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# Behavioral Health Services Department Provider Manual

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COUNTY OF SANTA CLARA  
**Behavioral Health Services**

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**Provider Relations | [www.bhdp.santaclaracounty.gov/](http://www.bhdp.santaclaracounty.gov/) | MARCH 7, 2025**

*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

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## 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<sup>1</sup> are responsible for adhering to the applicable requirements set

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<sup>1</sup> 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, [Provider portal | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](#). Providers may email [BHSDBusinessOffice@hhs.sccgov.org](mailto: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.

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## Chapter 2: Network Operations

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### 2.1 Network Operations

BHSD's Contracts Administration and Provider Relations is responsible for procurement and administrative management of BHSD's behavioral health provider network, which include network oversight, 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, waived 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 may be amended from time to time.

All licensed, waived, 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 found at the following link: [Provider portal | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](https://www.santaclaracounty.gov/behavioral-health-services)

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, waived 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: [Provider portal | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](#) 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)
- Emergency Medical Service Providers
- Clinical Supervisor (any staff providing supervision to other credentialed staff)

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](http://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 5:00 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](mailto: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 \(sccgov.org\)](https://www.sccgov.org/electronic-health-records-behavioral-health-services-county-of-santa-clara) Sample provider types are listed below.

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

Please note, that for any intern/trainee who is submitting billing they need to have a credentialed supervisor.

## **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.

### **Minimum Qualifications for Initial Credentialing**

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 registration. 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 any time they are participating as a BHSD provider:
  - Expiration, surrender, revocation, probation, accusation, suspension, or any other status change 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 agency.

Such notice shall be sent in writing to [BHSDBusinessoffice@hhs.sccgov.org](mailto:BHSDBusinessoffice@hhs.sccgov.org) and [BHSDCredentialing@vhp.sccgov.org](mailto:BHSDCredentialing@vhp.sccgov.org).

The notice shall include the following:

1. First and Last Name
2. NPI#
3. Status Type, i.e. expiration, surrender, revocation, probation, accusation
4. Effective Date of Status

Once BHSD and VHP has been notified, VHP will outreach to provider for additional

information and documentation,

### **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 or determine that their is a quality of care issue.

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](mailto: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](mailto: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

### **Transition from Associate to Licensed Providers**

When a provider is transitioning from an Associate status (ASW/AMFT/APCC) to a Licensed status (LCSW/LMFT/LPCC), an update must be sent to VHP to process the credential update. The effective date of the transition will be the license issuance date from the Behavioral Board of Sciences (BBS) as long as the individual is in good standing. If an individual is not in good standing or is in the process of changing employers within the provider network, the effective date of the transition will be the VHP approval date or the date the update was received.

### **2.4 Professional License Waiver Request Process**

DHCS requires professional license waivers (PLW) for the following practitioner types as described in [BHIN 24-033 - Mental Health Professional Licensure Waiver \(ca.gov\)](#) (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 DHCS Form 1739 [Mental Health Professional Licensing Waiver Request DHCS 1739.pdf \(ca.gov\)](#) and supporting documentation to [BHSDBusinessOffice@hhs.sccgov.org](mailto:BHSDBusinessOffice@hhs.sccgov.org) for review. If the individual satisfies the requirements, BHSD signs and submits the completed form 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.

While a PLW application is pending please be mindful not to code the applicant’s taxonomy as psychologist until the PLW is returned from DHCS. In the interim, the applicant’s taxonomy should be set an intern until the PLW is approved and returned to credentialing.

### **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](mailto: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 (BBS). For training, supervision and hours requirements for other types of interns and trainees who may be providing services (MFT, PCC, PhD, and PsyD) please refer to their respective license boards (e.g. [BBS](#), and [California Board of Psychology](#)) [county](#) and [state guidelines](#). 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 Board of Behavioral Sciences 90-day Rule

The "90-day rule" is a clause in California law that allows applicants for registration as an Associate Marriage and Family Therapist, Associate Professional Clinical Counselor, or Associate Clinical Social Worker (Associate), to count supervised experience gained during the window of time between the degree award date and the issue date of the Associate registration number, IF the Associate application is received within 90 days of the qualifying degree award date.

Applicants must obtain a copy of their completed "State of California Request for Live Scan Service" form and provide a copy to the Board when applying for licensure to count post degree experience hours gained under the 90-day rule.

Applicants must obtain a copy of their completed "Request for Live Scan Service" form from the employer and keep it in a safe place. The applicant must submit a copy of this form upon application for licensure. Other documentation cannot be accepted as the law does not allow for any alternatives.

Please refer to Business and Professions Code §4980.43, §4996.23 and §4999.46 And [Board of Behavioral Sciences - 90-Day Rule \(ca.gov\)](#)

## 2.10 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.

## 2.11 Emergency Medical Technicians/Paramedics

Emergency Medical Technicians (EMT)/Paramedics are healthcare professionals who provide immediate medical care to individuals in emergency situations. In California, individual EMT/Paramedical certification and licensing are completed at the county level by the California Emergency Medical Services Authority (EMSA).

For more information about individual EMT/Paramedical certification and licensing see:

<https://ems.santaclaracounty.gov/services/find-ems-policies-protocols-and-plans>

(County of Santa Clara; Emergency Medical Services System; Policy #201).

(County of Santa Clara; Emergency Medical Services System; Policy #205).

To begin the EMT or Paramedic credentialing process with BHSD/VHP complete the CSCPPA and submit a current copy of your EMT/Paramedic certification card. These documents should be submitted to: [BHSDCredentialing@vhp.sccgov.org](mailto:BHSDCredentialing@vhp.sccgov.org) for Credentialing committee review. VHP may request supplemental documentation to continue the credentialing process.

The CSCPPA can be found on this page: <https://bhdp.santaclaracounty.gov/provider-onboarding/initiate-credentialing>

## 2.12 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](mailto:BHSDBusinessOffice@hhs.sccgov.org). The SARF form and instructions are posted on the BHSD website and can be found on this link: [Request access to County EHR systems | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](https://www.santaclaracounty.gov/behavioral-health-services)

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.

## 2.13 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).

## 2.14 Leave of Absence (LOA)

A leave of absence is when a practitioner will take time off work for 30 days or more. As soon as an LOA is known, Participating Provider will complete [Provider Update 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.

## 2.15 Submitting Provider Updates

Participating providers will submit provider and/or practitioner updates by completing the following form: [Provider Update Form](#) and submitting by email to [BHProviderUpdates@hhs.sccgov.org](mailto:BHProviderUpdates@hhs.sccgov.org) Once the email is submitted, a ticket number will be assigned and added to the queue for processing.

The list of update types include the following:

- Clinic Location Update
- Credential Update
- License/Registration/Certification Renewal
- Provider Profile Update Request
- Trainee Supervisor
- Termination/Disassociation/LOA

## 2.16 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](mailto: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](#)

## 2.17 Medicare Site Enrollment

Medicare site enrollment is required before providers can bill Medicare. Providers will need to identify if they are Medicare provider in the annual census to inform BHSD that providers can accept Medicare referrals.

# 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:

<b>Provider Type: MH Providers, SUTS Providers, Both (MH and SUTS), Hospital, Residential, NTP</b>	<b>Category</b>	<b>Topic</b>	<b>Goal</b>
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 in our EHR system for Contract Agencies and County Clinics to complete and submit on an ongoing 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).

<b>Timely Access Standards Mental Health Plan</b>	
<b>Modality Type</b>	<b>Standard</b>
Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services	Offered an appointment within 10 business days of request for services
Psychiatric Services	<u>Non-urgent: Offered an appointment within 15 business days of request for services</u>  <u>Urgent: 48 hours without prior authorization</u>
<p>The above standards are applicable, unless as provided in CCR §1300.67.2.2(c)(5)(G) and (H)</p> <p>DHCS defines urgent as: When the beneficiary’s condition is such that they face 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.<sup>1</sup></p> <p><sup>1</sup> 28 CCR § 1300.67.2.2, subd. (b)(7); Health &amp; Safety Code § 1367.01, subd. (h)(2)</p>	

<b>Timely Access Standards DMC-ODS</b>	
<b>Modality Type</b>	<b>Standard</b>
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 <sup>1</sup>	Within 3 business days of request

<sup>1</sup> 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)

### **Timeliness Tool**

All Providers, Contacted Agencies, and County Clinics shall complete the BHSD Timeliness Tool in myAvatar for each referral or request for psychiatric services they receive. Contracted Agencies will complete the tool through the PCNx portal and County Clinics will complete tool in myAvatar. All referrals and requests for psychiatry services require the Timeliness Tool to be completed regardless of if client is admitted.

### **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. When the insurance is verified and if the beneficiary meets the criteria per CalAIM 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 within twenty-four (24) business hours to offer an appointment. Standard practice is to call three times if unable to reach the individual initially. The appointment offered must be for a time and date within 10 business days of the beneficiary's referral from the BHSD Call Center. If an appointment is not available within 10 business days, a timely access NOABD must be completed and sent to beneficiary and available to BHSD upon request. 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 their ability to accept referrals that would result in a program closure, refer to section 3.6 Closing a Program to Referrals.

### **Walk-in Workflow**

All Providers, Contracted Agencies and County Clinics may accept walk-in clients. The process allows clients to easily access services without undo barriers. Specific walk-in workflows for both mental health and substance use services can be found on the following link: [Walk-in Process](#)

### 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 this link: [CalAIM | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](https://www.santaclaracounty.gov/CalAIM/BehavioralHealthServices).

### 3.6 Data Collection

#### **Network Adequacy Reporting**

##### **Purpose of Data Collection**

274 Reporting	MHP's and DMC-ODS providers are required to submit provider network data using the 274 standard on a monthly basis. The 274 standard is an Electronic Data Interchange standard selected by DHCS, and approved by the CMS, to ensure that provider network data is consistent, uniform, and aligns with national standards. The 274 standard file also captures all the providers, sites, and bed counts for each county provider and CCP's in our network. BHSD uses the provider access collection tool (PACT) to capture all the required information by the state to ensure a user-friendly experience for providers.
Provider Directories	Data will also be used to feed provider data into the BHSD provider directories.
Network Adequacy	The data collection allows BHSD to strategize on improvements to its network adequacy for subacute beds, mental health treatment beds, and substance use treatment beds.
Placement Planning	Accurate and timely data collection also allow BHSD to monitor bed capacity and access for county clients.

##### **Outpatient 274 Reporting**

<b><u>Timelines</u></b>	
<b><u>Date</u></b>	<b><u>Process</u></b>
15 <sup>th</sup> of every month, if holiday or weekend, file will	Providers will log in to their PACT account to access their respective provider data and provider directory to

be prepared business day before	review and to make updates.
23 <sup>rd</sup> of every month	Monthly 274 files are due. Providers will have their files completed and will submit by clicking file completed in PACT.
23 <sup>rd</sup> - 26 <sup>th</sup> of every month	BHSD will notify the provider of errors in their files.
26 <sup>th</sup> - 29 <sup>th</sup> of every month	Providers will log in to their PACT account to correct errors and notify BHSD when updates are completed by emailing <a href="mailto:BHSDbusinessoffice@hhs.sccgov.org">BHSDbusinessoffice@hhs.sccgov.org</a> .

<b>274 Data Elements for MH Outpatient Providers: *= Required fields</b>
First name / Last name (no apostrophes or commas) *
Provider Gender *
Provider NPI *
Provider DEA Number (if applicable)
Languages spoken * (Fluent or Certified)
Provider Type* (Specialty)
CA License Number (numbers only) *
Service Type(s) *
Area of expertise *
Service Focus Type(s): (5 max)
Site providing services *
Full time equivalent (By Age group 0-20/ 21+) *
Maximum number of Medi-Cal Members that Provider Will Accept (By Age group 0-20/ 21+) *
Current Medi-Cal Members Assigned to this Provider (By Age group 0-20/ 21+) *
Cultural Competency Training*
Cultural Competency Training hours completed (If applicable)
Telehealth Provider: Y/N *
Field based services provided: Y/N *
Service Distance: (if applicable)
Areas of interest (Select all that apply) *
Treatment Approach (Select all that apply) *

<b>274 Data Elements for SUTS Outpatient Providers: *= Required fields</b>
First name / Last name (no apostrophes or commas) *
Provider Gender *
Provider NPI *
Provider DEA Number (if applicable)
Languages spoken * (Fluent or Certified)
Provider Type* (Specialty)
CA License Number (numbers only) *

Licensing/Certifying Entity *
Modality (Can select up to 6) *
Site providing services *
Full time equivalent (By Age group 0-20/ 21+) *
Maximum number of Medi-Cal Members that Provider Will Accept (By Age group 0-17/ 18+) *
Current Medi-Cal Members Assigned to this Provider (By Age group 0-17/ 18+) *
Cultural Competency Training*
Cultural Competency Training hours completed (If applicable)
Telehealth Provider: Y/N *
Field based services provided: Y/N *
Service Distance: (if applicable)
Areas of interest (Select all that apply) *
Treatment Approach (Select all that apply) *

### **Inpatient/Residential 274 Reporting**

<b>Frequency:</b> Mondays and Thursday of each week	
<b>Data Elements</b>	
Licensed Bed Count	The number of licensed beds (excluding beds placed in suspense and nursery bassinets) stated on the hospital license at the end of the reporting period.
Available Bed Count	The average daily complement of beds (excluding nursery bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Excludes beds placed in suspense or in nursing units converted to non-patient care uses which cannot be placed into service within 24 hours.
Staffed Bed Count	The average daily complement of beds (excluding nursery bassinets) that are set-up, staffed, and equipped, and in all respects, ready for use by patients remaining in the hospital overnight. Staffed beds change daily to reflect the average daily census.

### **Residential Provider Data Submission for System Placement**

<b>Data Submission Frequency:</b> Daily or Mondays and Thursdays	
Acute Inpatient Facilities	Daily
Subacute Facilities (skilled nursing facilities, mental health rehabilitation centers)	Mondays, Thursdays

Mental Health Residential Beds ( <i>Crisis Residential Treatment</i> )	Daily
Mental Health Residential Beds ( <i>Enhanced Adult Residential</i> )	Mondays, Thursdays
Substance Use Residential Beds	Mondays, Thursdays

**Data Elements**

Licensed Bed Count	The number of licensed beds (excluding beds placed in suspense and nursery bassinets) stated on the hospital license at the end of the reporting period.
Available Bed Count	The average daily complement of beds (excluding nursery bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Excludes beds placed in suspense or in nursing units converted to non-patient care uses which cannot be placed into service within 24 hours.
Staffed Bed Count	The average daily complement of beds (excluding nursery bassinets) that are set-up, staffed, and equipped, and in all respects, ready for use by patients remaining in the hospital overnight. Staffed beds change daily to reflect the average daily census.
Contracted Bed Count	The number of beds contracted with County of Santa Clara Behavioral Health Services Department.
# of Pending Admissions	The number of Santa Clara County clients accepted and pending admission into the facility since last update.
# of Client Admitted	The number of Santa Clara County clients admitted since last update.
# of Occupied Beds	The number of occupied beds in the facility who are Santa Clara County clients.
# of Conserved Clients	The number of Santa Clara County clients under conservatorship occupying beds in the facility.
# of Clients on Admin Days	The number of Santa Clara County client on administrative days is defined as when a client is stable and ready for lower level of care but remains facility for administrative reasons, not medical

	reasons.
# of Anticipated Discharges	The number of anticipated discharges in the next 5 days.

**Provider Access Collection Tool (PACT) app:**

To access your file click link below:

<https://bhdsar.sccgov.org/274App/>

How to request access to 274 web app:

To request staff access to the 274-web app, please email [BHSDBusinessoffice@hhs.sccgov.org](mailto:BHSDBusinessoffice@hhs.sccgov.org) with the following information:

- Staff name(s)
- Staff Email
- Name of Agency
- Mention if it is access for MH, SUTS or Both (for some agencies it can be both)

For back up purposes, we recommend having 2-3 staff assigned to have access per site/agency.

**274 Key definitions**

FTE: Full time equivalents. (MH only)

The FTE sum for one rendering provider shall not exceed 100). For example, if one FTE rendering provider serves children/youth 30% of the time and adults 70% of the time, enter the respective FTE value for that age group (i.e., 030 for 0-20; 070 for 21+). 20 hours per week or 0.5 equate to 050.

Maximum Number of Medi-Cal Members this Provider will Accept: Cannot be 0. Based on the maximum number of Medi-Cal beneficiaries the provider could serve during the amount of time specified in the FTE section by age group and location for the reporting month. (Does not affect call center numbers)

Current Medi-Cal members assigned to this provider: How many unduplicated Medi Cal beneficiaries served by practitioner for that age group and location that month at the time of completion. (billable and non-billable)

Admin/supervisory Staff: Administrative staff and/or members of leadership can only be included in your file if they have the capacity to serve clients on a regular and ongoing bases.

The specific instructions can be found on the BHSD website on this link: [Update and report provider data | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](#)

### **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 change in ability to receive referrals and identify the number of network providers who are not accepting new Medi-Cal beneficiaries. If upon review, the information is found to be insufficient BHSD may request additional information and/or keep the provider to temporarily stay open while options are explored to avoid a temporary closure.

The Network Change Request Form will contain detailed information about the change in ability to accept referrals, 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



- NPI for location temporarily closing program
- Impacted Location(s) (physical address)
- 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 Storytelling, AOA CALWORKS OPD,
- Impacted program Type (MH/SUTS)
- Impacted division of BHSD program temporarily closing
- Impacted age groups
- 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.

- **Required:** Complete [participating provider tracking table](#) for those you cannot currently accommodate.
- Send completed form by secure email to [BHSDBusinessOffice@hhs.sccgov.org](mailto:BHSDBusinessOffice@hhs.sccgov.org)
- and [BHSDCallcenter@hhs.sccgov.org](mailto:BHSDCallcenter@hhs.sccgov.org)

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 for Participating Providers to report changes in their ability to take referrals 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 23<sup>rd</sup> of the month prior to the closure.

2. NCR submissions must be vetted with agency management prior to 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 23<sup>rd</sup> 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.

For a complete list of active temporary closure, you can visit the [Provider Directory - Behavioral Health Services](#). Select the temporary closure drop down in the search field to filter agencies with active temporary closures.

### **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 as described in BHSD Policy PRR-011 Notification of Program and Legal Entity Closures. To report a permanent program closure, the Participating Provider must complete the Network Change Request Form ninety (90) days in advance 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 Provider Liaisons 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 finalize client notes, provide all documentation necessary to transition clients, and close cases in myAvatar and take all other necessary steps to facilitate client's transfer and transition.
  5. 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) teams ensure that our system continuously improves and delivers the appropriate levels of care needed. Utilization Management is administered by 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:

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

#### **Prior-Authorization and Re-Authorization**

BHSD's UM program will ensure beneficiaries have appropriate access to the correct level of care. For services that require a prior-authorization/authorization, all referrals are made based on medical necessity (medically necessary services). 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 [BHIN 22-016 \(ca.gov\)](https://www.dhcs.ca.gov/Information-Notices/BHIN-22-016) the following prior-authorizations, re-authorization, and concurrent review is required.

Prior-authorizations, re-authorizations and concurrent review are required for:

- SUTS Residential Services (BHIN 24-001)
- Eating Disorder Residential Services
- Intensive Home-Based Services
- Day Treatment Intensive (Currently not available)
- Day Rehabilitation (Currently not available)
- Therapeutic Behavioral Services (TBS)
- Therapeutic Behavioral Services – Intellectual Disability (ID)
- Therapeutic Foster Care (TFC)
- Electroconvulsive Therapy (ECT), must have an outpatient psychiatrist
- Transcranial Magnetic Stimulation (TMS), must have an outpatient psychiatrist

Prior-authorization, re-authorization, initial authorization and concurrent review for CRT requests require the completion of 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 \(sccgov.org\)](https://www.sccgov.org/bhsd/forms-behavioral-health-services). Attachments are also required for all requests. This includes a copy of the members Medi-Cal eligibility. It is essential if a member is in-custody that this is listed as their current address.

The requested start date of service will begin after request is received and authorized by UM. Services rendered prior to authorization cannot be billed. The only exception to this is for SUTS Residential Adult Services, if a member is pre-authorized from a source that is unable to complete a full ASAM (American Society of Addiction Medicine) Assessment, then the residential placement will complete the assessment within 72 hours of admission ( [BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf](#) ) and three days of services will be considered authorized. They will submit an initial authorization within 72 hours with the appropriate documentation.

Retrospective authorizations can be requested by completing the Authorization Request Form and marking in the Request Type, Retrospective Authorization. A retrospective authorization may be conducted under the following circumstances:

- Retroactive Medi-Cal eligibility determination;
  - Inaccuracies in the Medi-Cal Eligibility Data System; and/or
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries.

Once a service is authorized, it is important to keep the authorization in the individual's

chart, and to obtain a re-authorization, if additional days are needed. Services requested for pre-authorization, when authorized, will be confirmed with the referring and rendering provider (provider that the service is being referred to).

The rendering provider is expected to inform the referring provider and UM of the status of the referral and start date of the services. Please ensure timeliness is adhered to with referral, and information is shared with UM, so timeliness NOABD's can be sent when needed. It is considered best practice to call a minimum of three times prior to closing a referral, and if there is a rendering provider, to contact them if necessary.

UM will either authorize the service, request more information/pend the status until information is received, or deny the request. If additional information is needed, UM could modify the request and authorize some of the days or service requested.

<b>Service Type</b> <b>YOUTH</b>	<b>Authorization Form Requirement Prior Authorization (Days/Months)</b>	<b>Authorization Form Requirement Re-Authorization (Days/Months)</b>	<b>Additional Information to Attach to Authorization Form</b>	<b>LPHA Signed Diagnosis (Dx) and need for continued care required for all authorizations and re-authorizations.</b>
Youth - Intensive Home-Based Services (IHBS)	12 Months	3 months	ICC/IHBS Screening Form, Medi-Cal Verification Form and ROI. Re-auth: Medi-Cal Verification and continued need.	Required
Youth – Intensive Home-Based Services (IHBS) Short Term Stabilization	<i>60 days/2 Months PSS (Placement Supportive Services), ISS (Immediate Stabilization Services)</i>	<i>60 days/ 2 Months</i>	<i>This is for short term stabilization and can be used concurrently, with clinical justification and explanation of how services will not be duplicated. Please indicate if there are additional IHBS providers who are providing those services and that there is communication with the other provider. ICC/IHBS Screening form, Medi-Cal verification. For re-auth. Medi-Cal Verification and justification for continued need.</i>	Required
	<i>Or 90 days/3 Months for PCSS (Post-Crisis Stabilization Services)</i>	<i>Up to 90 days/3 Months</i>		

Youth - Therapeutic Behavioral Services (TBS)	6 Months	3 Months	TBS Screening form and all additional documentation required by form, ROI, and Medi-Cal Verification. Re-auth: Medi-Cal verification and continued need.	Required
Youth - Therapeutic Behavioral Services - Intellectual Disability (TBS - ID)	6 Months	3 Months	TBS Screening form and all additional documentation required by form, ROI, and Medi-Cal Verification. Re-auth: Medi-Cal verification and continued need.	Required, must also have dx showing need for ID
Youth - Substance Residential Treatment (SUTS)	30 days	30 days	ALOC/Brief ASAM, IEP (if there is one), Release of Information (all needed), Camp Admission Form, and Medi-Cal Verification. Re-auth: Medi-Cal verification and continued need.	Required, must have dx showing need for substance use treatment
Youth - Eating Disorder Residential	30 days	30 days	Updated Clinical information, Medi-Cal Verification	Required, LPHA must show client has eating disorder diagnosis

Service Type ADULT	Authorization Form Requirement Prior Authorization (Days/Months)	Authorization Form Requirement Re-Authorization (Days/Months)	Additional Information to Attach to Authorization Form	LPHA Signed Diagnosis (Dx) and need for continued care required for all authorizations and re-authorizations.
Adult - Substance Residential Treatment (SUTS)	Up to 30 days	Up to 30 days	Full ASAM, Medi-Cal Verification	Required, LPHA must have dx showing need for substance use treatment
	Up to 3 days		Brief ASAM, Medi-Cal Verification, New Care Plan for additional days	
Adult - Substance Residential Treatment (SUTS) Perinatal	Women with young children 90 days; Pregnant Women postpartum 60 days	Up to 30 days	ALOC, documentation showing children's ages and/or term of pregnancy, Medi-Cal Verification	Required, LPHA must have dx showing need for substance use treatment and Perinatal services
	Up to 3 Days		Brief ASAM, Medi-Cal Verification, and New Care Plan for additional days	
Adult -Eating Disorder Residential	Up to 30 days	Up to 30 days	Updated Clinical information, Medi-Cal Verification	Required, must have eating disorder diagnosis
Electro Convulsive Therapy	Number of units/ CPT Code needs to be included (see below) for up to 3 months (actively receiving services with Outpatient Psych.)	Number of units/ CPT Code needs to be included (see below) for up to 3 months (actively receiving services with Outpatient Psych.)	Information signed by MD showing treatment resistant Depression, Medi-Cal verification, El Camino ECT Referral Form. Re-auth, documentation showing update and for holistic treatment coordination of care with outpatient psychiatrist.	Required by MD showing treatment resistance depression
Transcranial Magnetic Stimulation	Number of units/ CPT Code needs to be included (see below) for up to 2 months (actively receiving services with OP Psych.)	Number of units/ CPT Code needs to be included (see below) for up to 2 months (actively receiving services with OP Psych.)	Information signed by MD showing treatment resistant Depression, Medi-Cal verification. Re-auth, documentation continued need.	Required by MD showing treatment resistance depression



Crisis Residential Treatment (CRT)	First concurrent Review up to 21 Days (no changes to the initial auth process).	In instances where there are additional Concurrent Review days, request the number of days medically necessary.	Approved initial request, Initial/updated Assessment, Progress Notes since the last authorization cycle, problem list including diagnosis signed by an LPHA, Medi-Cal verification.	Required
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**For Concurrent Review authorizations:**

**SMH Crisis Residential Treatment Services (CRTS)<sup>2</sup>**

Crisis Residential Treatment (CRT) services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRT programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

Referrals to CRT services can be made through the completion of the Supplemental Services Application (SSA) form with detailed information on behavioral health symptoms and challenges that require stabilization at this level of care. CRT services shall be authorized for an initial seven (7) days.

Upon admission, the provider will submit by day five of the stay, a UM DocuSign Authorization Form requesting up to 21 additional days (number of days should be based on need). Attached to the UM DocuSign Authorization Form, after selecting concurrent review as the type of request, provider must submit the initial assessment, progress notes documenting services since the last authorization cycle, problem list (including diagnosis signed by LPHA), Medi-Cal Verification. Access to the forms can be found: [Get BHSD forms | Behavioral Health Services | County of Santa Clara](#) A completed assessment shall be attached to the [Authorization Form](#) for concurrent reviews and submitted to the BHSD to request authorization for up to an additional twenty-one (21) calendar days, based on the client’s continued medical necessity for this level of care.

If additional days are required to further stabilize the individual, the CONTRACTOR shall submit updated concurrent review with written clinical justification demonstrating medical necessity. Days will be approved by the BHSD in alignment with the submitted clinical information outlining the continued need for this level of care.

<sup>2</sup> 1) Medicaid State Plan No: 12-025

2) Title 9, California Code of Regulations (CCR), §531, 541.24, 1810.208, 1840.312, 1840.334, 1840.356

3) DHCS BHIN 21-073

In the event that additional days are not approved, the expectation is that the client(s) shall be discharged to a more appropriate level of care, prior to the expiration of the program authorized period.

If the BHSD review results in a determination that the client is no longer meeting medical necessity, the program shall establish an appropriate care plan for the client and notify the county.

If the client is unmanageable or in a crisis, the program shall explore alternative treatment options to maintain the client in the facility prior to discharging the client back to the BHSD’s Acute Psychiatric or Medical Services.

Clients who are transitioning to lower levels of care in the community must be linked with an outpatient service team for continued care coordination.

Payments for urgent admissions that take place outside of normal office hours shall be honored and reviewed by the BHSD QM Placement Planning and Care Monitoring team by the next business day.

**SMH Adult Residential Treatment Services (ARTS)** – Currently not available

**Inpatient Psychiatric Hospital Services** (Please see Chapter 13: Inpatient Services section of Manual)

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p><b>All of the following criteria must be met:</b></p> <ol style="list-style-type: none"> <li>Beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/or a reasonable probability of significant deterioration in</li> </ol>	<p><b>All of the following criteria must be met:</b></p> <ol style="list-style-type: none"> <li>Beneficiary continues to meet admission criteria;</li> <li>A less restrictive level of care would not be adequate to safely and effectively treat the beneficiary’s current condition;</li> <li>Treatment is still necessary to reduce symptoms and improve functioning so beneficiary may be treated in a less restrictive level of care;</li> <li>There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care;</li> <li>Beneficiary progress is monitored regularly, and the treatment plan or problem list modified, if the beneficiary is not making</li> </ol>	<p><b>Any one of the following criteria must be met:</b></p> <ol style="list-style-type: none"> <li>Beneficiary no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; <b>OR</b></li> <li>Beneficiary or parent/guardian withdraws consent for treatment and the beneficiary does not meet criteria for involuntary/mandated treatment; <b>OR</b></li> <li>Beneficiary does not appear to</li> </ol>

<p>an important area of life functioning.</p> <p>2. Beneficiary's condition as described in paragraph (1) is due to either of the following: a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems and/or a suspected mental disorder that has not yet been diagnosed.</p> <p>3. Beneficiary is experiencing an acute psychiatric episode or crisis:</p> <p>a. which requires a 24-hour structured setting and if not admitted will likely require acute psychiatric hospitalization;</p> <p>b. which is expected that the proposed intervention will significantly diminish the impairment or</p>	<p>substantial progress toward a set of clearly defined and measurable goals;</p> <p>6. Beneficiary is engaged in treatment and amenable to goals/interventions set forth by the treatment team;</p> <p>7. Family/guardian/caregiver/significant others are participating in treatment as clinically indicated and appropriate, or engagement is underway;</p> <p>8. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out;</p> <p>9. There is evidence of coordination of care and active discharge planning for:</p> <p>a. transition of the beneficiary to a less intensive level of care; and,</p> <p>b. provider referral/linkage and teaching/coaching, with beneficiary active involvement, towards the development and connection to appropriate aftercare and non-mental health community supports, beginning from admission.</p>	<p>be participating in treatment; <b>OR</b></p> <p>4. Beneficiary is not making progress toward goals, nor is there expectation of any progress; <b>OR</b></p> <p>5. Beneficiary's individual treatment plan and goals have been met, and when indicated, beneficiary's support systems are in agreement with the aftercare treatment plan.</p>
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<p>prevent significant deterioration in an important area of life functioning;</p> <p>c. with no imminent risk to self or others requiring a higher level of care (i.e. acute psychiatric hospitalization);</p> <p>d. cannot be safely treated in a less restrictive setting</p> <p>4. Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care.</p> <p>5. Beneficiary is willing to participate in treatment voluntarily.</p>		
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**Exclusions**

<p><b>Any one of the following criteria is sufficient for exclusion from this level of care:</b></p> <ol style="list-style-type: none"> <li>1. Beneficiary does not meet Medi-Cal Specialty Mental Health access criteria</li> <li>2. Beneficiary has medical conditions that would prevent beneficial utilization of services; or</li> <li>3. Beneficiary’s psychiatric condition is of such severity that it can be safely treated only in an inpatient setting; or</li> <li>4. Beneficiary does not voluntarily consent to admission or treatment; or</li> <li>5. Beneficiary can be safely maintained and effectively treated in a less intensive level of care; or</li> <li>6. Request for service is being pursued to address a primary issue of homelessness or lack of identified disposition</li> </ol>
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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.

**Supplemental Services**

BHSD’s UM program recognizes the inherent value of offering a range of residential services to meet the needs of beneficiaries accessing specialty mental health services. For services that do not require pre-authorization, the program will assist with treatment

connection and placement based on the clinical need of each individual. A completed SSA form must be submitted for consideration.

An SSA must be completed to be considered for the following:

- Enhanced Adult Residential
- Crisis Residential Facilities
- Mental Health Rehabilitation Centers
- Skilled Nursing Facilities

Upon receipt of SSA, the BHSD’s UM program shall review and provide a decision within twenty-four (24) hours. Requests may be denied if the clinical presentation does not justify or accurately explain the medical necessity. A denial does not prevent a beneficiary from accessing the same residential placement in the future. Resubmissions of SSAs with updated clinical information will be considered by UM.

**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**

<b><u>STANDARDS:</u></b>		
<b>Service</b>	<b>Timely Access Standards</b> (from request to appointment)	<b>Time &amp; Distance Standards</b> (from Beneficiary’s place of residence)
<b>Telephone Wait Times</b>		
Customer Service Phone Call to County and	No longer than ten (10) minutes wait during normal business hours.	n/a

Certified Contracting Providers		
Screening Call Back Times from Gateway/Call Center	No more than 30 minutes from request.	n/a
<b>Emergent and Urgent Appointments</b>		
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
<b>Non-Urgent Appointments</b>		
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 \(calmhsa.org\)](https://www.calmhsa.org/calaim-documentation-guides) and trainings [California Mental Health Services Authority | CalAIM \(calmhsa.org\)](https://www.calmhsa.org/calaim) and County of Santa Clara [CalAIM | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](https://www.santaclaracounty.gov/calaim-behavioral-health-services) 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 \(calmhsa.org\)](https://www.calmhsa.org/calaim-documentation-guides) and trainings [California Mental Health Services Authority | CalAIM \(calmhsa.org\)](https://www.calmhsa.org/calaim) and the County of Santa Clara [CalAIM | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](https://www.santaclaracounty.gov/calaim-behavioral-health-services) 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](mailto:BHSD_DEI@hhs.sccgov.org)

### 3.12 ICC and IHBS Screening

As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, Mental Health Plans are required to provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to full scope Medi-Cal beneficiaries who are under 21 years of age and in need of these services ([MHSUD IN 16-004](#)). ICC is an intensive form of Targeted Case Management (TCM) intended for beneficiaries with more intensive needs, provides assessment, coordination of care, and treatment through a teaming process known as the Child and Family Team (CFT), and utilizes the Integrated Core Practice Model (ICPM) to guide service delivery through phases of care. IHBS consist of individualized, strength-based and skill-building interventions and psychoeducation to improve the functioning of a child or youth in the home and/or community.



The County implementation of ICC and IHBS screening across its BHSD Children, Youth, and Family (CYF) System of Care became effective on January 1, 2024 ([BHSD Policy CLI-007](#)). The [standardized ICC and IHBS screening form](#) was developed by CSC BHSD to align with DHCS regulations for determining and documenting a beneficiary's eligibility and needs for ICC and IHBS. Providers may use an electronic or EHR-embedded version of the form according to their preferences.

## **ICC Screening**

Starting January 1, 2024, participating providers are required to use the standardized form to screen eligible beneficiaries for ICC services. ICC screening must be administered by a member of the clinical team and completed as clinically appropriate and in a timely manner.

- Beneficiaries new to a program or agency must be screened as part of the initial assessment process to establish care.
- Beneficiaries who are in established care and has a completed initial assessment must be screened for ICC needs as clinically appropriate and in a timely manner according to the changes of a beneficiary's condition.
- For beneficiaries who are receiving ICC, the continued provision of ICC should be discussed by the CFT at least every 90 days.
- Screeners should leverage information and responses from clinical interview and required functional assessment tools (CANS/PSC-35) to complete the ICC screening and rescreening.
- Examples of screening and/or rescreening occurrences may include: (1) a beneficiary is being transitioned to a higher level of care; (2) a beneficiary is being discharged from hospitalization or custody; (3) Therapeutic Behavioral Services (TBS) is being added to a beneficiary's treatment plan; and/or (4) align with required functional assessment tool completion at every six months, whichever may come first.

### *ICC Screening Criteria Questions*

The key component of the ICC screening is the three criteria questions on the screening form. Based on the responses to these criteria questions, the screener will be able to determine whether the beneficiary meets ICC criteria. ICC needs is established when "Yes" is determined for all 3 criteria questions. A conversation must take place with the beneficiary and family to collaboratively discuss the appropriateness of ICC services for the beneficiary.

The first two questions affirm that the beneficiary (1) has full scope Medi-Cal; and (2) needs medically necessary specialty mental health services. The third question includes a list of recommended indicators for ICC services from the [Medi-Cal Manual for ICC, IHBS and TFC, Third Edition](#) that the screener must review and mark off when the condition applies to the beneficiary. The County's definitions of the recommended indicators can be found in the accompanying [info guide](#) for the screening form.

### *ICC Screening Outcomes*

The screener must document outcomes after each ICC screening. If a beneficiary does

not meet criteria for ICC services, the screener would document the outcome and the screening can conclude. If a beneficiary meets criteria for ICC services, the screener must document the outcome and whether services were discussed, offered, and accepted.

All forms pertaining to ICC screening, whether the beneficiary is eligible for and accepts ICC services or not, must be retained for auditing purposes.

### *ICC Service Request*

When the beneficiary accepts ICC services, the screener and/or care team would facilitate a service request to an appropriate program that offers ICC services. The screening form must be used to document administrative details of the service request.

### **IHBS Screening and Service Request**

IHBS screening and services are only provided to beneficiaries receiving ICC services. As part of ICC services, the established CFT will develop an individualized care plan for the beneficiary and determine the beneficiary's need for IHBS.

When IHBS is appropriate and agreed upon by the beneficiary and family, the ICC Coordinator and/or clinical team will proceed with submitting an IHBS service request to BHSD Utilization Management (UM) for authorization. IHBS section of the screening form must be completed with administrative information and justification for the service request. A LPHA from the program/agency must also provide attestation and signature for the request.

Since IHBS service requires prior authorization from UM, the requesting program/agency must also follow UM's authorization request process for IHBS and submit required forms and documentation. Authorization requests must be submitted and approved prior to the start of IHBS services.

The need to initiate or continued provision of IHBS should be discussed by the CFTs at least every 90 days.

### **Care Planning Requirements**

Under the most recent guidance [BHIN 23-068](#), DHCS utilizes the terms "care planning" and "care plan" to reference and be inclusive of activities and requirements for client plans, treatment plans, and service plans. While there were changes to clinical documentation requirements as part of CalAIM, specific care planning requirements for ICC remain in effect. Therefore, providers must develop and document the required elements of the care plan within the beneficiary records for those receiving ICC services. DHCS is not enforcing the use of a care plan or specific care planning requirements for IHBS.

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## Chapter 4: Encounter Data, Billing, and Claims

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### 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 \(sccgov.org\)](http://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 “305”
  - 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 “400”
  - 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.

### **Beneficiary Enrollment and Eligibility**

Contractor will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Specialty Mental Health and Drug Medi-Cal Billing Manual, unless directed otherwise in by the Director.

#### **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 305 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 \(sccgov.org\)](https://www.sccgov.org/electronic-health-records-behavioral-health-services).

## **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 \(sccgov.org\)](http://www.sccgov.org/electronic-health-records-behavioral-health-services)

## **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 \(sccgov.org\)](http://www.sccgov.org/electronic-health-records-behavioral-health-services)

### **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 305 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 400 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](mailto: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. 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 service and diagnosis.
2. BHSD will compensate County Contracted Provider as detailed in each Agreement's Exhibit B for SD/MHSA and DMC-ODS Agreements. 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.
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. See Section 4.11 Recoupment and Withholding Compensation below. 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.
4. 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.
5. 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 services or funding.
6. For cost-based programs, BHSD will approve or deny costs submitted based on state guidance, Generally Accepted Accounting Principles (GAAP), and the scope of work for the program. Under no circumstances will BHSD approve unallowable costs. Unallowable costs include:
  - a. Tobacco products, alcohol, non-prescription controlled substances
  - b. Food and beverages that violate County policies
  - c. Expenditures unrelated to providing contracted services to County beneficiaries
  - d. Personal expenditures of staff
  - e. Payments for items which are duplicative without a clear necessity (e.g: two internet lines for one location)

#### 4.11 Recoupment and Withholding Compensation

1. BHSD reserves the right to recoup or withhold amounts from future compensation due to providers in the event of an overpayment, denial, and/or disallowance for billed services and/or other payments due to BHSD under the terms of the applicable service contract.
2. An overpayment occurs when the County pays an invoice that includes amounts for claims that are denied by the DHCS, when the County pays an invoice which includes unallowable costs, or when the County pays an invoice for claims which are later disallowed by the County or DHCS.
3. A disallowance occurs when the County or State determines that a billed service did not meet the requirements for reimbursement. Below are some examples for disallowance or non-reimbursement. These examples are not a comprehensive or exhaustive list.
  - a. Identified overpayments and fraud, waste, and abuse
  - b. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.
  - c. The provided services were not within the scope of practice of the person delivering the service.
  - d. There was no documentation date in the medical record.
  - e. Services provided by non-qualified individuals
  - f. Providers are on the exclusion or sanction State or Federal list(s).
4. A denied claim occurs when the claim submitted to the County or DHCS does not meet the requirements for reimbursement under billing regulations promulgated by BHSD and/or DHCS. A claim denial results from many causes and providers can refer to the billing manual for a comprehensive list.
5. Other Healthcare Coverage (OHC) denials occur when the provider fails to identify or bill OHC of the beneficiary. 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. For denied claims, to avoid double payment, a claim that was denied by DHCS but paid by the County will be recouped and any subsequently approved replacement or resubmitted claim will be paid following adjudication in myAvatar of the newly submitted claim.

6. County Contracted Providers 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 through a process referred to as “Takeback”. If a Direct Service submitted to myAvatar is denied by the State
  - a. The denial will be matched to the service rendered
  - b. The MH91 reports (BHSD 7582, BHSD7583) will display an offsetting value in the State Denial Adjustment field and will net the Total Payable amount to \$0.00.
  - c. If the service is initially paid via an invoice, then denied in a later period, when the CCP submits invoice for Direct Service reimbursement, the County will reduce the cumulative amount by the amounts denied.

#### **4.12 Overpayment**

If BHSD determines that it has overpaid a claim or invoice, 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 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 \(SOC\) \(soc bb\) \(ca.gov\)](#)

#### **4.14 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.

#### **4.15 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](mailto:BHSD-Invoices@hhs.sccgov.org).

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# Chapter 5: Provider Beneficiary and Appeals Process

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## 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.

Adverse Benefit Determination [Hospitals/Psychiatric Health Facilities (PHFs)]



1. Hospitals/PHFs must adhere to all timelines for notifying BHSD of admissions and discharges, TAR submissions, and submissions of pertinent medical records needed to determine acuity. Failure to meet these timelines may result in a denial or adverse decision from BHSD.
2. A NOABD is issued for all Medi-Cal beneficiaries who have modifications/denials under certain circumstances, including:
  - a. Denial or limited authorization of a requested service.
  - b. Reduction, suspension, or termination of previously authorized services.
  - c. Denial of payment.
  - d. Failure to provide services in a timely manner.
  - e. Failure to act within provided timeframes for grievances and appeals.
  - f. Denial of member requests to dispute financial liability.
1. All modifications/denials adhering to the NOABD requirement must be documented using the appropriate form and mailed to the beneficiary and provider.
  - a. NOABD forms are kept for ten years along with the TAR.
  - b. For TARs pertaining to patients who are under age 18, BHSD will file the TAR copy and retain it until the patient reaches 18 years old and after the patient reaches 18 years old, an additional 10-year retention period will apply, according to Behavioral Health Services policy.

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## Chapter 6: Communicating with BHSD

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### 6.1 Communications with BHSD

BHSD's website, [Provider portal | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](https://www.santaclaracounty.gov/behavioral-health-services), 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](mailto: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, areas of interest, treatment options, temporary closures, 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	Types of Change	
A	<b>Temporary Program Closure</b>	<b>(Pause referrals)</b>
B)	<b>Permanent Closures</b>	Program Closure
		Location Closure
		LE Closure
C)	<b>Site Certification,</b>	New location
		Mental Health Add/Change Modes of Services
		Partial Move
		Renovation
D)	<b>New Program(s)</b>	Site must be certified and needing P-Auths
E)	<b>New Key Contact Info</b>	New website, CEO/CFO, HOS, Contract change/Ownership%, Hours of operation
F)	<b>Error</b>	Cancel Request/Submitted an error

The form must be completed by internal and County Contracted Providers (CCP). Provider Relations checks for NCR submissions daily on weekdays. Form requests submitted on weekdays prior to 4 p.m. will be acknowledged within 24 hours of receipt. Forms submitted outside those hours will be addressed on the next business day.

Instructions for completing the Network Change Request Form can be found on this link: [Update and report provider data | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](#)

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 telephone at (408) 885-3794 or in writing via email to [ComplianceOfficer@hhs.sccgov.org](mailto:ComplianceOfficer@hhs.sccgov.org).

#### 6.5 Reporting Fraud, Waste, and Abuse and Catastrophic Events

Provider will notify County by telephone at (408) 885-3794 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](mailto: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 (5<sup>th</sup> 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](mailto: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: [Update and report provider data | Behavioral Health Services | County of Santa Clara \(santaclaracounty.gov\)](#)

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](mailto:BHSDBusinessOffice@hhs.sccgov.org) upon execution of contract and within 35 calendar days of any changes.

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# Chapter 7: DMC-ODS Program Requirements

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## 7.1 Trainings

The required trainings for DMC-ODS participating providers are described below. Please reference Section 13 Trainings of this manual for the details.

### **Evidence Based Practices (EBP) Trainings**

At least two of the five EBP trainings below must be completed on an annual basis. One of the two must be Motivational Interviewing:

1. **Motivational Interviewing:** A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
2. **Cognitive-Behavioral Therapy:** Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
3. **Relapse Prevention:** A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment.
4. **Trauma-Informed Treatment:** Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
5. **Psycho-Education:** Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

### **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.

### **7.2 Substance Use Treatment Services (SUTS): Residential**

Residential DMC- ODS services are subject to prior authorizations and for members with a substance use diagnosis (SUD). Please see section 3.7 Utilization Management and Utilization Review. Residential treatment services are delivered to members when medically necessary in a short-term residential program, with an average length of stay of 30 days. [BHIN 24-001 DMC ODS Requirements for the Period of 2022-26](#) Pursuant to DMC-ODS, services are 'short-term' and intended to be individualized to treat the identified areas of need as shown in their full ASAM assessment which is completed within the first 72 hours. 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. Programs must identify if MAT services are necessary and integrate this into the individual's treatment.
10. 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. This includes housing

needs, for which planning should begin soon after intake.

### **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.

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## Chapter 8: Court System Requirements

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### 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](mailto: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/YYYY, 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: Children, Youth, and Family (CYF) Requirements

### Training:

Direct care CYF providers are required to take the following trainings. Please reference Section 13 Trainings of this manual for the details

Training	Frequency
Trauma Informed Systems (TIS) 101	One-time
Reflective Practice Part I (direct service staff)	One-time
Reflective Practice Part II (CPMs and Supervisors)	One-time
Client Culture	One-time
Cultural Competency	Annually
Sexual Orientation and Gender Identity and Expression (SOGIE) 101	One-time
MI	One-time
EBP Training <i>Note: For CYF Ethnic Outpatient direct service staff, training must include CDEP/CIP trainings</i>	Annually

Direct care staff are encouraged to understand the principles of EBP/CDEPs as determined by BHSD and be appropriately trained to support implementation of EBP/CDEPs within their scope of practice.

### CANS Data

Providers will make available CANS data for Child and Family Team (CFT) discussions, in conformity with all applicable laws.

After January 1, 2017, a child or youth is required to have a CFT within the first sixty (60) days of entering into the child welfare or probation foster care placement. As defined in California Welfare and Institutions Code (WIC), Section 16501, a CFT is also required for those children and youth residing in a group home or Short Term Residential Therapeutic Program (STRTP) placement with an existing case plan. Best practice dictates that meetings should occur as soon as possible for purposes, including but not limited to, case planning, placement determination, emancipation planning and/or safety planning. The CONTRACTOR providing mental health services to clients in the child welfare or probation system may also be invited to participate in CFT.

The provider will attend the CFT meeting, for Youth receiving this service, and shall summarize the CANS data in a template provided by BHSD to share with the CFT to help guide the process. The CONTRACTOR should obtain a Release of Information (ROI) from the client in order to be able to share the information with parties in attendance of the CFT that are not

covered by the Department of Health Care Services' (DHCS) Information Notice. Additional guidance can be found in ACL 18-09 (<http://www.cdss.ca.gov/Portals/9/ACL/2018/18-09.pdf?ver=2018-01-26-162122-640>) and ACL 18-85 (<http://www.cdss.ca.gov/Portals/9/ACL/2018/18-85.pdf?ver=2018-07-09-134620-230>).

### PSC-35

The PSC-35 is a tool required by the DHCS. This tool shall be administered for children ages 3 to 18 to support in decision making on appropriate level of care and treatment planning. Administration shall be completed at the beginning of treatment, every six (6) months following the first administration, and at discharge. The CONTRACTOR shall abide by the Operational Standards developed by BHSD and follow the state mandate which includes additional details related to outcomes and reporting requirements.

### TCP

Direct care staff will use TCP as the model for service delivery. All clinical staff shall be trained in TCP and shall practice to TCP standards and philosophy when developing case formulations and care planning, as outlined in the Standard of Practice Guidelines manual. The County Clinic or CCP shall be responsible for ensuring their staff is trained.

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## Chapter 10: Compliance

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### 10.1 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) signed 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.

### 10.2 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 (CSCHEPCO) within 24 hours of the discovery by phone at (408) 885-3794 or in writing via email to [ComplianceOfficer@hhs.sccgov.org](mailto:ComplianceOfficer@hhs.sccgov.org).

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# Chapter 11: Auditing

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## 11.1 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](mailto:QA@HHS.SCCGOV.ORG).

## 11.2 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.

## 11.3 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.

## 11.4 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 30 calendar days in advance of the audit review period which will be identified on the provider's audit schedule. Providers are expected to produce necessary documentation by the due dates in the schedule and cooperate with further requests for information, clarification, or documentation. Providers are required to submit all documentation by uploading to the respective provider folder in Sharepoint.

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 in the respective provider folder in Sharepoint.

Each deficiency identified must be addressed via a CAP. The CAP is due within thirty (30) calendar days of the date of the issuance date.

### Initial Provider Response

The provider shall complete the Provider Response Section of the CAP for each compliance deficiency that is identified as "partial" and/or "not met";

1. The Provide Response Section includes the following:
2. Provider Preliminary Action Plan: Provider must provide a specific description of how the deficiency will be corrected;
3. Responsible Person: Provider must identify the staff person responsible for correcting the deficiency and ensuring future compliance;
4. New Information Submitted: Provider must select "yes" or "no";
5. Proposed CAP Implementation Date: Provider must specify the date of implementation of each deficiency

As deficiencies are corrected, include relevant documentation which demonstrate the correction of a deficiency, if applicable.

Submit the completed CAP to your assigned SharePoint folder, then notify via e-mail to the BHSD Program Manager. The Manager will review each Provider response and proposed implementation date and send a response back to the Provider.

### Updated Provider Response

BHSD staff with subject matter expertise on each item will complete Auditor Section and Provider Relations Section to indicate whether or not the Provider's CAP response is accepted, and/or additional required action, recommendations or comments.

The Provider must respond to each County response that is not accepted.

The Provider shall respond to the County by adding their updated response and date of the updated response.

Submit the updated CAP spreadsheet to your assigned SharePoint folder, then notify via e-mail to the BHSD Provider Relations group at [BHSDPR@hhs.sccgov.org](mailto:BHSDPR@hhs.sccgov.org). This process will continue until each response is accepted by the appropriate staff. Once all the corrective actions are approved, the manager 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.

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## Chapter 12: Policies and Procedures

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### 12.1 Adherence to Policies and Procedures

Providers will adhere to BHSD policies and procedures including development of individual clinic and agency policies and procedures that align with the requirements in providing services to beneficiaries.

## Chapter 13: Trainings

**Required** = County and/or Program Specific

**Mandatory** = DHCS/CMS

**Optional** = Supportive content for doing your work

**Target Staff** = All, Clinical, Supervisor

Trainings			System of Care			Source of Training	Mandatory, Required or Optional	Audit for FY25
Training title	Target staff	Frequency	MH-AOA	MH-CYF	DMC-ODS			
Addiction Medicine (5 hours)	Clinical	Annual	No	No	Yes	BHSD Learning Partnership or Third Party	Mandatory	Yes
American Society of Addiction Medicine (ASAM) E-modules	All	One-Time (upon hire)	No	No	Yes	Access granted by BHSD for the Change Company trainings	Mandatory	Yes
CalOMS (as needed)	Clinical	One-time	No	No	Yes	Access granted by BHSD for the DHCS website trainings	Mandatory	Yes
Communicable Diseases: (Hep C, TB, HIV, AIDS)	All	Every 2 years	No	No	Yes	<u>County Staff:</u> HealthLearning <u>CCPs:</u> Third Party	Mandatory	Yes
Compliance	All	Annual	Yes	Yes	Yes	<u>County Staff:</u> Healthlearning <u>CCPs:</u> Third Party	Mandatory	Yes
Confidentiality/42 CFR Part 2	All	Annual	No	No	Yes	<u>County Staff:</u> Healthlearning <u>CCPs:</u> Third Party	Mandatory	Yes
Cultural Competency	All	Annual	Yes	Yes	Yes ( <u>must</u> )	BHSD Learning	Mandatory	Yes

Trainings			System of Care			Source of Training	Mandatory, Required or Optional	Audit for FY25
Training title	Target staff	Frequency	MH-AOA	MH-CYF	DMC-ODS			
					include CLAS)	Partnership or Third Party		
Evidence-based practices	Clinical	Annual	Yes	Yes	Yes	BHSD Learning Partnership or Third Party	Mandatory	Yes
First Aid & CPR	Clinical (WM Staff only)		No	No	Yes	Third Party	Mandatory	Yes
Law and Ethics	All	Every 2 years	Yes	Yes	Yes	BHSD Learning Partnership or Third Party	Mandatory	Yes
Naloxone	All	One-time	No	No	Yes	Third Party	Mandatory	Yes
Prevention of Sexual Harassment	All	Every 2 years	No	No	Yes	County Staff: SCCLearn CCPs: Third Party	Mandatory	Yes
SUTS DMC-ODS Regulatory and Compliance Training	Clinical	Annual	No	No	Yes	BHSD Learning Partnership or Third Party	Mandatory (under development)	No
SUTS Prevention ECCO	SUTS Prevention Staff	One-time	No	No	Yes	Access granted by BHSD for the DHCS website trainings	Mandatory	Yes
Withdrawal Management (WM) Training	Clinical (WM Staff only)	Annual	No	No	Yes	Third Party	Mandatory	Yes
Authorization	Clinical	One-time	Yes	Yes	Yes	BHSD Learning Partnership	Required	Yes
Motivational Interviewing	All	One-time	Yes	Yes	Yes	BHSD Learning Partnership or Third Party	Required	Yes
Prison Rape Elimination Act (PREA) Training	Locked Facilities	Every 2 years	Yes	Yes	Yes	SCCLearn	Required	Yes

Trainings			System of Care			Source of Training	Mandatory, Required or Optional	Audit for FY25
Training title	Target staff	Frequency	MH-AOA	MH-CYF	DMC-ODS			
Sexual Orientation and Gender Identity and Expression (SOGIE) 101	All	One-time	Yes	Yes	No	BHSD Learning Partnership or Third Party	Required	Yes
Adult Needs & Strength Assessment (ANSA)	Clinical	Annual	Yes	No	No	BHSD Learning Partnership	Required	No
Child & Adolescent Needs & Strengths (CANS) & Pediatric Symptom Checklist (PSC-35)	Clinical	Annual	No	Yes	No	BHSD Website On-line Training	Required	No
ASAM and the Stages of Change: A Clinical Review	Clinical	One-time	No	No	Yes	BHSD Learning Partnership or Third Party (TBD)	Optional	No
Care Coordination and Multidisciplinary Teams	Clinical	Annual	Yes	Yes	Yes	BHSD Learning Partnership or Third Party	Optional	No
Introduction to Transformational Care Planning	Clinical	One-time	Yes	Yes	No	BHSD Learning Partnership (TBD)	Optional	No
Reflective Practice Part I (direct service staff)	All	One-time	Yes	Yes	No	BHSD Learning Partnership or Third Party	Optional	No
Reflective Practice Part II (Supervisors)	Supervisors	One-time	Yes	Yes	No	BHSD Learning Partnership or Third Party	Optional	No
Trauma Informed Systems (TIS) 101	All	One-time	Yes	Yes	Yes	BHSD Learning Partnership or Third Party	Optional	No
Clinical Aspects of 5150	Clinical	Every 5 years	Yes	Yes	No	BHSD Learning Partnership	Training will be updated	No

### EBP List for DMC-ODS

1. Motivational Interviewing
2. Cognitive Behavioral Therapy
3. Relapse Prevention
4. Trauma-Informed Treatment
5. Psycho-Education

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## Chapter 14: Inpatient Providers Guidelines

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### **Inpatient Utilization Review Overview**

County of Santa Clara (CSC) Behavioral Health Services Department (BHSD) Utilization Management (UM) as required in California Code of Regulations, title 9, section 1810.440(b)(1)-(3), DHCS BHIN 22-017 and mandated by both the Department of Healthcare Services (DHCS) and the Centers for Medicare and Medicaid (CMS) evaluates medical necessity and appropriateness of services provided to Medi-Cal members (or unsponsored clients), concurrently for in-patient psychiatric services. If a case is submitted for a member with a primary insurance other than Medi-Cal, BHSD will not review the case.

CSC BHSD ensures authorization decisions are standardized. BHSD utilizes written policies and procedures to review authorization of psychiatric inpatient hospital services in accordance with state regulations 42 C.F.R., § 438.210(b)(1). BHSD utilizes these policies and procedures to ensure consistent application of review criteria and will consult with the requesting provider when appropriate to ensure accuracy. (42 C.F.R. § 438.210(b)(2)(i-ii).) All BHSD clinical reviewers have the appropriate clinical expertise and California licenses in behavioral health (42 C.F.R. § 438.210(b)(3).) BHSD ensures that its utilization management vendor also has compliant policies and procedures in alignment with the regulations identified above to authorize services on behalf of the County of Santa Clara.

### **Point of Notification of Hospitalization & Psychiatric Health Facility Admission**

Prior authorization for emergency psychiatric hospital services is not required. BHSD will approve the admission request if criteria are met for medical necessity (Cal. Code Regs., tit. 9, §§ 1820.200(d), 1820.205 and 1820.225) when BHSD receives the required supporting documentation.

Within 24 hours of admission, the facility must notify BHSD as detailed here.

Within 24 hours of admission, the hospital or Psychiatric Health Facility (PHF) must upload the following documentation:

- the signed admission order
- initial plan of care,
- authorization request,
- completed face sheet, including:



- hospital or facility name and address
- member name and date of birth,
- insurance coverage, Medi-Cal number and county of responsibility,
- patient's current address/place of residence
- working diagnosis,
- date and time of admission,
- <sup>3</sup>the name and contact information for the admitting, licensed practitioner.

BHSD or a contracted provider will make an authorization decision and provide notice within 24 hours (of the decision).

The County of Santa Clara currently has delegated some of the authorization functions to Acentra, consistent with federal law and the MHP's contract for specialty mental health services (BHIN 22-017). This includes uploading all documentation for inpatient hospitals and PHF reviews for all Medi-Cal and unsponsored clients.

Phone: 833-365-4282

Fax: 833-551-2630

Website:

Email: [CAreviews@Kepro.com](mailto:CAreviews@Kepro.com)

Please note the following website, <https://santaclara.kepro.com/> has videos and directions on how to submit all documentation, including the appeals process to the Santa Clara County Behavioral Health Department.

### **Bordering Counties and Out-of-State**

Bordering counties located in the following states are treated as if they are located in California for review and authorization purposes. They are configured to bill California Medi-Cal and are reimbursed through Conduent the Fiscal Intermediary, by submitting a Treatment Authorization Request (TAR).

Oregon Counties:

- Curry
- Josephine
- Jackson
- Klamath
- Lake
- Harney

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<sup>3</sup> (42 CFR § 456.170; 42 CFR § 456.180; 42 CFR § 441.155; BHIN 22-017 1a).

- Malheur

Nevada Counties:

- Washoe
- Carson City
- Douglas
- Lyon
- Mineral
- Esmeralda
- Nye
- Clark

Arizona Counties:

- Mohave
- La Paz
- Yuma

Out-of-State providers (unless from a bordering county of California) will need to contact the Medi-Cal provider support line at 1-916-636-1960 regarding reimbursement.

### **Concurrent Authorization - Procedures for Continued Stays**

Beginning January 8, 2024, County of Santa Clara Behavioral Health Services Department (CSC BHSD) provides concurrent authorization for all Medi-Cal members and unsponsored, an individual residing in the County of Santa Clara that currently has no insurance coverage. (For cases with a change in insurance, there are retrospective reviews completed.)

1. When medically necessary the hospital or PHF will submit a continued stay authorization request for a period of three (3) days or less before the end of the initial authorization period or subsequent authorization period [BHIN 22-017](#). A signed progress note must be uploaded for each day of hospitalization.
2. Once all the correct information is received to make a determination, a decision will be issued (BHIN 22-017 IIC; Welf. & Inst. Code 14197.1; Health & Saf. Code, §1367.01(h)(2)).
3. CSC BHSD or contracted providers will initiate a first-level concurrent review and either authorize or recommend a second-level review to modify or deny the hospital/PHF stay based on DHCS guidelines and evaluation tools.
4. If a second-level review is recommended, the case is put on hold, and a psychiatrist is sent a request to review.
5. If the California licensed psychiatrist, agrees with the Clinical Reviewer's findings that the criteria for approval is not met, then the request is denied

(42 C.F.R. § 438.210(b)(3); Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(e)).

6. When a request is denied a Notice of Adverse Benefit Determination (NOABD) is sent to both the member and the facility.

### **Administrative Days**

When a patient no longer meets medical necessity and is waiting for placement at another facility, requests are to be submitted for administrative days and not acute days per Cal. Code Regs., fit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400.

Outreach attempts to non-acute treatment facilities or other appropriate placements in a reasonable geographic area are to begin prior to or on the day the patient is placed on administrative days by the hospital or PHF. As long as a minimum of five contacts have been documented in a seven-consecutive-day period, seven consecutive administrative days will be approved. (BHIN 22-017 pg.10; Cal. Code Regs., fit. 9, § 1820.230(d)(2); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400). If there is a lack of available facilities this must be documented (Cal. Code Regs., fit. 9, § 1820.230(d)(2)(B)(1); Welf. & Inst. Code, §§ 14184.402, 14184.102 and 14184.400; Cal. Code Regs., fit. 9, § 1820.230(d)(2)(B)(2)).

The five contacts per week requirement may also be waived under the following circumstances: patient's information packet is under review; an interview with the patient at a placement option has been scheduled (and documentation of the interview provided); facility/provider has clearly documented they have exhausted all appropriate placement options and have escalated to facility and county leadership; the patient has been accepted to a placement option and a discharge date has been set; the patient has been rejected from a facility for a documented reason; or if a conservator has deemed a placement inappropriate or the hospital or PHF is waiting to hear from a conservator to authorize a transfer (BHIN 22-017 pg.11).

### Exclusions for Administrative Days

1. Administrative days requested for members referred to non-treatment facilities such as psychiatric respite facilities, board and care homes, or homeless shelters.
2. Members awaiting discharge to the community if the delay is due to travel arrangements or family situations.
3. Members awaiting community conservatorship or for case management linkage.

These guidelines aim to ensure that administrative days are only granted for specific circumstances related to placement in appropriate treatment facilities for non-acute beneficiaries, and they provide clear criteria for determining when such authorizations

are appropriate.

## **Modifications and Denials**

Denials and modifications may be based on acuity or administrative reasons. While Licensed Mental Health Professionals/Licensed Practitioner of the Healing Arts may review authorization requests and issue approvals within their scope of practice, all Mental Health Plan decisions to modify or deny a treatment request shall be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs (BHIN 22-017).

Please see Provider Appeals section below for more information on the appeals process.

## **Discharge**

1. Notification of BHSD: The provider must inform BHSD within 24 business hours of a patient's discharge.
2. Submission of TAR: The provider must submit a TAR within 14 calendar days of discharge or within 14 calendar days after 99 calendar days of continuous service if the member's hospital stay exceeds that amount of time (Title 9 Section 1820.220).
3. Error checking and notification: BHSD will check the TAR for errors. If errors are found, BHSD will notify the hospital/PHF. The hospital/PHF must submit corrections within 10 calendar days.
4. Approval and completion of TAR: Once approved, BHSD will complete the county section of the TAR with authorization.
5. Copy sent to Hospital: BHSD will send a copy of the completed TAR in their identified portal where they submit their information.
6. Transmission to Medi-Cal Fiscal Intermediary: BHSD will fax or mail the TAR to the Medi-Cal fiscal intermediary, Conduent, for services rendered at Medi-Cal billable hospitals.

### Medi-Cal Fiscal Intermediary

Conduent  
820 Stillwater Road  
West Sacramento, CA 95605-1630  
1-800-786-4346

## **Retrospective Reviews**

County of Santa Clara BHSD will conduct retrospective reviews in specific

circumstances as outlined in BHIN 22-017 pg.11. A retrospective review will be completed when there is a retroactive Medi-Cal eligibility determination; if there are inaccuracies in the Medi-Cal eligibility, if authorization through other health care coverage was pending (e.g. Medi/Medi patients, Medi-Cal as secondary insurance); and/or if the beneficiary failed to identify a payor.

Providers must submit the following documentation:

- Documentation of patient's arrival on unit (RN Observation rounds, RN admission note, etc.)
- Psychiatric Evaluation
- Treatment Plan
- MD progress notes
- Nursing Notes
- Medication Administration Record
- Social work/Placement Notes
- Discharge Summary with a valid ICD-10 diagnosis
- A TAR

County of Santa Clara BHSD's Utilization Review Department will make an authorization decision within fourteen (14) calendar days for Medi-Cal recipients, and within twenty-three (23) calendar days for Un-sponsored recipients. All documentation can be submitted to the Santa Clara County Utilization Review E-Fax at (408)-947-8707.

## **Provider Appeals**

The Provider Appeal Process shall include the following:

1. A provider may appeal a denied or modified request for payment authorization or a dispute with the Mental Health Plan/Behavioral Health Plan (MHP) concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to the MHP within ninety (90) calendar days from the date of the NOABD letter being sent (42 C.F.R. § 438.408(b)(1).)
2. The MHP shall have sixty (60) calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
  - a. If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

- b. If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the Department of Health Care Services (DHCS) pursuant to Section 1850.320.
- c. If applicable, the provider shall submit a revised request for MHP payment authorization within thirty (30) calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.
- d. If applicable, the MHP shall have fourteen (14) calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the documentation to the Medi-Cal fiscal intermediary that is required to process the MHP payment authorization.

**Second Level appeals (Medi-Cal Only): Appeals to the California Department of Health Care Services (9 CCR §§ 1850.320, 1850.325)**

If the provider opts to appeal to the Department of Healthcare Services (DHCS) for an appeal concerning a BHSD denial of payment authorization at a Medi-Cal billable facility, the appeal must be formally submitted within thirty (30) calendar days from the date of BHSD's written decision of denial. This submission should be in writing and accompanied by supporting documentation, which may include but is not limited to:

1. Any evidence corroborating claims regarding timeliness, should they be under question, such as fax records, phone logs, or internal memos.
2. Clinical documentation affirming the presence of medical necessity, should it be contested.
3. A concise explanation outlining the rationale behind why BHSD should have granted approval for the payment authorization.
4. Contact details, including the name(s), address, and phone number(s) of the designated individual(s) for communication purposes.
5. DHCS will inform both BHSD and the provider of receiving an appeal request within seven (7) calendar days, accompanied by a request for precise documentation validating the denial of the BHSD payment authorization.
6. If BHSD fails to submit the necessary documentation within twenty-one (21) calendar days, DHCS will rule in favor of the provider.
7. DHCS is allotted sixty (60) calendar days from the receipt of BHSD documentation to formally notify both the provider and BHSD in writing of its decision, along with the rationale behind it.
8. DHCS may provide both a provider representative and a BHSD representative with the chance to present oral arguments to DHCS.
9. Should DHCS approve a provider's appeal, BHSD must act within fourteen (14) calendar days upon receiving the provider's revised

payment request: either approving the BHSD TAR or submitting necessary documentation to the Medi-Cal fiscal intermediary for processing the BHSD payment authorization.

### **Expedited Appeals**

Expedited appeals (Cal. Code Regs. Tit. 9, § 1850.208) can be requested when the member's provider has determined that the time for a standard appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. These are completed and notifications are sent out within three (3) business days of the receipt of the appeal. The timeframe may be extended up to fourteen (14) calendar days after receipt of a request if an extension is requested, or if more information is needed. This expedited appeal process is based on the requirements for all Medi-Cal beneficiaries but is applied to all those getting care within BHSD network.

# Chapter 15: Contacts and Glossary of Terms

## 15.1 Contacts

Topic	Email	Phone
Audits (Administrative & Chart Review)	<a href="mailto:BHSDPR@hhs.sccgov.org">BHSDPR@hhs.sccgov.org</a>	N/A
Authorizations	<a href="mailto:BHSDUM@hhs.sccgov.org">BHSDUM@hhs.sccgov.org</a>	(669)297-5380
BHSD EHR Information (CCPs Only)	<a href="mailto:BHSD_EHR_info@hhs.sccgov.org">BHSD_EHR_info@hhs.sccgov.org</a>	N/A
BHSD EHR Information (County Only)	<a href="mailto:BHSD.EHR.Help@hhs.sccgov.org">BHSD.EHR.Help@hhs.sccgov.org</a>	N/A
BHSD Documentation Correction	<a href="mailto:ccppcnxdoccorrection@hhs.sccgov.org">ccppcnxdoccorrection@hhs.sccgov.org</a> – For help to process errors made in Avatar that county needs to support with	N/A
BHSD-TSS	<a href="mailto:support@tss.sccgov.org">support@tss.sccgov.org</a> with "for HHS-BHS Triage" included in the subject line – For CCPs needing to open tickets with Netsmart	(408) 970-2222
CalAIM	<a href="mailto:bhSDcalaim@hhs.sccgov.org">bhSDcalaim@hhs.sccgov.org</a>	(800) 704-0900
Call Center	<a href="mailto:BHSDCallcenter@hhs.sccgov.org">BHSDCallcenter@hhs.sccgov.org</a>	
Certificate of Insurance (County-staff only)	<a href="mailto:BHSDBusinessOffice@hhs.sccgov.org">BHSDBusinessOffice@hhs.sccgov.org</a>	
Credentialing	<a href="mailto:BHSDCredentialing@vhp.sccgov.org">BHSDCredentialing@vhp.sccgov.org</a>	(408) 885-2221
DMC Site Certification	<a href="mailto:BHSDBusinessOffice@hhs.sccgov.org">BHSDBusinessOffice@hhs.sccgov.org</a>	N/A
Eating Disorders	<a href="mailto:edreferrals@hhs.sccgov.org">edreferrals@hhs.sccgov.org</a>	N/A
HIMS	<a href="mailto:HHS-HHSHIMBHSD@hhs.sccgov.org">HHS-HHSHIMBHSD@hhs.sccgov.org</a> – For CCPs that see multiple MRNs for a single client and need to determine which MRN needs to be used	N/A
Hospital Liaison	<a href="mailto:BHSDCare@hhs.sccgov.org">BHSDCare@hhs.sccgov.org</a>	N/A
Invoices (Direct, Indirect, Cost-Based)	<a href="mailto:BHSD-Finance@hhs.sccgov.org">BHSD-Finance@hhs.sccgov.org</a>	N/A
MH Clinical Record Reviews; MH and SUTS Grievances, Appeals, State Fair Hearings; DHCS CAPS; Incident Reports;	<a href="mailto:qa@hhs.sccgov.org">qa@hhs.sccgov.org</a>	(408) 793-5894



and Documentation Questions		
MyAvatar Claiming (PCE and PCNX)	<a href="mailto:SCCBillingquestions@ntst.com">SCCBillingquestions@ntst.com</a>	N/A
PAVE	<a href="mailto:BHSDBusinessOffice@hhs.sccgov.org">BHSDBusinessOffice@hhs.sccgov.org</a>	N/A
Performance Measures Timeliness (NACT and TDAT) PIP(Program Improvement Project) including the Warm Hands Off Project	<a href="mailto:bhs_qi@hhs.sccgov.org">bhs_qi@hhs.sccgov.org</a>	N/A
Provider Manual	<a href="mailto:BHSDBusinessOffice@hhs.sccgov.org">BHSDBusinessOffice@hhs.sccgov.org</a>	N/A
Provider Update Form Submission	<a href="mailto:BHProviderUpdates@hhs.sccgov.org">BHProviderUpdates@hhs.sccgov.org</a>	N/A
Reporting Support	<a href="mailto:bhsd.reporting@hhs.sccgov.org">bhsd.reporting@hhs.sccgov.org</a>	N/A
Short Doyle/Medi-Cal Site Certification	<a href="mailto:BHSDSiteCert@hhs.sccgov.org">BHSDSiteCert@hhs.sccgov.org</a>	N/A
System Access Request	<a href="mailto:BHSDBusinessOffice@hhs.sccgov.org">BHSDBusinessOffice@hhs.sccgov.org</a>	N/A
Other inquiries	<a href="mailto:BHSDBusinessOffice@hhs.sccgov.org">BHSDBusinessOffice@hhs.sccgov.org</a>	N/A

## 15.2 Glossary of Terms

<b>270</b>	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.
<b>271</b>	The 271 transaction is the reply to the 270 eligibility inquiry. It transmits eligibility information to the requester.
<b>837P</b>	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.
<b>Abuse</b>	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.

	<ol style="list-style-type: none"> <li>2. Unknowingly misusing codes on a claim.</li> </ol>
<b>Adjusted Claim</b>	<ol style="list-style-type: none"> <li>1. Request for payment reconsideration for a paid or denied claim.</li> <li>2. Any claim for which a Remittance Advice (RA) was issued that was not paid appropriately or denied.</li> </ol>
<b>Administrative Review</b>	<p>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.</p>
<b>Adverse Benefit Determination</b>	<p>Means any of the following actions taken by a Plan:</p> <ol style="list-style-type: none"> <li>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.</li> <li>2. The reduction, suspension, or termination of a previously authorized service.</li> <li>3. The denial, in whole or in part, of payment for a service.</li> <li>4. The failure to provide services in a timely manner.</li> <li>5. The failure to act within the required timeframes for standard Resolution of grievances and appeals.</li> <li>6. The denial of a Beneficiary's request to dispute financial liability.</li> </ol>
<b>Amended Provider Dispute</b>	<p>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.</p>
<b>Appeal</b>	<p>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.</p>

<b>Authorization</b>	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.
<b>Beneficiary</b>	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.
<b>Bundled Claims</b>	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.
<b>Business Day</b>	A business day is a unit of time measure that refers to any day in which normal business operations are conducted.
<b>Calendar Days</b>	Means 365 days of the year.
<b>California Department of Public Health (CDPH)</b>	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.
<b>Capitation payment</b>	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.
<b>Claim</b>	<p>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:</p> <ul style="list-style-type: none"> <li>• A diagnosis</li> <li>• A procedure</li> <li>• Medical supplies</li> <li>• Medical devices</li> <li>• Pharmaceuticals</li> <li>• Medical transportation</li> </ul> <p>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.</p>

<b>Claims Acknowledgement (CA277)</b>	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.
<b>Complaint</b>	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.”
<b>Complete Claim, clean claim</b>	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
<b>Contested Claim Criteria</b>	Non-medical criteria used to guide the reconsideration of all disputes.
<b>Corrected Claims</b>	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.
<b>Corrective Action Plan (CAP)</b>	<p>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:</p> <ul style="list-style-type: none"> <li>• Identify the most cost-effective actions that can be implemented to correct error causes.</li> <li>• Develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient</li> <li>• Achieve measurable improvement in the highest priority areas</li> <li>• Eliminate repeated deficient practices.</li> </ul>
<b>Cost-Based Programs</b>	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

	<p>the Maximum Financial Obligation (MFO) of the program. Supporting documentation such as payroll records, invoices, receipts, a trial balance, G&amp;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.</p>
<b>County Contracted Providers</b>	<p>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.</p>
<b>Covered Diagnoses</b>	<p>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.</p>
<b>Credentialing</b>	<p>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.</p>
<b>Credentialing Attestation</b>	<p>For all network Participating Providers who deliver covered services, the Participating Provider must include a signed and dated statement attesting to the following:</p> <ul style="list-style-type: none"> <li>a. Any limitations or inability that affect the Participating Provider's ability to perform any of the position's essential functions, with or without accommodation.</li> <li>b. A history of loss of license or felony conviction.</li> <li>c. A history of loss or limitation of privileges or disciplinary activity.</li> <li>d. A lack of present illegal drug use.</li> <li>e. The application's accuracy and completeness.</li> </ul> <p>Credentialing Attestations must be completed at start of contract, at hire and minimally, every three (3) years thereafter.</p>
<b>Date of Determination</b>	<p>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.</p>
<b>Date of Receipt</b>	<p>The business day when the provider dispute, amended provider dispute or additional information is received by Plan.</p>

<b>Date of Service</b>	<p>For the purposes of evaluating claims submission and payment requirements under these regulations, means:</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol>
<b>Denial</b>	<p>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.</p>
<b>Denied Claims</b>	<p>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.</p>
<b>Department of Health Care Services (DHCS)</b>	<p>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.</p>
<b>Direct Service</b>	<p>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.</p>
<b>Disclosing Entity</b>	<p>A Medi-Cal provider (other than an individual practitioner or group of practitioners). For example, a health plan.</p>
<b>Drug Medi-Cal Organized Delivery System (DMC-ODS)</b>	<p>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</p>



	<p>the Centers for Medicare &amp; 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).</p>
<p><b>Early and Periodic Screening Diagnosis and Treatment (EPSDT)</b></p>	<p>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.</p>
<p><b>Electronic Data Interchange (EDI)</b></p>	<p>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.</p>
<p><b>Excluded Party Database Attestation</b></p>	<p>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.</p>
<p><b>Expedited Requests</b></p>	<p>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.</p>
<p><b>Rate Table</b></p>	<p>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).</p>
<p><b>Fraud</b></p>	<p>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</p>

	<p>or State law. (42 C.F.R. §§ 433.304, 455.2)</p> <p>Examples -</p> <ol style="list-style-type: none"> <li>1. Knowingly billing for services not performed.</li> <li>2. Knowingly falsifying information on documents to receive a higher payment.</li> </ol>
<b>Goodwill Payment</b>	<p>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.</p>
<b>Grievance</b>	<p>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.</p>
<b>Healthcare Access Program (HAP)</b>	<p>The State required annual amount that is based on household size, income, assets, and allowed expenses.</p>
<b>HealthCare Common Procedural Coding System (HCPCS)</b>	<p>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.</p>
<b>Holiday</b>	<p>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.</p>
<b>Indirect Service</b>	<p>Indirect Services are Non-Medi-Cal Eligible services, whether the client has Medi-Cal or not:</p> <ul style="list-style-type: none"> <li>• Outreach Services</li> <li>• Dedicated Beds</li> <li>• Any other Indirect Services authorized in the Participating Provider's Agreement with the County</li> </ul>
<b>Ineligible Person</b>	<p>Is an individual or entity who:</p> <ol style="list-style-type: none"> <li>1. Is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal or state health care</li> </ol>



	<p>program or in federal or state procurement or non-procurement programs; or</p> <p>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.</p>
<b>Information Necessary to Determine Payer Liability</b>	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.
<b>Interest on Late Claim Payment</b>	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.
<b>International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)</b>	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).
<b>Leave of Absence</b>	A leave of absence is when an employee will take time off work for 30 days or more.
<b>Medical Necessity Criteria</b>	<p>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.</p> <p>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-covered 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.</p>

	<p>Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary’s presenting condition.</p> <p>Refer to BHSD Policy ADM-007 Access and Availability of Services.</p>
<b>MyAvatar 835</b>	The 835 transaction is an electronic remittance advice that explains claims that have not passed adjudication rules in MSO.
<b>Non-Specialty Mental Health Services (NSMHS)</b>	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.
<b>Notice of Adverse Benefit Determination (NOABD)</b>	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.
<b>Organizational Provider</b>	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).
<b>Original Claim</b>	A professional or institutional medical claim that was initially submitted by provider to BHSD for processing.
<b>Participating Provider</b>	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.
<b>Payment Authorization</b>	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.
<b>Pended Claims</b>	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

	<p>pending. Pending 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.</p>
<b>Plan</b>	<p>BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).</p>
<b>Practitioner</b>	<p>Workforce Members who are providing direct Beneficiary care services, are licensed, registered, waived, certified or meet criteria as a paraprofessional.</p>
<b>Primary Source</b>	<p>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.</p>
<b>Prior Authorization</b>	<p>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.</p>
<b>Proof of Timely Filing</b>	<p>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.</p>
<b>Provider Services Agreement</b>	<p>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.</p>
<b>Reasonably Relevant Information</b>	<p>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.</p>
<b>Reconsideration</b>	<p>Review of a previously denied, underpaid, or overpaid claim where provider presents additional information to explain why the claim should be paid.</p>
<b>Re-Credentialing</b>	<p>The process of credential verification every three (3) years that a Participating Provider continues to meet Plan Credentialing requirements.</p>
<b>Remittance Advice (RA)</b>	<p>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.</p>

<b>Representative</b>	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.
<b>Resolution</b>	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.
<b>Resolution Final Determination</b>	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.
<b>Sanction</b>	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: <ul style="list-style-type: none"> <li>a. Delay payments until deficiency is addressed.</li> <li>b. Deny a portion of requested payments for activities not in compliance.</li> <li>c. Suspend services or new referrals.</li> <li>d. Reduced contract funding in the next FY.</li> <li>e. Termination the practitioner, contracted program or the entire contract.</li> <li>f. Decline to renew contracted program at the end of the current contract cycle.</li> <li>g. Initiate Federal suspension or debarment proceedings.</li> <li>h. Other legally available actions.</li> </ul>
<b>Specialty Mental Health Services (SMHS)</b>	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.
<b>Start-Up Expenses</b>	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.
<b>State 835</b>	Is an electronic Remittance Advice coming from the State that details what claims were paid and what claims were denied.
<b>State Fair Hearing</b>	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.
<b>Termination</b>	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.
<b>The Plan</b>	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).
<b>Timely Filing</b>	The time frame in which the provider/facility must submit the original (initial) claims to BHSD.
<b>Waste</b>	Inappropriate utilization of services and misuse of resources. Examples- 1. Ordering excessive laboratory tests. 2. Prescribing more medications than necessary to treat a condition.
<b>Workforce Member</b>	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.