to participate in auditing that covers everything from administration to clinical care and financing. The County of Santa Clara is required to conduct annual reviews of providers' charts regarding documentation consistent with established standards. Additionally, if at anytime, the County of Santa Clara requires review of providers charts, for any reason, providers are required to

comply with such requests. For example, County and State Audits, Grievances and/or any quality of care concern.

BHSD uses a comprehensive auditing tool that covers all aspects and is updated annually. Providers will be notified at least 60 calendar days in advance of the audit and expected to produce necessary documentation and cooperate with further requests for information, clarification, or documentation.

Depending on the outcome of the audit the county may issue findings and may require you to complete a corrective action plan (CAP). Providers are required to use the CAP template distributed with the report.

Each deficiency identified must be addressed via a CAP. The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

The CAP shall:

1. Address each compliance deficiency;
2. Include the date of response;
3. Provide a specific description of how the deficiency will be corrected;
4. Identify the staff person responsible for correcting the deficiency and ensuring future compliance;
5. Specify the date of implementation of each deficiency; and
6. As deficiencies are corrected, include relevant documentation which demonstrate the correction of a deficiency, if applicable.

<u>Initial Provider Response</u>

The Provider is responsible for completing the columns titled:

- Date with Provider Response
- Staff Responsible
- Proposed Implementation Date

Submit the completed CAP via e-mail to the BHSD analyst. The analyst will review each Provider response and proposed implementation date, and send a response back to the Provider.

<u>Updated Provider Response</u>

The BHSD analyst will complete the column titled:

- County Response to Provider

This column will indicate whether or not the County's response is accepted, and/or additional required action, recommendations or comments.

The Provider must respond to each County response which indicates, “Provider Response Not Sufficient,” or responses that require additional action.

The Provider shall response to the County by adding their updated response and date of the updated response to the column titled:

- Provider Response

Submit the updated CAP, in Word format, via e-mail to the BHSD Business Office bhsdbusinessoffice@hhs.sccgov.org. This process will continue until each response is accepted by the analyst. Once all the corrective actions are approved, the analyst will send a CAP Approval Letter. When the CAP has been approved by the County, the Provider may submit relevant documentation to demonstrate the correction of a deficiency.

NTP Programs are audited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as well as the DEA and other agencies. CAP plans are created and submitted to each organization as required by AMT management.

Chapter 11: Contacts and Glossary of Terms

11.1 Contacts

Topic	Email	Phone
Audits (Administrative & Chart Review)	BHSDPR@hhs.sccgov.org	N/A
BHSD EHR Information (CCPs Only)	BHSD_EHR_info@hhs.sccgov.org	N/A
BHSD EHR Information (County Only)	BHSD.EHR.Help@hhs.sccgov.org	N/A
BHSD Documentation Correction	ccppcnxdoccorrection@hhs.sccgov.org – For help to process errors made in Avatar that county needs to support with	N/A
BHSD-TSS	support@tss.sccgov.org with "for HHS-BHS Triage" included in the subject line – For CCPs needing to open tickets with Netsmart	(408) 970-2222
CalAIM	bhsdcalaim@hhs.sccgov.org	(800) 704-0900
Call Center	BHSDCallcenter@hhs.sccgov.org	
Credentialing	BHSDCredentialing@vhp.sccgov.org	(408) 885-2221
DMC Site Certification	BHSDBusinessOffice@hhs.sccgov.org	N/A
HIMS	HHS-HHSHIMBHSD@hhs.sccgov.org – For CCPs that see multiple MRNs for a single client and need to determine which MRN needs to be used	N/A
Invoices (Direct, Indirect, Cost-Based)	BHSD-Finance@hhs.sccgov.org	N/A
MH Clinical Record Reviews; MH and SUTS Grievances, Appeals, State Fair Hearings; DHCS CAPS; Incident Reports; and Documentation Questions	qa@hhs.sccgov.org	(408) 793-5894
MyAvatar Claiming (PCE and PCNX)	SCCBillingquestions@ntst.com	N/A
PAVE	BHSDBusinessOffice@hhs.sccgov.org	N/A

Performance Measures Timeliness (NACT and TDAT) PIP(Program Improvement Project) including the Warm Hands Off Project	bhs_qi@hhs.sccgov.org	N/A
Provider Manual	BHSDBusinessOffice@hhs.sccgov.org	N/A
Reporting Support	bhsd.reporting@hhs.sccgov.org	N/A
Short Doyle/Medi-Cal Site Certification	BHSDSiteCert@hhs.sccgov.org	N/A
System Access Request	BHSDBusinessOffice@hhs.sccgov.org	N/A
Other inquiries	BHSDBusinessOffice@hhs.sccgov.org	N/A

11.2 Glossary of Terms

270	The 270 transaction is a request for eligibility information. A provider submits a 270 transaction for a Beneficiary to a payer/insurance to find out the Beneficiary's eligibility information. Participating Providers are required to review real-time to determine eligibility.
271	The 271 transaction is the reply to the 270 eligibility inquiry. It transmits eligibility information to the requester.
837P	A standard format for all claim data. The 837 is a HIPAA compliant electronic submission of health care claim data. CCP's can submit their claim data via 837 and the Plan will submit eligible claims to the State via 837.
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 C.F.R. § 455.2) Examples - 1. Unknowingly billing for medically unnecessary services. 2. Unknowingly misusing codes on a claim.
Adjusted Claim	1. Request for payment reconsideration for a paid or denied claim. 2. Any claim for which a Remittance Advice (RA) was issued that was not paid appropriately or denied.

Administrative Review	If a claim under dispute was originally denied, underpaid, or overpaid based on non-medical criteria. The Claims Processor determines based on the contested claim criteria and any additional information presented by the provider whether the claim was incorrectly processed.
Adverse Benefit Determination	Means any of the following actions taken by a Plan: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of grievances and appeals. 6. The denial of a Beneficiary's request to dispute financial liability.
Amended Provider Dispute	Information not requested by BHSD but sent by provider. A provider submits an amended Provider Dispute within thirty (30) business days of the Date of Receipt of a closed Provider Dispute.
Appeal	An Appeal is a Plan review of a Notice of Adverse Benefit Determination (NOABD). A request for review of an Action, in response to a problem, such as denial or changes to services a Beneficiary believes they need. The Appeal may be filed in person, on the phone, or in writing. However, Appeals must be signed by the Beneficiary or by the Participating Provider on behalf of the Beneficiary. A process to have an authorization decision that adversely affects services provided to an individual, or involves denial of services to an individual, reviewed by a licensed professional to evaluate the medical needs or the individual and not in the original denial decision, to evaluate the medical needs of the individual for possible decision reversal.
Authorization	Approval from Plan prior to the Beneficiaries receiving services. Remittance Advice is a statement sent to a provider by Plan listing services provided, amount billed, payment made and/or the reason for the denial of services. Unbundling is the practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.
Beneficiary	A person seeking or receiving behavioral health services from BHSD that is either a person certified as eligible for Medi-Cal or Medicare services, or someone for whom there is no third-

	party payor who may become responsible for paying all or part of the person's medically necessary behavioral health services.
Bundled Claims	A Provider Dispute request with multiple claims that are similar in nature on a single document. The request is for more than one (1) member and/or more than one (1) claim number.
Business Day	A business day is a unit of time measure that refers to any day in which normal business operations are conducted.
Calendar Days	Means 365 days of the year.
California Department of Public Health (CDPH)	The state department responsible for public health in California. It is a subdivision of the California Health and Human Services Agency. It enforces some of the laws in the California Health and Safety Codes, notably the licensing of some types of healthcare facilities.
Capitation payment	A payment the State makes periodically to the Participating Provider on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The State makes the payment regardless of whether the Beneficiary receives services during the period covered by the payment.
Claim	A bill that providers submit to a Beneficiary's insurance provider. This bill contains unique medical codes detailing the care administered during a Beneficiary visit. The medical codes describe any service that a provider used to render care, including: • A diagnosis • A procedure • Medical supplies • Medical devices • Pharmaceuticals • Medical transportation When a provider submits a claim, they include all relevant medical codes and the charges for that visit. Insurance providers, or payers, assess the medical codes to determine how they will reimburse a provider for their services.
Claims Acknowledgement (CA277)	An electronic transaction format file that allows payers of health care claims to provide notification to the trading partner of all accepted and rejected claims. 837 is an electronic transaction format file that allows health care providers, both professional and institutional, to submit their claims for payment to health care payers.
Complaint	A Complaint is the same as a formal Grievance. A Complaint shall be considered a Grievance unless it meets the definition of an "Adverse Benefit Determination."

Complete Claim, clean claim	Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. 42 CFR § 447.45
Contested Claim Criteria	Non-medical criteria used to guide the reconsideration of all disputes.
Corrected Claims	Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original claim number. Corrected claims are considered new Claims for processing purposes. Corrected Claims must be submitted within the timelines outlined in this Policy.
Corrective Action Plan (CAP)	A corrective action plan (CAP) is a step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to: • Identify the most cost-effective actions that can be implemented to correct error causes. • Develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient • Achieve measurable improvement in the highest priority areas • Eliminate repeated deficient practices.
Cost-Based Programs	If authorized in the Participating Provider's Agreement with the County, a Participating Provider may submit cost-based invoices for expenses in excess of Direct Services, Indirect Services, and Cost-Based Services. An invoice itemizing labor, operating, and other costs must be provided. Total expenses less payments made from monthly Direct Services, Indirect Services, and Cost-Based Services Invoices will be paid up to the Maximum Financial Obligation (MFO) of the program. Supporting documentation such as payroll records, invoices, receipts, a trial balance, G&A overhead schedule, overhead schedule, and any other records necessary to support costs listed on the invoice should be submitted and copies retained for verification and reconciliation purposes.
County Contracted Providers	Contracted Providers (CCPs) that agree to provide covered specialty mental health services and/or substance use

	treatment services to Beneficiaries, or any other organization or person who agrees to perform any administrative function or service for BHSD specifically related to securing or fulfilling its obligations to the DHCS under the terms of their existing contracts.
Covered Diagnoses	A mental health or substance use disorder that qualifies for Medi-Cal reimbursement as identified in the California Code of Regulations and ASAM Criteria. Refer to BHSD Policies ADM-003 DMC-ODS Requirement for period 2022-2026 and ADM-005 Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements for new Cal-AIM criteria.
Credentialing	Credentialing is a uniform process for verifying, through Primary Source, the education, training, experience, licensure and overall qualifications of behavioral health and substance use disorder services Participating Providers.
Credentialling Attestation	For all network Participating Providers who deliver covered services, the Participating Provider must include a signed and dated statement attesting to the following: a. Any limitations or inabilities that affect the Participating Provider's ability to perform any of the position's essential functions, with or without accommodation. b. A history of loss of license or felony conviction. c. A history of loss or limitation of privileges or disciplinary activity. d. A lack of present illegal drug use. e. The application's accuracy and completeness. Credentialing Attestations must be completed at start of contract, at hire and minimally, every three (3) years thereafter.
Date of Determination	Date on Provider Dispute or Amended Provider Dispute Determination letter delivered by physical or electronic means to the claimant's office or other address of record.
Date of Receipt	The business day when the provider dispute, amended provider dispute or additional information is received by Plan.
Date of Service	For the purposes of evaluating claims submission and payment requirements under these regulations, means: 1. For outpatient services and all emergency services and care, the date upon which the provider delivered separately billable health care services to the enrollee. 2. For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a

	Plan and a Plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.
Denial	A determination that a specific service is not medically/clinically appropriate, necessary to meet needs, consistent with the person's diagnosis, symptoms and functional impairments, the most cost-effective option in the least restrictive environment, and/or consistent with clinical standards of care and/or per policy and contractual requirements.
Denied Claims	A claim will be denied if Medi-Cal does not cover the service rendered, if it is a duplicate of a prior claim, if the required Prior Approval is not obtained, or if the data is invalid or logically inconsistent. Please refer to the Billing Section of your Provider Manual for details. Providers should review the denied claim on their remittance advice (RA) statement and resubmit on a new claim.
Department of Health Care Services (DHCS)	Department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal, which provides health care services to low-income people.
Direct Service	Services that have the potential to earn Medi-Cal if the client has Medi-Cal as their payor. There are two types of clients receiving Direct Services: sponsored, and unsponsored. A sponsored client has Medi-Cal coverage, and an unsponsored client does not have Medi-Cal coverage.
Disclosing Entity	A Medi-Cal provider (other than an individual practitioner or group of practitioners). For example, a health plan.
Drug Medi-Cal Organized Delivery System (DMC-ODS)	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021, to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed

	care, and Specialty Mental Health Services (SMHS).
Early and Periodic Screening Diagnosis and Treatment (EPSDT)	EPSDT is a federal entitlement that requires states and counties to provide comprehensive and preventative health care services to low-income children under 21 who are enrolled in Medicaid. In California, Medicaid is referred to as Medi-Cal. The EPSDT component of Medi-Cal aims to ensure that all children and adolescents have access to appropriate preventive, dental, mental health, substance use, developmental, and specialty services. The federal government matches state dollars to fund these mandatory services.
Electronic Data Interchange (EDI)	The electronic interchange of business information using a standardized format; a process which allows one company to send information to another company electronically rather than with paper. Business entities conducting business electronically are called trading partners.
Excluded Party Database Attestation	A mechanism or form used by Participating Provider's or designee(s) to demonstrate they have conducted monthly required database checks to ensure its Practitioners are in good standing and not listed on any of the excluded party databases.
Expedited Requests	An Expedited Request occurs when the standard process could jeopardize the Beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. If the Beneficiary or Provider expedited hearing request is approved, a decision will be issued within three (3) business days of the date of the request. Expedited Requests may include Grievances, Appeals and State Fair Hearings. Expedited Requests must be resolved within seventy-two (72) hours of receipt of the request.
Rate Table	The rate table consists of a direct, indirect and cost based statement and Director approved advanced payment provisions that the Plan has agreed to pay to the CCP for services rendered during the course of the services agreement. The fee table describes the funding sources, populations to be served, the rates per service items and total number of units allowed. The fee table outlines the Plan's Maximum Financial Obligation (MFO).
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 C.F.R. §§ 433.304, 455.2) Examples - 1. Knowingly billing for services not performed.

	2. Knowingly falsifying information on documents to receive a higher payment.
Goodwill Payment	Goodwill payment is a payment being made as a gesture of goodwill where the original decision to deny the claim is not being overturned. BHSD will pay the claim in order to maintain the established relationship. Goodwill payments are not required to include interest and penalties if they are paid late.
Grievance	An expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Beneficiary's rights regardless of whether remedial action is requested. Grievance includes a Beneficiary's right to dispute an Extension of time proposed by BHSD to make an authorization decision. There is no distinction between an informal and formal Grievance.
Healthcare Access Program (HAP)	The State required annual amount that is based on household size, income, assets, and allowed expenses.
HealthCare Common Procedural Coding System (HCPCS)	A Center for Medicare and Medicaid Services (CMS) uniform coding system consisting of descriptive terms and codes used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.
Holiday	An event of any duration where the office will not be open during regular hours for Beneficiary services, such a Labor Day, Thanksgiving, or staff training days. The CCP is expected to maintain at minimal a skeleton crew that will facilitate the processing of referrals coming from the BHSD Call Center or 24-Hour Care unit.
Indirect Service	Indirect Services are Non-Medi-Cal Eligible services, whether the client has Medi-Cal or not: • Outreach Services • Dedicated Beds • Any other Indirect Services authorized in the Participating Provider's Agreement with the County
Ineligible Person	Is an individual or entity who: 1. Is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal or state health care program or in federal or state procurement or non-procurement programs; or 2. Has been convicted of a criminal offense that falls within scope of 42 U.S.C. §§ 1320a-7a or similar state

	statute, but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.
Information Necessary to Determine Payer Liability	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claim's adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Interest on Late Claim Payment	Interest accrued on a claim that is processed and paid past the regulatory requirements of forty-five (45) business days. Calculation of interest is based on the daily interest rate. The formula is as follows: divide the interest rate of 15 % by 365 days, multiply the number of delayed days by the allowed amount of the claim and then multiply by daily interest rate.
International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)	A medical classification list by the World Health Organization (WHO) used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. Maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
Leave of Absence	A leave of absence is when an employee will take time off work for 30 days or more.
Medical Necessity Criteria	For individuals 21 years of age or older, for DMC-ODS and MHP, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in WIC §14059.5. Definition of Medical Necessity. For individuals under 21 years of age, for DMC-ODS and MHP, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in 42 CFR §1396d(r)(5) Early and periodic screening, diagnostic, and treatment services. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

	Refer to BHSD Policy ADM-007 Access and Availability of Services.
MyAvatar 835	The 835 transaction is an electronic remittance advice that explains claims that have not passed adjudication rules in MSO.
Non-Specialty Mental Health Services (NSMHS)	NSMHS are delivered via Managed Care Plan (MCP) and Fee for Service (FFS) delivery systems and are provided to recipients, age 21 years and over with mild-to- moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.
Notice of Adverse Benefit Determination (NOABD)	Informs the Beneficiary of a denial or change to their SMHS or DMC-ODS services. It also notifies the Beneficiary of the right to request an appeal if the Beneficiary does not agree with BHSD's decision. The NOABD outlines the delays in resolving grievances, appeals, providing services in a timely manner, delays in authorization, or to dispute financial liability.
Organizational Provider	Refers to facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. This element applies to all organizational providers with which the organization contracts (e.g., telemedicine providers, urgent care centers).
Original Claim	A professional or institutional medical claim that was initially submitted by provider to BHSD for processing.
Participating Provider	A County, Individual Provider or County Contracted Provider (CCP) that has agreed to contract with the BHSD Plan to provide eligible services to Beneficiaries covered by its plan.
Payment Authorization	Payment Authorization" means the written, electronic or verbal authorization given by a Plan to a provider for reimbursement of specialty mental health services or DMC-ODS services provided to a beneficiary.
Pended Claims	A pended claim is one in which the Claims Processor cannot make a final determination without further review or investigation. A claim may be pended if it contains erroneous information, does not match state insurance information, or requires manual review to be resolved. The Claims Processor will review the pended claim. Any claim pended during the current payment cycle will appear on the remittance advice statement with a descriptive message about why the claim was pended. Pended claims may ultimately be approved for payment, reduced or denied. Some common reasons to pend

	a claim are listed in the Adjudication Rules section of this policy.
Plan	BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).
Practitioner	Workforce Members who are providing direct Beneficiary care services, are licensed, registered, waivered, certified or meet criteria as a paraprofessional.
Primary Source	Refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
Prior Authorization	The process of obtaining approval or authorization to perform a covered service in advance of its delivery. Required for Adult Residential, Therapeutic Behavioral Services, Treatment Foster Care and planned psychiatric hospitalization. The Plan will make authorization decisions within five (5) business days of receipt of request.
Proof of Timely Filing	Documents from the provider and/or the facility that shows the original claim submission date. Must show the member's name, date of service billed, and date claim was submitted to the Plan.
Provider Services Agreement	This Service Provider Agreement serves to record the agreement between the parties and to regulate all aspects of the services and/or products to be supplied by the Service Provider and the general business relationship between the parties.
Reasonably Relevant Information	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of Plan's or Plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Reconsideration	Review of a previously denied, underpaid, or overpaid claim where provider presents additional information to explain why the claim should be paid.
Re-Credentialing	The process of credential verification every three (3) years that a Participating Provider continues to meet Plan Credentialing requirements.
Remittance Advice (RA)	A written explanation sent to the provider of service on how the claim was processed by Plan. The RA includes information as the member's name, date of service, claim number, amount submitted by provider, amount paid by Plan and reason for either payment or denial. The RA is mailed with the payment to the provider.

Representative	A person who is authorized by the Beneficiary to act on behalf of or assisting a Beneficiary, and may include, but is not limited to, a family member, a friend, a BHSD or provider employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.
Resolution	Means the Grievance or Appeal has reached a final disposition with respect to the Beneficiary's submitted Grievance or Appeal. BHSD Grievance will send the Notification of Grievance Resolution (NGR) to notify Beneficiaries of the results of the Grievance Resolution. The NGR shall contain a clear and concise explanation of the BHSD Provider or Plan's decision.
Resolution Final Determination	Resolution and a written determination must be completed within forty-five (45) business days after the date of receipt of the provider dispute or the amended provider dispute. Determination letter must list pertinent facts and reason as to dispute decision including any goodwill payments.
Sanction	An action deemed necessary taken by to act upon an outstanding deficiency to promptly ensure contract and performance compliance. Sanctions may include but are not limited to: a. Delay payments until deficiency is addressed. b. Deny a portion of requested payments for activities not in compliance. c. Suspend services or new referrals. d. Reduced contract funding in the next FY. e. Termination the practitioner, contracted program or the entire contract. f. Decline to renew contracted program at the end of the current contract cycle. g. Initiate Federal suspension or debarment proceedings. h. Other legally available actions.
Specialty Mental Health Services (SMHS)	Specialty mental health services include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.
Start-Up Expenses	If allowed, claims for start-up and related expenses must be billed using the cost-based/cost reimbursement invoice.

	Supporting documentation for start-up expenses should be submitted and copies retained for verification and reconciliation purposes.
State 835	Is an electronic Remittance Advice coming from the State that details what claims were paid and what claims were denied.
State Fair Hearing	A State Fair Hearing is an independent review conducted by the California Department of Social Services (CDSS) to ensure that Beneficiaries receive behavioral health services to which they are entitled under the Medi-Cal program. A Beneficiary may request a State Hearing to resolve appeals related to denial, termination or modification of existing services or unreasonable delay in receiving services. a. The hearing must be requested by the Beneficiary within mandated timelines.
Termination	Participating Provider voluntarily ended employment or contract; or BHSD ended the Participating Provider's employment or contract, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal Program.
The Plan	Provides oversight to behavioral health Medi-Cal carve out programs in Santa Clara County. BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).
Timely Filing	The time frame in which the provider/facility must submit the original (initial) claims to BHSD.
Waste	Inappropriate utilization of services and misuse of resources. Examples- 1. Ordering excessive laboratory tests. 2. Prescribing more medications than necessary to treat a condition.
Workforce Member	Employees, residents, students, volunteers, interns, and other persons whose conduct, in performance of work for a covered entity, is under the direct control of the covered entity, whether or not they are paid by the covered entity.