Behavioral Health Department
Alameda County Health

Alameda County Behavioral Health Department (ACBHD)

Mental Health Individual Provider (MHIP) Handbook

Developed by the following ACBHD Departments:

ACCESS
Benefits and Billing Services
Contracts
Quality Assurance
Utilization Management

September 8, 2025

Who is this handbook for?

This Provider Handbook pertains only to the Mental Health Individual Provider (MHIP) network. This includes Alameda County Behavioral Health Department (ACBHD)-contracted individual and group providers.[1]

Please note:

This MHIP Handbook may be updated and as such, all changes to this handbook that are referenced in notices, letters and/or memorandums have the authority of policy and are binding, as indicated, to ACBHD and contracted providers (referred to as Providers).

Disclaimer:

The documents included in this handbook are for reference purposes only. For the most current version of these documents, use the web links provided or contact the appropriate ACBHD unit. You can access the most current version of this Handbook here: https://bhcsproviders.acgov.org/providers/network/provider_network.htm.

[1] Group providers are considered "groups" of individual providers. Each provider in a group must be credentialed and licensed.

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Chapter 1. Alameda County Behavioral Health Department

A. Understanding What Specialty Mental Health Services Are

In California, the Department of Health Care Services (DCHS) is the state agency responsible for the administration of the state's Medicaid program. In California, we refer to Medicaid as "Medi-Cal." At the time of publication, Medi-Cal served over 13 million people, or one third of all Californians. Medi-Cal covered 40% of children and youth and 43% of individuals with disabilities in California.

Specialty Mental Health Services (SMHS) serve beneficiaries who are identified as having moderate to severe mental health needs and are managed locally by county Mental Health Plans (MHPs). Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with Community Based Organizations (CBOs) and individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs. This array includes highly intensive services and programs, including therapy, community-based services, wraparound, and intensive case management programs.

Alameda County Behavioral Health Department (ACBHD) is the MHP for Alameda County. ACBHD is also the County's Drug Medi-Cal Organized Delivery System (DMC-ODS). Medi-Cal Managed Care Plans (MCPs) oversee the delivery of mental health services to Medi-Cal beneficiaries who are identified as having a mild to moderate mental health needs. These are called Non-Specialty Mental Health Services.

SMHS are provided to persons with mental health conditions that require intervention to support the person's ability to safely participate in their communities and achieve wellbeing. The Medi-Cal populations served by county MHPs include youth, including foster and probation youth, adults and older adults living below federal poverty levels with mental health conditions or trauma significantly impairing their ability to successfully participate in their communities.

B. ACBHD Mission, Vision, and Values

Our Mission

To support and empower individuals experiencing mental health and substance use conditions along their path towards wellness, recovery, and resiliency.

Our Vision

We envision a community where all individuals and their families can successfully realize their potential and pursue their dreams where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

Our Values

A-C-B-H-C-S: Our values represent who we are and who we strive to be!

Access. We value collaborative partnerships with peers and consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them along their journey towards wellness, resilience, and recovery.

Consumer & Family Empowerment. We value, support, and encourage individuals and their families to exercise their authority to make decisions, choose from a range of available options, and to develop their full capacity to think, speak, and act effectively in their own interest and on behalf of others they represent.

Best Practices. We value clinical excellence by implementing best practices, promising community-driven ideas, and effective outcomes, including prevention and early intervention strategies, to promote well-being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.

Health & Wellness. We value the integration of psychological, emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the multi-dimensional effects of mental illness and substance use disorders.

Culturally Responsive. We honor the voices, strengths, leadership, practices, language and life experience of ethnically and culturally diverse individuals and their families across the lifespan. We value operationalizing these experiences in our service settings, collaborative treatment planning, and the strategies we use to engage our communities.

Socially Inclusive. We value advocacy and education to eliminate stigma, discrimination, isolation, and misunderstanding of persons experiences mental illness, trauma, and substance abuse disorders. We support social inclusion and the full participation of our clients, consumers, patients, and family members to achieve fuller lives in communities of their choice – where they can live, learn, love, work, play, and pray in safety, security, and acceptance.

C. Understanding Eligibility for Specialty Mental Health Services

To be eligible for Medi-Cal SMHS, including MHIP outpatient therapy, an individual must:

- Be a resident of Alameda County
- Have Medi-Cal or be eligible for Medi-Cal[2]
    - If a client has Medi-Cal plus Medicare or Medi-Cal plus a commercial insurance plan, they must first be referred for outpatient mental health services through Medicare or through the commercial insurance plan. Medi-Cal is always the payor of last resort.
- Meet the access criteria for SMHS (see below)
- Meet the service criteria for this level of care (explained further in this section)

For the purposes of this handbook, individuals who receive SMHS are referred to as "members" or "clients".

Medi-Cal Specialty Mental Health Access Criteria

Effective January 1, 2022, the definition of medical necessity and the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services) is as established below.

ACBHD contracted outpatient providers will use the following Criteria for Adult and Youth to Access the SMHS.

For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet both of the following criteria, (1) and (2) below:

(1) The member has one or both of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The member's condition as described in paragraph (1) is due to either of the following:

a. 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.

[2] In some limited situations, MHPs may also serve individuals who are not eligible for Medi-Cal. These limited situations are described in greater detail later in this handbook.

b. A suspected mental disorder that has not yet been diagnosed.

For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

(1) The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

(2) The member meets **both of the following** requirements in a) and b), below:

a) The member has **at least one** of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate

iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal MCP is required to provide.

AND

b) The member's condition as described in subparagraph (2) above is due to one of the following:

i. 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.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a member under age 21 meets the criteria as described in (1) above, the member meets criteria to access SMHS; it is not necessary to establish that the member also meets the criteria in (2) above.

Specialized Services

ACBHD is the MHP for Alameda County. The plan primarily serves Alameda County residents with Medi-Cal who meet the eligibility criteria above. At the same time, there are Specialized Services that may be provided through different payors such as through:

- Child and Family Services (CFS)
- Medically Indigent Children (MIC) Program
- HealthPac (Health Program of Alameda County)

This handbook describes how these Specialized Services are managed in Chapter 4.

D. Provider Type Definitions

Outpatient Provider: Provider who renders mental health services in an outpatient setting.

- Individual:
  - Licensed clinician (LCSW, LPCC, MFT, PhD, and PsyD) who renders managed care outpatient SMHS.
  - Licensed psychiatrist who renders psychiatric evaluations/treatment services, to include medication monitoring.
  - Licensed psychologist who provides psychological testing.
- Group:
  - A group of two or more licensed mental health providers who render managed care outpatient SMHS. For the purposes of this manual, groups are considered as a group of individual providers, with each provider bearing the responsibilities that are outlined in this manual.

Inpatient Professional (IP) Service Provider (In-Network and Non-Network)**:** Psychiatrist or psychiatry group who render psychiatric evaluation and treatment services to beneficiaries who have been admitted to an acute medical or psychiatric inpatient setting or medical emergency room.

- Individual:
  - An individual licensed psychiatrist.
- Group:
  - A group of two or more licensed psychiatrists.

E. How to Contact ACBHD

The MHIP network is co-managed by several ACBHD units. Each unit plays a distinct and important role in supporting the network of providers. To ensure that Provider concerns

and/or questions are handled in a timely and appropriate manner, Providers should use the guide below to contact the appropriate ACBHD unit.

Unit	What Each Unit Does	Contact Information
Acute Crisis Care and Evaluation for System-wide Services (**ACCESS**)	• Initial verification of eligibility • Screening for access criteria and level of care • Referrals to providers • Referrals to Psychological Testing • Updating availability and capacity of service providers • Clinical consultation with providers	ACCESS 2000 Embarcadero, Suite 205 Oakland, CA 94606 **P:** (800) 491-9099 **F:** (510) 346-1083 accessdesk@acgov.org
Contracts Unit	• MHIP Provider Application • Contract and/or amendments • Credentialing and/or re-credentialing • Monitoring exclusions and debarments • Disenrollment • Monitoring insurance coverage and license status • Updating contact information	Contracts Unit c/o MHIP 1900 Embarcadero, Suite 205 Oakland, CA 94606 **P**: (510) 567-8296 **F**: (510) 567-8290 MHProviders@acgov.org
Billing and Benefits	• Billing/Claims • Payments • Claim Appeals	Billing & Benefits Support Unit P.O. Box 738 San Leandro, CA 94577-0738

Support Unit Claims Processing Center	• Rates • Staff numbers • Member Insurance Eligibility	**P:** (800) 878-1313 **F:** (510) 567-8081 Medi-Cal Eligibility Help Desk (888) 346-0605
Quality Assurance (QA)	• Clinical care and documentation standards • Documentation training • Chart audits and site review • Informing Materials • Quality of care • Death and Incident reporting • Whistleblower Program	Quality Assurance 2000 Embarcadero, Suite 400 Oakland, CA 94606 **P:** (510) 567-8105 **F:** (510) 639-1346 QAOffice@acgov.org QA Technical Assistance: QATA@ACgov.org Whistle Blower Hotline: (844) 729-7055 Grievance and Appeal (G&A) Consumer Assistance for clients: (800) 779-0787; File A Grievance (Client/Patient Only) – Alameda County Behavioral Health (acbhcs.org) Grievance and Appeal Resources for Providers and Provider Notice of Adverse Beneficiary Decision (NOABD): http://www.acbhcs.org/providers/QA/NOABD.htm To request Informing Materials: QAOffice@acgov.org HIPAA Breach: BreachNotification@acgov.org

Chapter 2. Contract Requirements

A. Contract Requirements for Outpatient Providers

General Provider Responsibilities

Providers must adhere to the requirements outlined in this handbook along with the specifications in their signed contract, subsequent communications from ACBHD, and all applicable laws and regulatory requirements. Non-compliance with any of these requirements may result in suspension of referrals, involuntary disenrollment and/or termination of the Provider's ACBHD contract.

Minimum Number of ACBHD Clients

It is the responsibility of Providers to maintain the minimum number of three ACBHD member slots at any given time. Providers should call ACCESS at (800) 491-9099 when they are temporarily unable to accept new referrals. Providers designated to provide Specialty Services may be exempt from the minimum client requirements. Please contact the Contracts Unit if you are unsure.

Timeliness of Initial Appointment

Upon receipt of a *Referral Letter* from ACCESS, the Provider is expected to reach out to the member and schedule the initial appointment to occur within 10 business days of the date on the Referral Letter, or within 48 hours for urgent needs. **If the Provider is unable to offer an appointment within 10 business days of the date on the referral, the Provider must inform ACCESS immediately and a new referral will be made for the member.** Providers shall ensure the same hours of operation as provided to all other patients served regardless of the MHP-sponsored health care coverage.

Licensure, Permits and Certificates

Providers shall obtain and maintain during the term of the contract agreement, all appropriate licenses, permits, and certificates required by all applicable Federal, State, County and/or municipal laws, regulations, guidelines, and/or directives as may be amended from time to time for the operation of its facility and/or for the provision of services hereunder. ACBHD uses the Council for Affordable Quality Healthcare's (CAQH) ProView system to manage provider licensing and credentialing requirements. Providers shall maintain current copies of appropriate licenses, permits, and certificates in their CAQH ProView profile. Unlicensed or associate level providers are not permitted to provide services under this contract, even with supervision.

Liability Insurance

Providers shall maintain the minimum insurance requirements set forth in the Exhibit C (available on CAQH). Providers shall maintain current, at all times, copies of their certificates of insurance in their CAQH ProView profile before they expire in order to avoid delays in processing submitted claims. Failure to adhere to these requirements will affect the Provider's good standing with the MHP and will result in a payment withhold of submitted claims and suspension of new client referrals beyond the insurance expiration date.

Administrative and Program Standards

Providers shall comply with all administrative standards and program requirements as specified by all applicable Federal, State, County and/or municipal laws, regulations, guidelines, and/or directives. Providers shall comply with the *Alameda County Ethical Code*[3] the ACBHD Ethical Conduct Code,[4] professional organizations, applicable to Provider licensure.

Changes in Contact Information and Service Delivery Site

Providers must report any changes to the Contracts Unit and update their CAQH ProView profile within 10 business days of the event. Changes may include changes to name, phone number, fax number, address, service delivery site, name, and any changes in State-issued license. Failure to report contact information changes may result in delays in receiving payments, delivery of income tax reporting documents at the end of the calendar year, and important information in order to maintain good standing as an MHIP Provider.

Credentialing and Re-Credentialing

In compliance with Title 42, Code of Federal Regulations (CFR) Part 438.214 and DHCS MHSUDS_Information Notice_18-019,[5] ACBHD requires the primary source verification of all MHIP Providers' credentials. The verification of credentials is performed in accordance with the standards of the National Committee on Quality Assurance (NCQA).

[3] https://www.acgov.org/sleb/documents/ethics.pdf
[4] https://bhcsproviders.acgov.org/providers/QA/docs/qa_manual/2-1%20Ethical_conduct_policy.pdf

[5] https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-019%20PROVIDER%20CREDENTIALING%20AND%20RE-CREDENTIALING/MHSUDS_Information%20Notice_18-019_Final%20Rule_Credentialing.pdf

ACBHD currently utilizes CAQH ProView, a secure online, profile-based system to allow providers to enter and maintain information. Providers must create a profile in CAQH ProView and complete their provider application upon receiving instructions from ACBHD. The ProView profile information should always contain current information, and the Provider is required to attest to the accuracy of their profile every 120 days. All new Providers and/or Groups of Providers are subject to initial credentialing during the pre-contracting process and re-credentialing every three years thereafter. ACBHD notes the initial date of credentialing in the letter sent to Providers after initial credentialing.

ACBHD's decision to contract with any Provider may also be influenced by non-credentialing factors, such as, but not limited to, geographic area, language, and specialty of the Provider. It is ACBHD's sole decision whether to enter a contractual relationship with a specific Provider or group of Providers.

Ongoing Monitoring for Exclusions, Sanctions and Debarment

In compliance with 42 CFR 455.436 and 483.214, all ACBHD Providers are monitored on an ongoing basis to ensure that they are in good standing with Centers for Medicare and Medicaid Standards (CMS) Department of Health and Human Services and not on any list of providers who are excluded from participation in federal and state health care programs (i.e., Office of Inspector General (OIG) List of Excluded Individuals and Entities) and State Medicaid programs (i.e., Medi-Cal Suspended and Ineligible List). Providers are also monitored to ensure their professional license is in good standing with the issuing licensing board.

Verifying Medi-Cal Eligibility

When providing services to individuals on Medi-Cal, providers must verify (and retain proof of verification) member's Medi-Cal eligibility **prior to providing services,** at a minimum, on a monthly basis. We strongly recommend that Providers verify eligibility prior to each session and maintain a printed copy of the eligibility check for their records as clients' health insurance can change at any time including retroactively. For assistance with basic Medi-Cal benefit questions, contact the ACBHD Medi-Cal Benefits Help Desk at (888) 346-0605.

B. Contract Requirements for Inpatient Providers

In-Network Contracted Provider

ACBHD only contracts with group providers to perform inpatient professional services in a hospital setting or at a facility located within Alameda County. These providers are part of the MHP; and therefore, follow the same contracting requirements.

Non-Network Provider

Non-Network Providers who rendered psychiatric evaluation and treatment services to Alameda County beneficiaries admitted in an acute medical or psychiatric inpatient setting or medical emergency room while travelling outside Alameda County must contact the Contracts Unit to request a *Non-Network Provider Application*. Non-Network Providers are not credentialed or re-credentialed by ACBHD but must provide certification from the hospital in which they are affiliated that they are in good standing along with additional documentation.

In order to become a Non-Network Provider, the following information must be submitted to the Contracts Unit:

- Completed and signed Non-Network Provider Application (with signed Certification page)
- Completed and signed W-9
- Verification from affiliated hospital of Joint Commission Accreditation and certification statement that provider is in good standing

Important to Note:

For Inpatient services to be reimbursed, a Non-Network Provider has 60 calendar days from the date they receive a rejection letter from the ACBHD Claims Processing Center (CPC) to complete the Non-Network Provider Application process. If all information is not received within the 60-day timeline, the Non-Network Provider Application, and the claims submitted for that Provider, will be denied.

Once all information above is received and all claims have been submitted and reviewed for accuracy and audit compliance, the Non-Network Provider will receive an approval letter.

Chapter 3. ACCESS

A. What is ACCESS?

ACBHD Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) is a 24-hour resource and major entry point for Medi-Cal beneficiaries to obtain mental health services. ACCESS provides mental health screening and triage through licensed clinicians who evaluate eligibility and treatment needs and ensure expedient and appropriate access to ACBHD services.

Who does ACCESS Serve?

In order to be eligible for SMHS through ACBHD, an individual must be a resident of Alameda County, have Alameda County Medi-Cal or be eligible for Alameda County Medi-Cal or HealthPAC, and meet Medi-Cal's SMHS access criteria which is listed in Chapter 1 of this Handbook. The SMHS access criteria can also be found in DHCS BHIN 21-073.[6]

What does ACCESS offer?

- Information and referrals to individuals seeking SMHS
- Screening and triage of calls to identify service needs
- Assessment and referral for persons in immediate crisis
- Connection to emergency and other urgent delivery service systems
- Referrals to County-owned and operated clinics, Community Based Organizations, and MHIP providers
- Direction for out-of-county providers
- Information regarding linkages to community resources
- Information regarding member problem resolution processes
- Referral to the Consumer Assistance Office, Quality Management and Assurance units

In order to meet the needs of Alameda County's diverse community, the ACCESS telephone menu of options is provided in six languages: English, Spanish, Cantonese, Vietnamese, Mandarin and Cambodian. ACCESS staff utilizes Globo for additional languages and California Relay for persons who are deaf or hard of hearing. Providers may use GLOBO for interpretation services. The following language specific ACCESS numbers, staffed by the following contracted Community Based Organizations, are also available:

- Asian Languages
    - Asian Health Services ACCESS Line @ 510-735-3939

[6] https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf

- Spanish
    - La Clinica de La Raza @ 510-535-6200 (Oakland/North County)
    - La Familia Counseling @ 510-881-5921 (South County)
- Deaf and Hard of Hearing
    - Deaf Community Counseling @ 510-225-7013; 510-984-1654 (video phone)

How does ACCESS screen for SMHS eligibility?

ACCESS clinicians receive calls from individuals, friends/family, medical providers, social service representatives, law enforcement and other community agencies requesting information and referral. The ACCESS clinician will complete the Standardized Screening Tool for an individual who is not currently receiving SMHS. If a third party is seeking services on behalf of another, the ACCESS clinician will gather information and work to connect the individual to appropriate services with the consent of the individual and/or their legal guardian.

During an ACCESS screening, callers are asked to describe mental health concerns they have – including the severity of those concerns as well as the impact they have upon day-to-day functioning. Signs and symptoms of concern may include thoughts, feelings, and behaviors (e.g., sadness, paranoia) that contribute to problems in daily living.

ACCESS screening also includes verification of insurance eligibility. ACBHD insurance plans/programs include Alameda County Medi-Cal, Children and Family Services (per MOU with CFS), Health Program of Alameda County (HealthPAC), Medically Indigent Child (MIC) and Medicare/Medi-Cal (for services not covered by Medicare).

As described above, ACCESS staff makes a preliminary determination that the member requesting services meets Medi-Cal SMHS Access Criteria and insurance criteria prior to making a referral. MHIP Providers are responsible for assessing if the client meets SMHS access criteria on an ongoing basis.

B. How do members connect with MHIP Providers through ACCESS?

There are two ways members can connect to an MHIP Provider for outpatient therapy.

1. Through a referral from ACCESS
2. Through a member and therapist connecting directly without a referral from ACCESS

Both processes are described below:

1. Referrals from ACCESS

Most often beneficiaries will connect to MHIP Providers following a screening with ACCESS. Once eligibility is determined, ACCESS staff can make a referral. Referrals to MHIP Providers are based upon the member's mental health needs and provider availability. ACCESS matches beneficiaries to services based upon several factors including preference for a provider with a specific language/cultural background, provider's gender, geographic location, and provider's clinical specialties.

Once an MHIP Provider is identified, ACCESS sends a *Referral Letter* by fax, U.S. Mail, or email that notifies them that a member has been referred. This notification includes the requested service, clinical information, the member's insurance plan and special instructions that correspond with that plan. ACCESS verifies Medi-Cal eligibility for the month of the referral only. It is the responsibility of the MHIP Provider to verify Medi-Cal status for all subsequent months and before each session.

What to do When You Receive a Referral from ACCESS

Upon receiving a *Referral Letter* from ACCESS, the MHIP Provider is expected to reach out to the member and offer the initial appointment that is within 10 business days of the member's request, or within 48 hours for urgent needs. If you are unable to offer an appointment date within 10 days, or within 48 hours for urgent needs, inform ACCESS immediately and a new referral will be made for the member.

2. Connecting for Services Directly Without a Referral from ACCESS

The below process describes in detail the steps of bringing in a new client into your practice without an ACCESS referral. Please note that the data elements for collecting Timeliness Tracking data are included below for ease of reference. Timeliness Tracking is a requirement for all SMHS Providers. More details on this topic are covered within the Quality Assurance chapter of this handbook (Chapter 7).

1. Client seeks services directly from provider
    a. For Timely Access Data Tool (TADT) Tracking purposes,[7] this would be the "Date of Requested Service".
    b. To ensure alignment with our timely access policy: If you are not able to offer a first appointment within 10 business days from the date of request for nonurgent needs or within 48 hours for urgent needs, in addition to letting ACCESS know, you must send a written notification of an adverse

[7] Reference Section 5 of the QA Manual

determination, also referred to as Notice of Adverse Benefit Determination (NOABD) to the client and a copy of the NOABD to the ACBHD QA office. You can find ACBHD's NOABD policy and templates here.[8]

c. The first date you offer an appointment to the member is considered the First Service Appointment Offer Date/Time.
d. The day of the first meeting with the client is considered the First Service Appointment Rendered Date for Timeliness Tracking purposes.

2. Provider completes risk assessment and responds to any crisis needs accordingly.
3. Provider gathers client information necessary to complete a SmartCare Registration form.[9]
4. Provider completes assessment
    a. Reminder: if client is need of Substance Use services you may make a referral to ACBHD's Substance Use and Referral Helpline by calling 1-844-682-7215
5. Provider determines if client meets SMHS access criteria
    a. Provider may chose to document this on the BH Screening Tool for Outpatient Services[10] form, but use of this form is not a requirement.
6. If client meets SMHS access criteria and the client is under 21 years old, the provider assesses client for *Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care(TFC)* (guidance available in Mental Health Assessment, Appendix B[11]) and maintains such assessment in client's chart.
7. If client meets SMHS access criteria and is an adult, we strongly recommend the Provider complete the Adult/Older Adult Level of Care Determination Tool[12] and maintain it in client's chart.
    a. If Tool does not identify outpatient therapy as appropriate level of care, Provider can call ACCESS to discuss potential transition or adding adjunct services for client.
8. If upon completion of the Assessment, provider determines client **meets** SMHS access criteria and determines outpatient therapy is the best matched level of care for the client at this time, provider continues to provide treatment to client.
    a. For the purposes of NACT Timeliness Tracking, this may be the Follow Up Appointment Date.
    b. Provider calls ACCESS to open the client.

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[8] https://bhcsproviders.acgov.org/providers/QA/NOABD.htm

[9] https://bhcsproviders.acgov.org/providers/smartcare/forms/MHS_Client%20Registration%20Form_Fillable%20Form_v2.pdf

[10] https://bhcsproviders.acgov.org/providers/QA/memos/2022/Behavioral%20Health%20Screening%20Tool%20for%20Outpatient%20Services.pdf

[11] https://bhcsproviders.acgov.org/providers/network/docs/2023/FFS-Mental-Health-Assessment-2023.03.29.docm

[12] https://bhcsproviders.acgov.org/providers/network/docs/forms/Adult%20and%20Older%20Adult%20Level%20of%20Care%20Tool%20for%20FFS%20therapists_8.2.23.pdf

i. Provider will provide basic demographic information such as name, DOB, address, contact information, etc., gathered during assessment process.
ii. Provider will provide brief clinical information detailing reason for treatment.
iii. ACCESS Clinical Review Specialist (CRS) will coordinate with the Health Insurance Technician (HIT) to verify the client's insurance.
iv. ACCESS CRS will enter information into database to link Provider with client which is necessary for processing claims.
v. ACCESS CRS confirms opening with Provider and will move forward with issuing referral letters to the client and provider.
vi. Client ID# (aka PSP#/SmartCare ID#) may or may not be available to the Provider at the time of the call with ACCESS. Regardless, Client ID# number will be included in the referral letter received by the Provider.

9. If upon completion of the Assessment, provider determines client **does not** meet SMHS criteria, provider completes Transition of Care Tool[13] and sends it to the client's identified MCP on the same day they complete it. The MCP can be identified by the insurance verification, and more information on this tool can be found in this Transition of Care Tool Training.[14]
    a. Providers must send the client a NOABD letter[15] letting them know they do not meet criteria for SMHS and send a copy of this letter to the ACBHD QA office.
    b. Provider communicates to client that they should receive a call from the MCP within 2-3 business days to schedule an appointment with new provider.
    c. See below section "When a Client No Longer Meets Access Criteria for SMHS" for additional steps.
    d. If the Provider would like to seek payment for the Assessment of a client who did not meet SMHS, please follow the steps identified in 8b i – vi and let the ACCESS CRS know to link this client to the Provider but that this claim is for Assessment only and that no referral letter needs to be sent to the Client.

C. Continuity of Care

All eligible Medi-Cal members who meet access criteria for SMHS have the right to request continuity of care. Members with pre-existing provider relationships who make a continuity of care request to ACBHD shall be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or terminated network provider, to complete a course of treatment and to arrange for safe transfer to another provider.

[13] https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf
[14] https://bhcsproviders.acgov.org/providers/QA/docs/training/2024/Transition%20of%20Care%20Tool.pdf
[15] https://bhcsproviders.acgov.org/providers/QA/NOABD/NOABD%20Letters%20and%20Attachments/NOABD%20Letter%20Translations/Translated%20Templates_English/NOABD_English_Coversheet_Template.pdf

Individuals can request Continuity of Care by calling the ACCESS department at 1-800-491-9099.

D. Providers Ongoing Relationship with ACCESS

ACCESS is a resource for MHIP Providers and can assist with such things as clinical consultation, triage of urgent mental health needs, and linkage to community resources. ACCESS clinicians can assist MHIP Providers with connecting beneficiaries to higher or lower levels of care and adjunct services when appropriate.

When a Client Needs a Higher Level of Care within ACBHD

If, following a comprehensive assessment or during treatment, a Provider finds that a member needs a higher level of care or additional services (e.g., medication support or psychological testing) then they may be referred to ACCESS for screening and referral. Within the context of treatment, sometimes additional services are desired such as medication evaluation or psychological testing. These requests can be made through ACCESS as well. Psychological testing requests must be medically necessary or clinically indicated to evaluate a mental health condition, to establish or clarify a diagnosis and to guide treatment.

When a Client No Longer Meets Access Criteria for SMHS

If, following a comprehensive assessment or during treatment, a Provider finds that a member no longer meets ACCESS criteria for SMHS, then they should initiate the transition process to a lower level of care if the client wants to continue receiving mental health services. When this occurs, the Provider should complete the Transition of Care tool[16] and send it to the client's MCP (MCP) (following the guidance provided in this Transition of Care Tool Training[17]). The MCP provides Non-SMHS to Medi-Cal beneficiaries. Once the Provider sends the Transition Tool to the MCP, it is necessary for the Provider to continue to provide services to the client until the Provider is confident the client is securely linked with an MCP provider. If Providers have questions regarding the use of the Transition Tool or process, please contact ACCESS. Providers can also review DHCS' Frequently Asked Questions list for Screening and Transition Tools[18] for more information.

[16] https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf
[17] https://bhcsproviders.acgov.org/providers/QA/docs/training/2024/Transition%20of%20Care%20Tool.pdf
[18] https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-FAQ.aspx

Chapter 4. Specialty Services

A. Services to Individuals through Alameda County Social Services Agency Children and Family Services

ACBHD and Alameda County Social Services Agency (ACSSA) Children and Family Services (CFS) have an agreement in which ACSSA pays for mental health services for minor dependent individuals and/or parent/caregivers who may or may not be eligible for Medi-Cal benefits or who do not meet medical necessity criteria for SMHS. Mental health services to individuals served by ACSSA must be initiated by the individual's Child Welfare Worker (CWW) if the member is seeking treatment in order to meet a CFS court order or case plan. All approvals of services must come through ACCESS.

Please note that the Utilization Charts discussed in Chapter 5 of this handbook do not apply to CFS clients. The Utilization Charts only apply to service provision of ACBHD clients when ACBHD is the payor source.

Providers shall deliver the services listed for each type of CFS Mental Health Services:

CFS Mental Health Services	Services to be Provided
Psychosocial Assessment (also known as Mental Health Assessment)	Providers identify and clarify the member's presenting problem, the psychological impact of the situation, the member's strengths and challenges, the member's mental health diagnosis, and recommendations regarding treatment and/or placement needs.
Treatment Plan	A treatment plan must be developed with input from the member, family (as indicated) and CWW before treatment services can begin.
Psychotherapy	Providers deliver treatment with the goal of decreasing the member's symptoms and improving functioning.
Psychological Evaluation/Testing	The testing may be provided by a licensed psychologist or an organization's doctoral intern under the supervision of a licensed psychologist. The Provider collects information, reviews records, and administers a battery of tests. The Provider provides diagnostic clarification, identification and treatment recommendations. The Provider conducts interviews with parents/caregivers and reviews relevant member records. The Provider's testing report will include a mental health diagnosis, as appropriate; diagnostic conclusions; and recommendations that address the CWW's specific questions. Psychological testing requests from CWW's

CFS Mental Health Services	Services to be Provided
	that do not meet medical necessity criteria are paid for by ACSSA (Psychological Testing Authorization Request is not needed).
Medication Evaluation and Monitoring	Providers evaluate whether medication would alleviate member's symptoms, and if so, monitors effects of the medication. Only contracted psychiatrists, or the following disciplines within an organization can provide these services: psychiatric nurse practitioners, physician assistants, or clinical psychiatric pharmacists working under the supervision of a psychiatrist.

CFS Customized Services

CFS may also request Customized Services, which are mental health services that address the unique needs of Social Services, but are not billable to Medi-Cal. If a CWW requests Customized Services, they must obtain supervisor approval and provide additional CFS authorization to ACCESS prior to ACCESS making a referral to Providers. Providers should not deliver Customized Services unless they have received a *Referral Letter* from ACCESS requesting this specific service.

Upon receipt of ACCESS *Referral Letter*, Providers shall deliver the following CFS Customized Services listed below. These services require CWW's Supervisor signature prior to ACCESS' referral.

CFS Customized Services	Services to be Provided
Attachment Evaluation	Collect information on the quality of the attachment relationship between parent/caregiver and the minor and whether the relationship can meet the minor's basic psychological and emotional needs. This evaluation is often given in conjunction with psychological testing of the child.
Caregiver Competence Evaluation	Collect information on the parent/caregiver's ability to provide basic safety, stability and emotional care to the minor. This evaluation is often given in conjunction with psychological testing.
Developmental Assessment	Performs in-depth assessment of early childhood development.
In-Depth (procedure code is called Client Evaluation) Progress Report	Provide a written report, typically for presentation to the court that contains substantially more detail and takes more time than a standard progress report.

The below services may only be delivered by Providers that ACBHD has pre-screened and authorized.

CFS Customized Services	Services to be Provided
Sexual Perpetrator Evaluation	Evaluate whether an individual may be victimizing others and provide treatment recommendations.
Sexual Perpetrator Treatment	Provide individual and/or group therapy with the goal of alleviating risk of victimizing others.
Evaluation of Dangerous Client	Perform court ordered psychological evaluation of an adult with history of violent behavior who may pose a risk to the provider.
Treatment of a Dangerous Client	Provide court ordered individual and group therapy to adult with history of violent behavior who may pose a risk to the provider.

CFS Reports

As a condition of being an ACBHD MHIP Contractor and accepting CFS referrals, the Provider must submit written Progress Reports/Treatment Summary to the assigned CWW once every six months, or upon request. Generally, requests are given to Providers with ten working days' notice. For new beneficiaries, Providers will generally be given 15 working days. Providers may bill for this service. A CWW may request a more in-depth report. For rates, see Exhibit B of your contract.

Providers should contact the CWW to ensure the report's purpose and expectations are clear. Reports should include a brief summary of relevant history with recommendations that are concrete, specific and relevant to the member's current context. Providers' interpretation must be kept to the Provider's scope of practice and expertise. Reports provided by Providers may influence the results of a parent/caregiver's termination of parental rights. When drafting reports, Providers should take care to consider:

- Limitations of the tests or methods used
- Provider objectivity, such as, but not limited to, cultural biases and experiences
- The member's situational factors, such as, but not limited to language/cultural differences, stress, etc.
- Proper grammar and spelling are expected

These are a few basic categories of reports for CFS services a Provider must submit:

CFS Reports	Report Criteria
CFS Progress Report/Treatment Summary	Unless the CWW indicates otherwise, this report must include presenting problems; a diagnosis from the

(procedure code listed as Casework Report)	Diagnostic and Statistical Manual (DSM-5); treatment goals and a narrative. The narrative must include attendance, engagement and progress toward goals. Generalizations are not sufficient. Providers may only bill for either the CFS Progress Report/Treatment Summary or the CFS Mental Health Assessment once every six months.
CFS Mental Health Assessment	This report provides a psychosocial assessment. Provider may bill for the time it takes to write the report under the same billing code as the progress report. Providers may only bill for either the CFS Progress Report/Treatment Summary or the CFS Mental Health Assessment once every six months.
Psychological Testing	Providers must write the report to address the specific questions of the CWW. Providers should address the limitations of testing and the potential uses of the report.

B. Psychological Evaluation and Testing

For details related to the psychological testing please review the Psychological Testing Requirements and Payment Authorization policy[19] on the ACBHD Provider website.

C. Services to Youth on Probation

If a probation officer contacts the Provider directly, the Provider should refer that person to ACCESS.

D. Eating Disorder Services

ACCESS refers beneficiaries who may be displaying symptoms of an eating disorder to an MHIP Provider who is competent in working with this population. Most beneficiaries will be referred to providers who have experience working with individuals with eating disorders, while those with more severe symptoms are referred to one of our eating disorder specialists. Providers can become eating disorder specialists by obtaining an Eating Disorders certificate from a credentialed program or have extensive experience working in an Eating Disorder program.

E. Interventional Psychiatry

Interventional psychiatry involves using procedures and/or devices to manage mental health conditions. ACBHD contracts with Bay Psychiatric Associates (BPA) to offer a range of interventional psychiatry services including Transcranial Magnetic Stimulation (TMS), Electroconvulsive Therapy (ECT), Ketamine, and Esketamine. Due to the specialized nature

[19] https://bhcsproviders.acgov.org/providers/PP/200-1%20Psych%20Testing%20Authorization%20P&P.pdf

of these treatments, recommendations for treatment are streamlined through existing SMHS providers to make direct referrals to BPA. BPA then coordinates additional evaluation and record collection for prior authorization and approval from ACBHD Utilization Management Division (see Chapter 5).

F. HealthPAC

Health Program of Alameda County, or HealthPAC, is an Alameda County program that provides affordable health care to uninsured people living in Alameda County. In order to be eligible for HealthPAC an individual must not be eligible for Medi-Cal. Some referrals to the MHIP network may be HealthPAC referrals. HealthPAC eligibility lasts for one year, and providers are expected to note the start and end dates of a client's eligibility, and check it at the year mark. If the client is not longer enrolled in HealthPAC at the year mark, providers should call ACCESS to discuss options.

G. Other Referral Sources

Some referrals may not originate from ACCESS such as:

Murphy Conservatorship

Providers may enroll with ACBHD to provide services for beneficiaries who have an established Murphy Conservatorship through the courts. In order to bill for Murphy Conservatorship services, all Providers must receive a referral from the Public Guardian's Office located within ACSSA.

Lanterman Petris Short (LPS)

Providers may enroll with ACBHD to provide services for beneficiaries who have an established LPS through the courts. In order to bill for LPS services, all Providers must receive a referral from the Public Guardian's Office located within ACSSA.

Diversion from State Hospitals (DSH)

Providers may enroll with ACBHD to provide services for beneficiaries who have an established DSH through the courts. In order to bill for DSH services, all Providers must receive a referral from the ACBHD Forensic, Diversion, Re-entry Services System of Care.

Competency to Stand Trial

Qualified Providers may be asked to provide evaluation services for juvenile beneficiaries who are court ordered to receive an evaluation to determine if they are competent to stand trial.

Chapter 5. Utilization Management

ACBHD Utilization Management (UM) provides oversight of behavioral health, including both SMHS and Substance Use services, from a utilization perspective to ensure that the appropriate level of care and service is available for beneficiaries when they need it.

A. For Outpatient Providers

Utilization Tables

Utilization Tables are a mechanism to manage and monitor client service utilization. These tables provide evidence-based guidelines for the frequency of service by modality type per client by month. For example, per the "General Utilization Table for Individual Providers", Providers shall render between two to ten individual therapy sessions per month per client. All services rendered must be justified and clinically appropriate based on the client's current mental health needs. *If a client is need of additional services outside the amount listed on in the "monthly session guidelines" column, the Provider shall contact Utilization Management at 510-567-8141, submit clinical documentation for utilization review and support regarding potential referrals for appropriate level of care.*

There are two distinct Utilization Tables:

1. General Utilization Table
    a. Please use this Utilization Table when providing and claiming for services that are not considered to be "specialty services" described in Chapter 4 of this Handbook.
2. Eating Disorder Services Utilization Table
    a. Only providers who are identified as Eating Disorder Specialists may use this table.

Both tables are updated frequently due to the implementation of California Advancing and Innovating Medi-Cal (CalAIM). As a result, please access the Utilization Tables on the Provider's website on the MHIP Providers Website.[20] **Please note that the Utilization Tables do not apply to CFS clients.** The Utilization Tables apply only to ACBHD clients when ACBHD is the payor source.

Claiming for Services

MHIP providers may submit payment claims directly to the ACBHD Billing and Benefits' Claims Processing Center (CPC). For claims to be processed, the number of sessions for each service type on the claim form must be within the Utilization Table guidelines column

[20] https://bhcsproviders.acgov.org/providers/network/provider_network.htm

for that specific service type. For example, a claim will be processed if it states the Provider rendered five individual therapy sessions, two case management sessions, and one assessment session. However, it will be returned to the provider with guidance to contact Utilization Management if the claim form states eleven individual therapy sessions, or nine family therapy sessions were provided.

If a Provider submits a claim that indicates service provisions outside of the Utilization Table monthly session guidelines without approval by UM, the claim may be denied and sent back to the Provider. At that time the Provider shall contact the UM office to discuss *utilization review, individual client needs, and potential referrals for additional or new level of care*. This may cause a delay in getting claims paid and we strongly recommend that Providers ensure they contact UM, prior to submitting the claim.

If there is a justifiable clinical need outside the Utilization Table monthly session guidelines, the Provider shall contact UM and discuss the clinical rational for requesting additional sessions **prior** to submitting claims. As clinically needed, the UM Clinical Review Specialist will determine how many additional sessions over the guidelines on the Utilization Table are approved and will communicate the specific number of additional sessions for the specified client and month to the Claims Processing Center (CPC).

Eating Disorder Services

Therapists providing Specialized Eating Disorder Services have a different set of codes and rates that apply to the services they render. Thus, a separate Utilization Table is provided reflecting evidence-based practices for service provision and utilization. The Eating Disorder Utilization table includes the service names, billing codes, time associated with each code, details related to codes, and monthly session guidelines for Providers delivering Specialized Eating Disorder Services to clients.

B. For Inpatient Professional Service Providers

ACBHD Utilization Management (UM) serves as the ACBHD MHP Point of Authorization (POA) responsible for acute inpatient chart review to determine whether Medi-Cal medical necessity reimbursement criteria has been met. Psychiatric evaluation and treatment services rendered by psychiatrists are referred to as professional fees and are not included in the inpatient daily reimbursement rate. Professional fee services are categorized as SMHS outpatient services and can be rendered to beneficiaries admitted to acute psychiatric inpatient, acute medical inpatient, or medical emergency rooms. Professional fee reimbursement claims are submitted to Billing and Benefits Support Claims Processing Center (CPC), via the Center for Medicare and Medicaid Services (CMS) *Claim Form CMS 1500 (CMS 1500)*.

ACBHD UM reviews inpatient admissions for Alameda County Medi-Cal members. When a Medi-Cal/Medicare (Part A) member does not have Medicare Part B (outpatient), refer to the Billing and Claims chapter of this handbook for further instructions on how to request Medi-Cal reimbursement for professional fees.

Acute Psychiatric Inpatient: In-Network and Non-Network

Acute psychiatric inpatient reimbursement requests are submitted to UM through a Treatment Authorization Request (TAR 18-3) by the inpatient facility. In accordance with California Code of Regulations (CCR), TAR submission to ACBHD UM is required within 14 calendar days from the date of discharge. Within 14 calendar days of the TAR receipt, to include all necessary clinical documentation, ACBHD UM determines whether the inpatient day(s) in question meet Medi-Cal reimbursement criteria for acute or administrative days. These reimbursement authorizations are entered in a local Alameda County member database and the completed TAR is faxed to both the Medi-Cal Fiscal Intermediary and to the inpatient facility as notification.

Once a TAR is submitted to ACBHD UM, professional fee reimbursement claims via the form can be submitted to ACBHD Claims Processing Center (CPC). CPC verifies in the local Alameda County member database that the inpatient days have been reviewed and authorized for either acute or administrative days. Claims will be returned if there is no record of TAR receipt by UM or if the inpatient day(s) are determined to not meet Medi-Cal medical necessity criteria for reimbursement.

Acute Medical Inpatient: Non-Network Only

The Provider submits a copy of the professional fee reimbursement claim via the CMS 1500 form to ACBHD UM, along with clinical documentation of the psychiatrist's assessment. Required accompanying clinical documentation must include clinical determinations and recommendations, psychiatric diagnoses, and the rationale for the attending medical physician psychiatric consult order. A copy of the psychiatric consult order may also be included. Within 14 calendar days of receipt of all necessary documentation, ACBHD UM will render a reimbursement decision and send written notification of approval or denial decisions.

Upon receipt of the UM written approval decision, the inpatient facility or designated entity submits the professional fee reimbursement claim via the original CMS 1500 to ACBHD CPC. CPC staff verify in the appropriate Alameda County member database that UM has completed approval authorizations for the professional fee reimbursement requests prior to remitting payment.

Chapter 6. Billing and Claims

A. The Claims Processing Center

The Claims Processing Center (CPC) is one unit within the ACBHD Billing and Benefits Support (BBS) Unit. The CPC is responsible for ensuring accurate and timely claims processing and prompt payment to Providers.

Payments are contingent on:

- Provider contracting with ACBHD
- Provider remaining in good standing with contract requirements
- Member's continued insurance eligibility
- Timeliness of claim submission
- Member being open to Provider in ACBHD billing system. Note: The ACBHD ACCESS department opens the member to the Provider at onset of services
- Provider delivers and claims for a quantity of services that does not exceed the maximum amount identified on the Utilization Table

Rates

Financial agreements between ACBHD and Providers that include, but are not limited to rates, exclusions and coordination of benefits; will be written in contract/agreements with ACBHD and Providers and are not affected by material presented in this handbook. The Exhibit B in the Provider's SMHS Contract reflects a Provider's contracted fee schedule and allowable procedure codes for billing. As contracted providers for the ACBHD MHIP, Providers agree to accept a contracted fee schedule as payment, in full, for services provided to ACBHD clients.

Missed Appointments

ACBHD does not authorize payment to Providers for member's missed appointments; nor may a member be billed.

Medi-Cal Eligibility Verification

ACBHD recommends that providers retain proof of Medi-Cal eligibility for each client each time a service is rendered. Medi-Cal eligibility has the potential to change at any time, including retroactively.

Providers must conduct verification at a minimum, on a monthly basis, as benefits may change. ACBHD Billing and Benefits Support (BBS) Unit offers a Medi-Cal Eligibility Help Desk phone support to assist with basic Medi-Cal benefit questions, at (888) 346-0605.

As a contracted State Medi-Cal Provider, ACBHD administers the per provider accounts that allows for Medi-Cal verification processes. Providers must also verify member's eligibility and other primary coverage:

- Prior to rendering services and prior to claims submission.
- When a potential member presents him/herself as a Medi-Cal member or presents a Medi-Cal Identification Card.

For more information regarding verifying Medi-Cal eligibility please see a training power point[21] which is available on the Provider's website regarding the process for checking member insurance, including how to distinguish between designations of private Kaiser and Kaiser MCP.

Share of Cost

Providers agree to bill ACBHD directly, not the member, for services provided.

Providers may only bill the member for the Medi-Cal Share of Cost amount in compliance with 42 C.F.R. 438.900. The Share of Cost amount is deducted from the MHP Plan rate, not from the charge rate. ACBHD is not responsible for helping to meet the Share of Cost obligation. When billing for services rendered to a member, the Share of Cost should be noted as the amount paid and the amount should be deducted from the total charges on the claim. The Share of Cost amount is deducted from the ACBHD payment rate, not from Provider's customary charge rate.

Documentation of charges used to meet the Share of Cost obligation must be maintained by Providers and documented on the CMS 1500, form in Box 29 (Amount paid) when submitting claims to ACBHD CPC. In addition, providers must include a completed Share of Cost / Spend Down Clearance Request form with their claim submission to the CPC.

Medi-Cal Beneficiaries with Other Health Insurance Coverage (OHC)

Providers are responsible for determining when a member has other health insurance in addition to Medi-Cal. Medi-Cal is always considered to be the payor of last resort for SMHS delivered to individuals with Medi-Cal. As a result, if an individual has both Medi-Cal and a

[21] https://bhcsproviders.acgov.org/providers/network/docs/2025/Verifying_Medical_Eligibility.pdf

private/commercial insurance plan, the private/commercial insurance plan is the responsible payor.

Providers must submit documentation, i.e., Explanation of Benefit or Remittance Advice, of payment or a valid denial from the insurance carrier attached to the claim form to the CPC. The OHC payment amount is deducted from the total charges and documented on the CMS 1500 form in box 29 (Amount paid) when submitting claims to CPC. The CPC will adjudicate the service(s) based on the ACBHD contracted rate minus the insurance payment.

Only the following denials are considered "valid" for reimbursement:

- Not a covered benefit
- Benefits have been exhausted
- Coverage has been terminated

In general, if a client has Other Health Coverage such as a commercial or a Medicare insurance plan, then they should receive outpatient therapy services from that other plan. If you find that a current client has had a change in insurance and now has a commercial or Medicare plan, it is essential to work with that individual to transition their services to the primary insurance plan if the client needs ongoing behavioral health services. If you have questions about this process, you may call the Medi-Cal Eligibility Help Desk phone support at (888) 346-0605 or ACCESS at (800) 491-9099.

Medi-Cal Beneficiaries with Medicare

Providers are responsible for determining whether a member is covered by Medicare. If Providers are enrolled with Medicare, they should bill Medicare as the primary payer and **not** claim any balance to ACBHD. To request Medicare enrollment, call the Medicare Provider Service Center at (800) 541-5555 or via the DHCS webpage at http://www.dhcs.ca.gov. Claims received for clients with Medicare and Medi-Cal will be returned to the provider.

B. Claim Submission

Providers must submit all original CMS 1500 claims to Billing and Benefits Support CPC within 60 days from the end of the month of service. ACBHD may deny claims received later than 60 days after the month of service. Payment of claims is dependent on continued insurance eligibility, medical necessity, referral, and timeliness of claim submission.

Providers must submit claims for services rendered as described below:

CMS 1500

Providers must complete all form areas using the contracted procedure codes as seen in Exhibit B-1 in your ACBHD contract and DSM-5 diagnosis codes. The Authorized Person's

Signature in Box 12 and 13 may be designated as "signature on file" with supporting signature documentation kept at the Provider's site. The rendering Provider's NPI number must be entered in Box 24-J. Providers must sign Box 31. This form may be downloaded from the Center for Medicare & Medicaid Services website: https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1188854.

Mail all claims to:
Billing and Benefits Support – Claims Processing Center
P.O. Box 738
San Leandro, CA 94577-0738

Year End Claim Deadline
June 30th is the end of the ACBHD fiscal year. Every year, BBS will send Providers a minimum of three letters indicating the deadline for submitting fiscal year claims. It is essential for all Providers to meet this annual deadline for all services provided within that year. Late claims will be denied.

Late Claim Submission

ACBHD must submit claims to the State within a strict timeline based on the date of service. Thus, ACBHD strictly enforces the claims submission timeline of 60 days from the month of service. Sometimes there are valid reasons for a late claim submission. In these rare instances, Providers may request a late submission exception by completing and submitting a *Late Claim Submission Exception Request* form to the CPC. Claims over one year old must include a copy of the member's proof of benefits over the year and must be submitted to the CPC within 10 business days from the date of the letter. Providers should contact the CPC at (800) 878-1313 with any questions.

Claim Processing and Payments

Billing and Benefits Support Unit CPC goal is to adjudicate claims within 21 working days from the receipt of a claim. Claims are adjudicated for payment based on ACBHD ACCESS opening the client to the therapist in the ACBHD billing system, the client meeting access criteria and member monthly benefits eligibility, and the Provider being in good standing in terms of contract requirements. If or when a claim does not meet this criteria, payment or processing may be delayed or denied.

All claims are subject to a comprehensive review for accuracy and audits for compliance. All claims that pass the review will be adjudicated for payment processing. The CPC will notify Providers, as time permits by mail or phone, of claims requiring further information or action.

There are several potential reasons ACBHD may take back or adjust a payment. This action is referred to as a Revert. Circumstances may include beneficiaries who receive retroactive

Medicare, beneficiaries with an unmet Share of Cost, or with other health insurance, etc. The CPC will process a revert service that reduces the payment amount from the Providers next check.

CPC will issue payments for all adjudicated claims via mail with a Remittance Advice (RA) that will reflect all paid and/or reverted services. Providers are expected to review the RA to assist with tracking billing and payments.

Claim Returns

CPC may return claims to Providers that do not pass the reviews and audits or when additional information is needed in order to process the claim for payment. Providers are allowed up to 45 days from the date of the claims return letter to resubmit the claim. Claims received after this deadline will be denied.

Claim Denials

CPC may deny claims to Providers that do not pass the edits and audits necessary to process the claim for payment. Denied claims may not be corrected but may be appealed within 30 days of the denial date.

Claim Appeals

Providers who have received a denial for services and have a valid justification for payment reconsideration may submit a Claims Appeal form, accompanied with a copied claim form and supporting documentation within 30 days of the denial letter to the CPC.

BBS will acknowledge the receipt of an appeal within 15 days by sending a letter to the Provider, and will respond with a final decision within 45 days of receipt of the appeal and indicate:

- The reason for the decision that addresses each issue raised in the appeal
- Any action required by the Provider
- Denial or payment

If the appeal is denied, Providers may submit a Second Level Appeal to the ACBHD Billing and Benefits Unit within 30 days from the appeal denial decision date when they do not agree with the appeal decision and have a valid justification for payment reconsideration.

BBS Administration will respond to all Second Level Appeals with a final decision within 60 days of receipt of the Second Level Appeal.

Claim Inquiries

Providers who have submitted a claim and have not received a payment, return letter or denial within 30 to 45 days, should submit a *Claims Inquiry* form along with an original claim form. The CPC will research the circumstances and respond accordingly via payment, denial or request for further information.

Client and Service Information (CSI)

The State Department of Health Care Services Agency (DHCS) requires all Counties to collect and report CSI data for all clients receiving Mental Health services. CSI data will be used in conjunction with Behavioral Health Service Act (BHSA) data to evaluate the achievements of the County's BHSA plan. Due to this state mandate by DHCS, it is essential that every Provider complete all client data fields on the forms mentioned below. Providers must complete and submit the Client Registration and Client Episode Opening forms to the ACBH CPC, along with the first CMS 1500 claim form submission for the client's initial service date(s).

Client Registration

All members must be registered in ACBHD's accounts payable and accounts billable systems. The Client Registration form must be completed and submitted to the CPC along with the first CMS-1500 claim form submission for the client's initial service date(s). Providers will also need to submit a Client Registration form whenever any demographic data is being updated or corrected.

Client Episode Opening and Update Forms

For services to be processed and adjudicated, a member must have an episode treatment period opened in ACBHD's accounts payable and accounts billable system. A Client Episode Opening form must be completed and submitted to the CPC along with the first CMS-1500 claim form submission for the client's initial service date(s).

A Client Episode Update form must be completed and submitted to the CPC whenever updates or corrections are necessary due to changes in client episode data (i.e. diagnosis codes, income, employment, etc.)

Episode Closing

A Client Episode Closing form must be completed and submitted to the CPC along with the CMS-1500 claim form that reflects the client's final date of service(s). When a provider will no longer be providing services to a member, the episode must be closed.

Chapter 7. Quality Assurance

As a condition of being an ACBHD MHIP Provider, Providers shall comply with applicable Federal and State regulations as well as any additional requirements set by ACBHD. Refer to the Quality Assurance Manual[22] and QA Memos and Notices[23] on the ACBHD Provider Website which contain applicable regulations, policies and procedures, and requirements, some of which are summarized below.

A. Training for MHIP Providers

All MHIP Providers are expected to attend ACBHD trainings to learn how to:

- Manage the client referral process
- Complete eligibility screening
- Complete and submit claims
- Check each client's Medi-Cal eligibility
- Document services according to current SMHS documentation standards
- Conduct clinical quality review team (CQRT) reviews on charts
- Refer clients to other levels of care and/or for additional services through ACBHD or their Medi-Cal MCP
- Close a client to services

These trainings will help to ensure that services provided by Providers are appropriate and payable. In most situations, Providers are encouraged to attend these trainings prior to submitting any claims to the Claims Processing Center (CPC).

MHIP Providers are **required** to attend clinical documentation training presented by the QA Office soon after being accepted as a MHIP. Proof of completion of this training will be required as part of the re-credentialing process. Providers must attend these trainings as soon as possible after they have been contracted with ACBHD.

Providers can access trainings through the ACBHD Provider Website[24] and will be informed of training opportunities via email.

[22] https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm
[23] https://bhcsproviders.acgov.org/providers/QA/memos-2023.htm
[24] https://bhcsproviders.acgov.org/providers/network/provider_network.htm

B. Consumer Rights

Informing Materials

Provider shall review ACBHD's *Informing Materials* packet with each member at the initial session, annually, and upon request, and obtain the member's or legal representative's signature (initials annually) on the *Informing Materials – Your Rights & Responsibilities: Acknowledgement of Receipt* form which shall be kept in the member's medical record. The Informing Materials packet includes sections on the following:

- Consent for Services
- Freedom of Choice
- Guide to Medi-Cal Mental Health Services, Member Handbook, & Provider Directory
- Confidentiality & Privacy
- Advance Directive Information: *Your Right to Make Decisions about Medical Treatment*
- Beneficiary Problem Resolution Information
- Maintaining a Welcoming & Safe Place
- Notice of Privacy Practices

Informed Consent & Informing Materials

Medi-Cal members receiving services funded, all or in part, by ACBHD must be provided with a copy of the Informing Materials – Your Rights and Responsibilities packet, on the Informing Materials page of the ACBHD Provider website. This document contains information about the member's rights and responsibilities and is available in all Alameda County threshold languages. Providers with the required education, knowledge, training, and scope of practice should review the content with each member at intake, annually thereafter, and upon request. After satisfactory review of the packet, the Acknowledgment of Receipt signature page must be completed, signed, and retained in the member's medical record. By completing and signing the signature page, members acknowledge their consent to voluntarily receive services from that provider. Providers may supplement the Informing Materials packet but cannot alter, contradict, overrule, or remove any information. Informing Materials guidelines and materials can be found here.[25]

Telehealth Consent

Per BHIN 23-018,[26] California Department of Health Care Services (DHCS) requires providers do all of the following:

[25] Informing Materials List | ACBH Providers Website
[26] BHIN 23-018 Updated Telehealth Guidance for SMHS and SUD Treatment Servies in Medi-Cal.pdf

- Obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services prior to the initial delivery of covered services via telehealth (synchronous audio and video) or telephone (audio only).
- Explain specific information to beneficiaries regarding the use of telehealth.
- Document in the member's medical record their verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services.

Also, to preserve a member's right to access covered services in person, a provider furnishing services through telehealth must do one of the following: 1. Offer those same services via in-person, face-to-face contact; or 2. Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different provider to arrange for that care.

See Telehealth Consent Form in section 7 of the QA Manual[27] for specific details required when obtaining verbal consent and optional templates and forms that can be used for this purpose.

Minor Consent to Treatment

Per Assembly Bill No. 665, effective July 1, 2024, a minor who is 12 years of age or older can consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services if the minor, in the opinion of the attending professional, is mature enough to participate intelligently in services. The minor consent to treatment excludes convulsive therapy, psychosurgery and psychotropic drugs.

The minor's mental health treatment or counseling must include involvement of the minor's parent or guardian unless the professional person treating or counseling the minor determines that their involvement would be inappropriate. This bill requires the professional person treating or counseling the minor to consult with the minor before determining whether involvement of the minor's parent or guardian would be inappropriate. This decision and any attempts to contact parents must be documented in the minor's record.

If the minor consents or could have consented to care, the provider may only share the minor's health information with their parents or guardian with the signed authorization of the minor. This is true even if in consultation with the minor, it is determined that the minor's parents can be informed and involved in treatment. See Memo 2024-01 on the QA Manual[28] page of the Provider website for more information.

Consumer Grievance and Appeal Process

Providers shall be knowledgeable about ACBHD's member grievance and appeal process and provide information to beneficiaries as needed. Provider shall post ACBHD's Consumer Grievance and Appeal poster in a conspicuous place, preferably in a waiting area outside of Provider's office, and make available ACBHD's Consumer Grievance and Appeal material

[27] https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm
[28] Ibid

and forms in such a manner that member does not need to ask for the material. See Section 10 of the QA Manual[29] for more information.

C. Confidentiality and Breaches

Providers shall comply with all applicable Federal, State, County and/or municipal laws, regulations, guidelines and/or directives pertaining to the confidentiality of individually identifiable health information including, but not limited to: the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH), and Welfare and Institutions Code requirements regarding confidentiality of patient information, and records, commencing with Section 5328. Provider shall inform and train its officers, employees and agents of the provisions for confidentiality of all information and records as set forth in those laws. Providers shall be familiar with the requirements of HIPAA/HITECH.

Breaches of Confidentiality

As a condition of being part of ACBHD's MHIP Provider Plan, Providers shall follow State and Federal guidelines pertaining to breaches of confidentiality. Providers agree to hold ACBHD harmless for any breaches or violations arising from the action/inactions of Providers, their staff and sub-contractors. All breaches of confidentiality shall be reported to ACBHD per the Privacy and Security Incident Reporting Policy,[30] via the Privacy/Security Incident Reporting Form. [31]

Business Associates – Sharing of Information

As part of ACBHD's MHP, all contracted Providers are considered Business Associates and as such, all providers shall share necessary member information with any other service provider within ACBHD's System of County-operated and County-contracted providers for:

- Treatment activities (including the need to make timely referrals among programs for purposes of providing integrated services within this system of care)
- Payment activities of said providers, and/or for
- Health care operations of said providers if each of the entities has or had a relationship with the member.

[29] https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm
[30] https://bhcsproviders.acgov.org/providers/PP/1704-1-1%20Privacy%20and%20Security%20Incident%20Reporting%20Policy.pdf
[31] https://app.smartsheet.com/b/form/0669dd55f23b4d77843674eac79c3c46

Notices of Adverse Benefit Determination for Medi-Cal Beneficiaries

All Providers are required to issue Notices of Adverse Benefit Determination (NOABDs) to Medi-Cal beneficiaries in certain circumstances as outlined in ACBHD's Notice of Adverse Benefit Determination (NOABD) Policy.[32] NOABD templates can also be found here.[33] NOABDs inform beneficiaries of the action and their rights when certain actions are taken. The following NOABDs are to be issued by Providers:

Notice of Adverse Benefit Determination	**Providers must issue a NOABD when:**
NOABD – Delivery System	It is determined, on the basis of an assessment, that the Medi-Cal member does not meet medical necessity criteria or is otherwise not entitled to receive SMHS from the MHP. The NOABD – Delivery System and the language services notices are to be given directly to or sent to the member, or parent or legal guardian, by the Provider within two business days of the action being taken and a copy of all documents to: ACBHD Quality Assurance 2000 Embarcadero, Suite 400 Oakland, CA 94606 Or via FAX (510) 639-1346 Refer to the *Notice of Adverse Benefit Determination (NOABD) Policy,* QA Manual, Section 10[34] for further details.
NOABD – Timely Access	The Provider has not provided services in a timely manner based on standards established by the MHP. The Provider responsible for providing the services shall send the NOABD – Timely Access to the member, parent, or legal guardian, and send a copy of all documents to QA (address above). Refer to the policy for further details.

D. Documentation Standards

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, documentation standards for Medi-Cal SMHS significantly changed as of July 1, 2022. ACBHD adopted the CalMHSA Documentation Manual.[35] If you have specific documentation questions, please email the QA office at QATA@acgov.org.

[32] https://bhcsproviders.acgov.org/providers/PP/300-1-2%20NOABD%20P&P.pdf
[33] https://bhcsproviders.acgov.org/providers/QA/NOABD.htm
[34] http://www.acbhcs.org/providers/QA/qa_manual.htm
[35] https://bhcsproviders.acgov.org/providers/QA/docs/qa_manual/7-2_Doc_Manual_Post_CalAIM_%203.3.25.pdf

E. Monitoring for Quality and Compliance

The Quality Assurance (QA) office will train providers on the use of the Clinical Quality Review Team (CQRT) form to review their documentation to ensure it meets SMHS requirements. Annually, the QA team will randomly select five percent of MHIP providers across our system for a CQRT review. During this review, providers will be asked to share their completed CQRT forms with QA staff and will be provided with feedback and coaching.

F. Maintenance and Retention of Records

Providers shall adhere to the maintenance, access, disposal and transfer of records in accordance with professional standards and all applicable Federal, State, County and/or municipal laws, regulations, guidelines and/or directives, including, if applicable, the specified regulations of the Substance Abuse and Crime Prevention Act of 2000. Records shall be organized and contain sufficient detail to make it possible for contracted services to be evaluated and meet documentation standards. See Section 7 of the QA Manual[36] for more information. Providers shall permit authorized ACBHD personnel to make periodic inspections of the records. Providers shall furnish information and patient records such as these personnel may require for monitoring, reviewing and evaluating fiscal and clinical effectiveness, appropriateness, and timeliness of the services being rendered under this contract. Clinical records are to be destroyed in a manner to preserve and assure member confidentiality.

All member records must be retained as long as required by law, and until ACBHD has finalized that fiscal year's cost settlement with DHCS (whichever is longer). Currently the last ACBHD/DHCS finalized cost settlement was through 6/30/2013. No records containing services beyond that date may be destroyed. Other requirements pertaining to records retention follows:

Clinical records must be preserved for a minimum of 10 years following discharge/termination of the member from services, with the following exceptions:

- Un-Emancipated Minors: The records of un-emancipated minors must be kept for at least one year after such minor has reached age 18, and in any case, not less than 10 years.

- For psychologists: Clinical records must be kept for 10 years from the member's discharge/termination date; in the case of a minor, 10 years after the minor reaches age 18

- Third party: If a Provider uses a third party to perform work related to their ACBHD contract, the Provider must require the third party to follow these same standards

[36] https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm

- Audit situations: Records shall be retained beyond the 10-year period if an audit involving those records is pending, until the audit findings are resolved. The obligation to ensure the maintenance of records beyond the initial 10-year period exists only if the MHP notifies Contractor of the commencement of an audit prior to the expiration of the 10-year period.

Given the above extensions beyond the 10-year period it is highly recommended that all Providers maintain their client's records for 15 years after the last service OR 15 years after the client's 18th birthday, whichever is later.

G. Provider Out of Business

In the event a Provider goes out of business or no longer provides mental health services, the Provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of clinical records for the minimum retention time as described above. As well, the Provider must notify the ACBHD Quality Assurance Office of who will be responsible for the maintenance of the records.

H. Unusual Occurrence (Sentinel Event) And Death Reporting

Providers shall submit an *Unusual Occurrence/Death Reporting Form* to the ACBHD QA Office within seven days of the knowledge of the Unusual Occurrence or death involving any Member. Please see the *Unusual Occurrence and Death Reporting Policy* and forms in the QA Manual[37] Include link to policy page on provider website Reporting is used to identify and address:

- Utilization patterns that suggest issues with access to services
- Gaps within the service continuum
- Linkage with services
- Coordination of care
- Quality improvement
- Trends and patterns within any identified series of Unusual Occurrences
- Issues involving client safety

I. Service Verification

ACBHD regularly verifies with beneficiaries that they did, in fact, receive services claimed for by Providers. Services may be verified by ACBHD via a letter to the member, a phone call to the member, or other method. Providers shall regularly verify the member's contact

[37] QA Manual | ACBH Providers Website

information with the member and update ACBHD's records as needed. Please see ACBHD's *Service Verification Policy* in the QA Manual, Section 15.[38]

J. Other ACBHD Resources

Please see the QA Manual,[39] for other applicable resources.

[38] http://www.acbhcs.org/providers/QA/qa_manual.htm
[39] Ibid