Alameda County Behavioral Health

Mental Health Plan Fee-for-Service (FFS) Provider Handbook

Developed by the following ACBH Departments:

ACCESS
Benefits and Billing Services
Contracts Unit
Quality Assurance
Utilization Management

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Who is this handbook for?

This Provider Handbook pertains only to the Mental Health Plan (MHP) Fee-for-Service (FFS) Providers. This includes Alameda County Behavioral Health (ACBH)-contracted individual and group providers, as well as a handful of organizational providers. If you are an organizational provider and not sure whether your contract falls under MHP FFS, please contact the Contracts Unit to confirm at: MHProviders@acgov.org or 510-567-8296.

Please note:

This MHP FFS Provider 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 ACBH 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 ACBH unit.

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1. Introduction and Overview of Alameda County Behavioral Health Care Services

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." The Medi-Cal program is a mix of federal and state regulations serving over 13 million people, or one third of all Californians. Medi-Cal covers 40% of children and youth and 43% of individuals with disabilities in California. Medi-Cal behavioral health services are "carved out", meaning that they are delivered through separate managed care delivery systems, each of which is responsible for delivering different sets of services to individuals depending on their care needs.

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. Specialty Mental Health Services (SMHS) are managed locally by county Mental Health Plans (MHPs) and serve beneficiaries who are identified as having moderate to severe mental health needs. ACBH is the county MHP for Alameda County. 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 Fee for Service (FFS) 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.

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 elderly, disabled, adults, youth and foster or probation youth below federal poverty levels with mental health conditions or trauma significantly impairing their ability to successfully participate in their communities. In short, MHPs serve some of the most vulnerable populations.

B. ACBH Mission, Vision, and Values

Alameda County Behavioral Health (ACBH) is the Mental Health Plan (MHP) for Alameda County. ACBH includes both Specialty Mental Health Services (SMHS) and the county's Drug Medi-Cal Organized Delivery System (DMC ODS). This handbook provides information for MHP Fee for Service (FFS) providers within the SMHS division of ACBH.

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 Specialty Mental Health Services (SMHS) including MHP FFS outpatient therapy an individual must:

- Be a resident of Alameda County
- Have Medi-Cal or be eligible for Medi-Cal or HealthPAC (Health Program of Alameda County)
    - If a client has Medi-Cal plus Medicare or Medi-Cal plus a commercial insurance plan, then they need to 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 Specialty Mental Health Services (see below)
- Meet the service criteria for this level of care (explained further in this section)

Medi-Cal Specialty Mental Health Access Criteria

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

ACBH Contracted Outpatient Providers will use the following **Criteria for Adult and Youth to Access the Specialty Mental Health Services** as established in DHCS Behavioral Health Information Notice Number 21-073.

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

(1) The beneficiary 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 beneficiary'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.

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

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

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

a) The beneficiary 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 specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary'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 beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

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

ACBH is Alameda County's Mental Health Plan

Alameda County Behavioral Health Care Services (ACBH) is the Mental Health Plan (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)
- CalWORKs
- Medically Indigent Children (MIC) Program
- HealthPac (Health Program of Alameda County)

This handbook describes how these Specialized Services are managed in chapter 9.

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 specialty mental health services (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.
- Organization:
    - A Medi-Cal site certified organization that includes both licensed and unlicensed clinicians who render managed care outpatient SMHS.

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 ACBH

The MHP FFS Provider system is co-managed by several ACBH 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 ACBH unit.

Unit	What Each Unit Does	Contact Information
Acute Crisis Care & 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 (formerly known as the Network Office)	• MHP FFS Provider Application • Contract and/or amendments, including Urgent Interim Agreements • Credentialing and/or re-credentialing • Monitoring exclusions and debarments • Disenrollment • Monitoring Insurance coverage and License Status • Updating contact information	Contracts Unit c/o MHP FFS 1900 Embarcadero, Suite 205 Oakland, CA 94606 **P**: (510) 567-8296 **F**: (510) 567-8290
Billing and Benefits Support Unit (formerly known as Provider Relations) Claims Processing Center	• Billing/Claims • Payments • Claim Appeals • Rates • Staff numbers • Beneficiary Insurance Eligibility	Billing & Benefits Support Unit P.O. Box 738 San Leandro, CA 94577-0738 **P:** (800) 878-1313 **F:** (510) 567-8081 Medi-Cal Eligibility Help Desk (888) 346-0605 EligibilityHelpDesk@acgov.org
Quality Assurance (QA)	• Clinical care and documentation standards • Documentation training • Chart audits and site review • Informing Materials	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

	• Quality of care • Death and Incident reporting • HIPAA Breach reporting • Whistleblower Program • Certifying/re-certifying site for Medi-Cal (Organizations only)	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: http://www.acbhcs.org/providers/QA/NOABD.htm To request Informing Materials: QAim@ACgov.org Provider Notice of Adverse Beneficiary Decision (NOABD): http://www.acbhcs.org/providers/QA/NOABD.htm Provider Site Certification: SiteCertification@ACgov.org Credentialing and Waiver Requests: qaoffice@acgov.org HIPAA Breach: BreachNotification@acgov.org

Chapter 2. Contract Requirements

A. Provider 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. It is the responsibility of Providers to maintain the minimum number of three ACBH beneficiary slots at any given time. Outpatient Providers should call ACCESS at (800) 491-9099 when they are temporarily unable to accept new beneficiary referrals. Providers designated to provide Specialty Services may be exempt from the minimum client requirements. Please contact the Contracts Unit if you are unsure. Upon receipt of a *Referral Letter* from ACCESS, the provider is expected to reach out to the beneficiary and schedule the initial appointment to occur within 10 business days of the date on the Referral Letter. **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 beneficiary.** Providers shall provide the same hours of operation as provided to all other patients served regardless of the MHP-sponsored health care coverage.

Licensure, Permits and Certificates:

As a condition of being a contracted ACBH MHP FFS Provider, 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. ACBH 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. Failure to keep required licensure, permits and certificates may result in contract termination.

Liability Insurance:

As a condition of being a contracted ACBH MHP FFS Provider, Providers shall maintain the minimum requirements set forth in the Exhibit C of their signed ACBH contract. 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. Continuous non-compliance will also result in involuntary disenrollment and termination of the Provider's ACBH contract.

Administrative and Program Standards:

As a condition of being a contracted ACBH MHP FFS Provider, 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* as posted on the Alameda County General Services Agency website, at http://www.acgov.org/auditor/sleb/documents/ethics.pdf, and by the Ethical Code of Conduct of all professional organizations, applicable to Provider licensure.

Changes in Contact Information:

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 including 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 MHP FFS 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, ACBH requires the primary source verification of all MHP FFS Provider's credentials. The verification of credentials is performed in accordance with the standards of the National Committee on Quality Assurance (NCQA).

ACBH 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 within five (5) business days of receiving an Urgent Interim Agreement with ACBH. 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 are subject to initial credentialing during the pre-contracting process and re-credentialing will occur every three (3) years thereafter.

ACBH'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 ACBH's sole decision whether to enter a contractual relationship with Providers. ACBH re-credentials individuals and Providers who are part of a group every three years from the initial date of credentialing. ACBH notes this date in the letter sent to Providers after initial credentialing. Providers who fail to comply with the County's re-credentialing standards within a timely manner may be involuntarily disenrolled from the MHP FFS Provider system.

Ongoing Monitoring for Exclusions, Sanctions and Debarment

FFS Individual, Group including Inpatient and Organizational Providers:

In compliance with 42 CFR 455.436 and 483.214, all ACBH 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.

Organizational Providers:

Organizational Providers shall perform the following tasks related to Exclusion List Monitoring per ACBH's *OIG and Other Exclusion List Monitoring, Oversight and Reporting Policy* of the QA Manual, Section 15: http://www.acbhcs.org/providers/QA/qa_manual.htm:

- Update their ACBH Staff Roster with staff additions, departures, and staff information changes at least monthly using the *Staff Number Request E-Form*. Staff in this context includes contractor's clinical and non-clinical employees, volunteers, and agents of contractor who provide goods and services under the contract with ACBH.
- Attest monthly that they have updated their Staff Roster using the *Monthly Staff Change Attestation E-Form*.
- Screen all potential employees, volunteers, and agents prior to employment or contracting.

Failure to comply with the OIG attestation requirements will result in a payment withhold of the provider's submitted claims.

Verifying Beneficiary Medi-Cal Eligibility

As a condition of being a contracted ACBH MHP FFS Provider, Providers must verify and (retain proof of verification) beneficiary's Medi-Cal eligibility **prior to providing services,** and 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 ACBH Medi-Cal Benefits Help Desk at (888) 346-0605.

B. Provider Contract Requirements for Inpatient Providers:

In-Network Contracted Provider

ACBH 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 ACBH 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 JCAHO 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 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

What is ACCESS?

Alameda County Behavioral Health (ACBH) 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 ACBH services.

Who does ACCESS Serve?

In order to be eligible for **Specialty Mental Health Services (SMHS)** through ACBH, an individual must be a resident of Alameda County, have Alameda County Medi-Cal or be eligible for 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.

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 & Cambodian. ACCESS staff utilizes Language Line Solutions for additional languages and California Relay for persons who are deaf or hard of hearing. Beneficiaries may also use the following language specific ACCESS numbers which are staffed by the following contracted Community Based Organizations:

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

What does ACCESS offer?

- Information and referrals to Medi-Cal beneficiaries seeking Specialty Mental Health Services
- Screening and triage of beneficiary 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 Fee-for-Service Providers
- Direction for out-of-county providers to beneficiary enrollment and authorization services
- Information regarding linkages to community resources
- Information regarding beneficiary problem resolution processes
- Referral to the Consumer Assistance Office, Quality Management and Assurance units

How does ACCESS screen for SMHS eligibility?

ACCESS clinicians receive calls from individual beneficiaries, friends/family, medical providers, social service representatives, law enforcement and other community agencies requesting information and referral. When a Medi-Cal beneficiary who is currently not receiving mental health services, seeks services through ACCESS for themselves, the ACCESS clinician will complete the Standardized Screening Tool in accordance with BHIN 22-065. If a third party is seeking services on behalf of an adult beneficiary, the ACCESS clinician will gather information and work to connect the individual to appropriate services with the beneficiary's consent. If a third party is seeking services on behalf of a child or youth beneficiary who is not currently receiving mental health services, the ACCESS clinician will complete the Standardized Screening Tool.

During an ACCESS screening, beneficiaries and other 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. ACBH insurance plans/programs include Alameda County Medi-Cal, Children and Family Services (per MOU with CFS), Health Program of Alameda County (HealthPAC), CalWORKs, 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 beneficiary requesting services meets Medi-Cal SMHS Access Criteria prior to making a referral. MHP FFS Providers are responsible for assessing if the client meets SMHS access criteria on an ongoing basis.

How do beneficiaries Connect with MHP FFS Providers through ACCESS?

There are two ways beneficiaries can connect to an MHP FFS Provider for outpatient therapy.

1. Through a referral from ACCESS

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

Both processes are described below:

Referrals from ACCESS

Most often beneficiaries will connect to MHP FFS Providers following a screening with ACCESS. Once eligibility is determined, ACCESS staff can make a referral. Referrals to MHP FFS Providers are based upon the beneficiary'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 MHP FFS Provider is identified, ACCESS sends a *Referral Letter, (Appendix D)*, by fax or US Mail and email that notifies them that a beneficiary has been referred. This notification includes the requested service, clinical information, the beneficiary'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 FFS Provider to verify Medi-Cal status for all subsequent months and preferably before each session.**

What to do When You Receive a Referral from ACCESS

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

Beneficiaries and Provider 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 Specialty Mental Health Providers. More details on this topic are covered within the Quality Assurance chapter of this handbook.

1. Client seeks services directly from provider
    a. For Network Adequacy Certification Tool (NACT) Timeliness Tracking purposes 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, you must send a Timely Access NOABD to the client and a copy of the NOABD to the ACBH QA office. You can find ACBH's NOABD policy and templates here.

2. Provider completes risk assessment and responds to any crisis needs accordingly
    a. The day that you have your first meeting with the client is considered the Assessment Start Date for NACT Timeliness Tracking purposes.

3. Provider gathers information necessary for SmartCare Registration form.

4. Provider calls ACCESS
    a. ACCESS Clinical Review Specialist (CRS) coordinates with the ACCESS HIT to verify insurance.
    b. ACCESS CRS enters information into SmartCare to link Provider with Client which is necessary for processing claims
    c. ACCESS CRS confirms opening with Provider and gives Provider the client's ID number

5. Provider completes assessment
    a. For NACT Timeliness Tracking, the Assessment End Date would be the day provider completes assessment
    b. Reminder: if client is need of Substance Use services you may make a referral to ACBH's Drug Medi-Cal Organized Delivery System (DMC-ODS) by calling 1-844-682-7215

6. Provider determines if client meets SMHS access criteria
    a. Provider can document this on the BH Screening Tool for Outpatient Services form but it is not a requirement

7. If client meets SMHS access criteria and the client is under 21 years old, the provider completes the *Intensive Service Needs Assessment for ICC/IHBS/TFC* and maintains it in client's chart.

8. 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 and maintain it in 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.

9. If upon completion of the Assessment, provider determines client **does not** meet SMHS criteria, provider completes Transition Tool and sends it to the client's identified Managed Care Plan (MCP) on the same day they complete it. The MCP can be identified by the insurance verification.
    a. Providers must send the client a Delivery System NOABD letter letting them know they do not meet criteria for SMHS and send a copy of this letter to the ACBH 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. Provider continues to deliver services until the client is securely connected to a provider through the MCP.

10. If upon completion of the Assessment, provider determines client **does meet** 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 Treatment Appointment Date.
    b. In the future, if the provider determines client needs a higher level of care or additional Specialty Mental Health Services, they can call ACCESS to discuss the specific client situation.
    c. In the future, when the provider identifies the client may be ready to transition out of Specialty Mental Health Service and into Non-specialty Mental Health Services, the provider and client would use a person-centered shared decision making process to work through this transition together. The provider would complete a Transition Tool and send it to the client's Managed Care Plan.
        i. The Provider would continue providing services to the client until it is verified that the client is securely linked to the provider through the Managed Care Plan.

Continuity of Care

All eligible Medi-Cal beneficiaries who meet access criteria for Specialty Mental Health Services have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to ACBH 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, necessary to complete a course of treatment and to arrange for safe transfer to another provider. Individuals can request Continuity of Care by calling the ACCESS department at 1-800-491-9099.

FFS Providers Ongoing Relationship with ACCESS

ACCESS is a resource for MHP FFS 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 MHP FFS 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 ACBH

If, following a comprehensive assessment or during treatment, a provider finds that a beneficiary 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.

When a Client No Longer Meets Access Criteria for SMHS

If, following a comprehensive assessment or during treatment, a Provider finds that a beneficiary 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, please complete the Transition of Care tool and send it to the client's Managed Care Plan (MCP). The MCP provides Non Specialty Mental Health Services to Medi-Cal beneficiaries. Once you send the Transition Tool to the MCP, it is necessary for you to continue to provide services to the client until you are confident the client is securely linked with an MCP provider. If you have questions regarding the use of the Transition Tool or process, please contact ACCESS. You can also review DHCS' Frequently Asked Questions list for Screening and Transition Tools for more information.

When a Client Needs Additional ACBH Services While Maintaining FFS Outpatient Therapy

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.

Chapter 4. Specialty Services

A. Services to Individuals Through Alameda County Social Services Agency (SSA) Children and Family Services (CFS)

ACBH and Social Services' Children and Family Services (CFS) have an agreement in which SSA 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 Social Services must be initiated by the individual's Child Welfare Worker (CWW) if the beneficiary 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 do not apply to CFS clients. The Utilization Charts are in chapter 5 of this handbook and only apply to service provision of ACBH clients when ACBH 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 beneficiary's presenting problem, the psychological impact of the situation, the beneficiary's strengths and challenges, the beneficiary's mental health diagnosis, and recommendations regarding treatment and/or placement needs.
Treatment Plan	A treatment plan must be developed with input from the beneficiary, family (as indicated) and CWW before treatment services can begin.
Psychotherapy	Providers deliver treatment with the goal of decreasing the beneficiary'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 beneficiary 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 that do not meet medical necessity criteria are paid for by Social Services (PTAR is not needed).

CFS Mental Health Services	Services to be Provided
Medication Evaluation and Monitoring	Providers evaluate whether medication would alleviate beneficiary'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, he or she 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 he or she has 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.

These services may only be delivered by Providers that ACBH has pre-screened and authorized to render these services

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 part of ACBH's MHP FFS Plan and accepting CFS referrals, the Provider must submit written Progress Reports/Treatment Summary (procedure code listed as Casework Report) 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. The Provider may bill for this service (for rates, see Exhibit B-1 in your contract). A CWW may request a more in-depth report (for rates, see Exhibit B-1 in 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 beneficiary'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; and
- The beneficiary'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 (procedure code listed as Casework Report)	Unless the CWW indicates otherwise, this report must include presenting problems; a DSM-5 diagnosis; 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 on the ACBH Provider website.

C. Services to Youth on Probation and/or CalWORKs Recipients

All initial referrals for these services, including those for youth on Probation and CalWORKs recipients, must come through ACCESS. If a probation officer contacts the Provider directly, refer that person to ACCESS.

Providers may submit claims for two reports associated with providing CalWORKs services. Providers will be reimbursed by Alameda County CalWORKs for completing these reports.

CalWORKs Reports	Report Criteria
Initial Assessment Report	Providers must complete this report within five days of the Initial Assessment and send to the CalWORKs program as indicated on the required form. The CalWORKs staff member assigned to the case will provide this form to you.
Monthly Progress and Attendance Report	Providers must complete this report by the fifth day of the following month, as indicated on the required form. The CalWORKs staff member assigned to the case will provide this form to you.

D. Eating Disorder Services

ACCESS refers beneficiaries who present with eating disorders to an MHP FFS Provider who is competent in working with this population. Most beneficiaries are 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, and satisfactorily completing the ACBH *Eating Disorder Supplemental Questionnaire*.

E. Other Referral Sources

Some referrals may not originate from ACCESS such as:

1. Murphy Conservatorship
   Providers may enroll with ACBH 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 of Alameda County Social Services.

2. Lanterman Petris Short (LPS)
   Providers may enroll with ACBH 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 of Alamedas County Social Services.

3. Diversion from State Hospitals (DSH)
   Providers may enroll with ACBH 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 ACBH Forensic, Diversion, Re-entry Services System of Care.

4. 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. (Please contact the ACBH Guidance Clinic GuidanceClinic@acbhcs.org for more information).

Chapter 5. Utilization Management

ACBH Utilization Management Program (UM) provides oversight of behavioral health, including both Specialty Mental Health Services and Substance Use Treatment 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:

Shifting from Requests to Continued Services (RCS') to a Utilization Table

On March 30, 2016, our federal government through Centers for Medicare and Medicaid Services (CMS) issued the Parity Rule to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid/Medi-Cal beneficiaries. It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule requires states to ensure that limitations imposed for Medicaid behavioral health services are no more restrictive than the predominant limitations imposed for substantially all medical and surgical services within a benefit classification.

In accordance with the Parity Rule, Mental Health Plans (MHPs), such as ACBH, shall not require prior authorization for outpatient mental health services.

While preauthorization of outpatient therapy services has ended; and the Request for Continued Services (RCS) form is no longer required for review by Utilization Management (UM) staff, we continue to require a mechanism to manage utilization. The Utilization Table below provides guidelines for the frequency of service by modality type by client by month. For example, per the Utilization Table below, Providers can render up to ten individual therapy sessions and up to four case management sessions per month per client. At the same time, all services rendered must be justified and clinically appropriate based on the client's current mental health needs.

Utilization Tables

There are two distinct Utilization Tables. One is the "MHP FFS General Utilization Table for Individual and Organizational Providers". 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.

The second Utilization Table is for MHP FFS Eating Disorder Services. Only providers who are identified as Eating Disorder Specialists may use this table. Both tables are updated frequently at this time due to the implementation of CalAIM Payment Reform. As a result, please access the Utilization Tables on the Provider's website on the MHP FFS Providers tab. **Please note that the Utilization Tables do not apply to CFS clients.** The Utilization Tables apply only to ACBH clients when ACBH is the payor source.

Claiming for Services

ACBH outpatient contracted MHP FFS providers may submit payment claims directly to the ACBH 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 equal to or less than what is listed in the maximum column 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 denied and returned if the claim form states eleven individual therapy sessions, or nine family therapy sessions were provided.

If a Provider submits a claim that includes more sessions than identified in the maximum column of the Utilization Table without first getting approval by UM, the claim will be denied and sent back to the Provider. At that time the Provider can contact the UM office to discuss approval for the additional sessions. This will cause a delay in getting claims paid and we strongly recommend that Providers ensure they contact UM for approval of additional sessions over the maximum, prior to submitting the claim.

If there is a justifiable clinical need for more sessions than the maximum column on the Utilization Table, the Provider shall contact UM and discuss the clinical rational for requesting additional sessions **prior** to submitting claims for sessions that are over the maximum column on Utilization Table. If approved, the UM Clinical Review Specialist will determine how many additional sessions over the maximum identified on the Utilization Table are approved and will communicate the specific number of additional sessions approved 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 required in order to manage the use of these services. The Eating Disorder Utilization table above includes the service names, billing codes, time allowed and monthly maximum units for Providers delivering Specialized Eating Disorder Services to clients.

B. For Inpatient Professional Service Providers

ACBH Utilization Management (UM) serves as the ACBH 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 *(*Exception: Short-Doyle Medi-Cal Acute Psychiatric Hospitals)*. 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 *Health Insurance Claim Form CMS 1500 (CMS 1500).*

ACBH UM reviews inpatient admissions for Alameda County Medi-Cal beneficiaries. When a Medi-Cal/Medicare (Part A) beneficiary 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 ACBH 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, ACBH 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 beneficiary 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 ACBH UM, professional fee reimbursement claims via the CMS 1500 form can be submitted to ACBH Claims Processing Center (CPC). CPC verifies in the local Alameda County beneficiary 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 ACBH 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, ACBH UM will render a reimbursement decision and send the inpatient facility 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 ACBH CPC. CPC staff verify in the appropriate Alameda County beneficiary 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 of ACBH Billing and Benefits Services (BBS). The CPC is responsible for ensuring accurate and timely claims processing and prompt payment to Providers.

Payments are contingent on:

- Provider contracting with ACBH
- Provider remaining in good standing with contract requirements
- Beneficiary's continued insurance eligibility
- Timeliness of claim submission.
- Beneficiary being open to Provider in ACBH billing system. Note: The ACBH ACCESS department opens the beneficiary 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 ACBH and Providers that include, but are not limited to rates, exclusions and coordination of benefits; will be written in contract/agreements with ACBH and Providers and are not affected by material presented in this handbook. The Exhibit B-1 in the Provider's ACBH Contract reflects a Provider's contracted fee schedule and allowable procedure codes for billing. As contracted providers for the ACBH MHP, Providers agree to accept a contracted fee schedule as payment, in full, for services provided to MHP beneficiaries.

Missed Appointments

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

Medi-Cal Eligibility Verification

ACBH 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. ACBH Billing and Benefits Unit (BBS) 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, ACBH as the intermediary obtains a State personal identification number (PIN) per provider agency that allows for Medi-Cal verification processes. Providers must also verify beneficiary's eligibility and other primary coverage:

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

For more information regarding verifying Medi-Cal eligibility please see a training power point which is available on the Provider's website and a memo from June 13, 2022, regarding the process for checking beneficiary insurance.

Share of Cost

Providers agree to bill ACBH MHP FFS directly, not the beneficiary, for services provided. Beneficiaries may only be billed for the Medi-Cal Share of Cost amount. The Share of Cost amount is deducted from the MHP FFS Plan rate, not from the charge rate.

Providers may only bill the beneficiary for the Medi-Cal Share of Cost amount. ACBH is not responsible for helping to meet the Share of Cost obligation. When billing for services rendered to a beneficiary, 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 ACBH 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 ACBH CPC. In addition, providers must include a completed SOC / 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 beneficiary has other health insurance in addition to Medi-Cal. Medi-Cal is always considered to be the payor of last resort. As a result, if an individual has both Medi-Cal and a 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 BHCS CPC. The CPC will adjudicate the service(s) based on the BHCS 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 1-800-491-9099.

Medi-Cal Beneficiaries with Medicare

Providers are responsible for determining whether a beneficiary is covered by Medicare. If Providers are enrolled with Medicare, they should bill Medicare as the primary payer and **not** claim any balance to ACBH. 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. ACBH 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 ACBH contract and Diagnostic and Statistical Manual (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 at kept at the Provider's site. The rendering Provider's NPI number must be entered in Box 24-J. Providers must sign Box 31.

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 fiscal year and every year the CPC 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

ACBH must submit claims to the state within a strict timeline based on the date of service. Thus, ACBH 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 beneficiary's proof of benefits over the year letter from Social Services 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 & Benefits Support CPC goal is to adjudicate claims within 21 working days from the receipt of a claim. Claims are adjudicated for payment based on ACBH ACCESS opening the client to the therapist in the ACBH billing system, the client meeting access criteria and beneficiary 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.

Reverts: When Claims Need to be Repaid to ACBH

There are several potential reasons a service may need to be repaid to ACBH. 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 ACBH CPC will process a revert service that reduces the payment amount from the Providers next check.

CPC will issue payments for all adjudicated claims once per week. Claim payments will be mailed to Providers 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.

Billing & Benefits Support Unit (BBS) will acknowledge the receipt of an appeal within 15 days by sending a letter to the Provider.

BBS 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 2nd Level Appeal to the ACBH 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 2nd Level Appeals with a final decision within 60 days of receipt of the 2nd 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.

Chapter 7. Quality Assurance

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

A. Training for FFS Providers

All Outpatient MHP FFS Providers are expected to attend ACBH 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 CQRT (clinical quality review team) reviews on charts
- refer clients to other levels of care and/or for additional services through ACBH or their Medi-Cal Managed Care Plan
- 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).

Individual MHP FFS Providers are **required** to attend a clinical documentation training presented by the QA Office soon after being accepted as an MHP FFS Provider and again within the three-year credentialing period. Proof of completion of this training will be required as part of the re-credentialing process. Organizational supervisors are required to attend clinical documentation training annually and are expected to train their organizational staff.

Providers must attend these trainings as soon as possible after they have been contracted with ACBH (or after receiving a Letter of Intent to contract with ACBH).

Providers can access trainings through the ACBH Provider Website and will be informed of training opportunities via email.

B. Consumer Rights

Informing Materials

Provider shall review ACBH's *Informing Materials* packet with each beneficiary at the initial session, annually, and upon request, and obtain the beneficiary'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 beneficiary'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

ACBH MHP FFS Providers shall use ACBH's Informing Materials Packet and obtain applicable Releases of Information for all ACBH beneficiaries. Informing Materials guidelines and materials can be found here.

Consumer Grievance and Appeal Process

Provider shall be knowledgeable about ACBH's beneficiary grievance and appeal process and provide information to beneficiaries as needed. Provider shall post ACBH's Consumer Grievance and Appeal poster in a conspicuous place, preferably in a waiting area outside of Provider's office, and make available ACBH's Consumer Grievance and Appeal material and forms in such a manner that beneficiary does not need to ask for the material. See Section 10 of the QA Manual 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 ACBH's MHP FFS Provider Plan, Providers shall follow State and Federal guidelines pertaining to breaches of confidentiality. Providers agree to hold ACBH 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 ACBH per the Privacy and Security Incident Reporting Policy.

Business Associates – Sharing of Information
As part of ACBH's MHP FFS Provider Plan, all contracted Providers are considered Business Associates and as such, all providers shall share necessary beneficiary information with any other service provider within ACBH'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 beneficiary.

D. 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 ACBH's Notice of Adverse Benefit Determination (NOABD) Policy. NOABD templates can also be found here. 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 beneficiary does not meet medical necessity criteria or is otherwise not entitled to receive a specialty mental health service (SMHS) from the Mental Health Plan. The NOABD – Delivery System and the language services notices are to be given directly to or sent to the beneficiary, or parent or legal guardian, by the Provider within two business days of the action being taken and a copy of all documents to:

Notice of Adverse Benefit Determination	Providers must issue a NOABD when:
	ACBH 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: http://www.acbhcs.org/providers/QA/qa_manual.htm for further details.
NOABD – Timely Access	The Provider has not provided services in a timely manner based on standards established by the Mental Health Plan. The Provider responsible for providing the services shall send the NOABD – Timely Access to the beneficiary, parent, or legal guardian, and send a copy of all documents to QA (address above). Refer to the policy for further details.

E. Documentation Standards

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

F. **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 FFS 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.

G. 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

for more information. Providers shall permit authorized ACBH 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 beneficiary confidentiality.

All Beneficiary Records must be retained as long as required by law, and until ACBH has finalized that fiscal year's cost settlement with DHCS (whichever is longer). Currently the last ACBH/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 beneficiary 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 beneficiary'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 ACBH contract, the Provider must require the third party to follow these same standards
- 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 fifteen (15) years after the last service OR fifteen (15) years after the client's eighteenth (18) birthday, whichever is later

H. 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 ACBH Quality Assurance Office of who will be responsible for the maintenance of the records.

I. UNUSUAL OCCURRENCE (SENTINEL EVENT) AND DEATH REPORTING

Providers shall submit an *Unusual Occurrence/Death Reporting Form* to the ACBH QA Office within seven days of the knowledge of the Unusual Occurrence or death involving any Beneficiary. Please see the *Unusual Occurrence and Death Reporting Policy* and forms in the 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

J. SERVICE VERIFICATION

ACBH regularly verifies with beneficiaries that they did, in fact, receive services claimed for by Providers. Services may be verified by ACBH via a letter to the beneficiary, a phone call to the beneficiary, or other method. Providers shall regularly verify the beneficiary's contact information with the beneficiary and update ACBH's records as needed. Please see ACBH's *Service Verification Policy* in the QA Manual, Section15: http://www.acbhcs.org/providers/QA/qa_manual.htm.

K. MEDI-CAL SITE CERTIFICATION

All MHP FFS *Organizational* Providers shall have a valid Medi-Cal Site Certification and a valid fire clearance at all times in order to operate and to claim to Medi-Cal. See the *Medi-Cal Site Certification for Providers of Mental Health Services* Policy and Procedure:

https://www.acbhcs.org/providers/PP/Policies.htm

L. EXCLUSION LIST MONITORING

Per Federal and State regulations, ACBH monitors that all providers of services, both individual provider and agencies, who receive federal funding such as Medicaid (Medi-Cal in California) are not included on any federal or state list that excludes the provider from receiving federal funds. ACBH monitors the specified lists on a monthly basis. For more information, refer to

OIG and Other Exclusion List Monitoring, Oversight, and Reporting Policy and Procedure located in the Policy and Procedure Manual

https://www.acbhcs.org/providers/PP/Policies.htm

M. OTHER ACBH Resources

Please see the QA Manual, for other applicable resources.