



COUNTY OF SAN LUIS OBISPO  
HEALTH AGENCY

BEHAVIORAL HEALTH DEPARTMENT

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# NETWORK PROVIDER HANDBOOK

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## INTRODUCTION

Welcome to San Luis Obispo County Mental Health Services, which serves as the local Mental Health Plan (MHP) for San Luis Obispo County residents. The Network Provider Handbook provides information about the MHP's policies and standards for professionals providing outpatient mental health services. It is a companion document to your current contract and to documentation training materials you've received.

The MHP uses a wellness and recovery-oriented approach to treatment. Network Providers add to the array of services the MHP offers by providing brief, solution focused therapy to help clients resolve issues that interfere with optimal functioning.

We hope that this information will be helpful in our joint efforts to serve our community.

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*The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class*

**County of San Luis Obispo Health Agency**

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## **Client Considerations**

- Clients who require a complex array of services or long-term treatment are best served through the MHP's comprehensive, community-based, coordinated system of care.
- Clients who require less complex or short-term services are best served by individual Network Providers using brief and solution focused intervention strategies.
- Clients and families are active participants in treatment planning and service delivery.
- Clients' language and cultural needs are addressed in a sensitive and competent manner.
- Clients' rights and dignity are respected at all times during treatment.

## **Network Provider Panel Credentialing**

The MHP maintains a Network Provider panel in a manner consistent with the MHP's contract with the State Department of Health Care Services. The Network Provider panel is of sufficient size and diversity to meet the anticipated needs of clients for professional services in their own communities.

To ensure clients' access to needed services, particular attention is paid to Network Provider:

- ✓ Geographic location
- ✓ Availability of timely appointments
- ✓ Cultural/linguistic abilities
- ✓ Specialties
- ✓ Physical access for disabled clients

The MHP does not discriminate against Network Providers who serve high-risk populations or specialize in conditions that require costly treatment.

The MHP credentials Network Providers before acceptance onto the panel and re-credentials at least every three years.

The MHP verifies (at initial credentialing and at specified intervals thereafter) that no Network Provider is listed on the Excluded Provider List of the Office of the Inspector General (LEIE), Medi-Cal List of Excluded Providers (MCS&I), Excluded Parties List System/System Award Management (EPLS/SAM), Social Security Death Master File (SSDMF), or National Practitioner Databank (NPDB).

The MHP gives written notice of termination of a Network Provider to affected clients within 15 days after issuance of the termination notice.

### **Network Provider Responsibilities**

- Adhere to the professional and ethical standards of respective licensing agencies. Review and sign the MHP's Compliance Plan and Code of Conduct and Ethics when beginning and renewing contracts with the MHP.
- Maintain Professional Liability and Comprehensive General Liability insurance as detailed in the most current Network Provider contract.
- Maintain professional license in good standing.
- Avoid discrimination on the basis of race, color, religion, marital status, mental or physical handicap, national origin or ancestry, or any other protected class under the law.
- Provide the same level of services during the same hours of operation to all clients served, regardless of status or source of funding.
- Provide timely access to services. "Timely" is defined as a first appointment within ten (10) business days of referral unless the client's condition requires more prompt intervention.
- Maintain a practice facility that is accessible by persons with disabilities or physical impairments. If the primary practice facility is not accessible, the provider must arrange for an acceptable alternative to treating clients with disabilities or physical impairments.

- Maintain practice facilities in a manner which provides physical safety for clients, visitors and other personnel.
- Report any unusual incidents, as defined by the MHP's *Outpatient Incident Report* policy, to the MHP within five working days.

## **Treatment Authorization**

### **Referrals**

Referrals for Network Provider services come from Mental Health Clinics following an initial comprehensive mental health assessment. Referrals are forwarded to Mental Health Managed Care for assignment to a Network Provider. Network Provider specialty and availability, as well as the client's needs/preferences, are primary factors in determining Network Provider assignment.

### **Initial Authorization**

A Managed Care therapist contacts prospective Network Providers to determine availability. When a Network Provider accepts a referral, he/she will receive an Initial Authorization. The client or the client's representative will be instructed to call the Network Provider to schedule an appointment. The initial authorization ends when the authorized visits have been completed or a six (6) month period has elapsed, whichever comes first.

### **Requesting Additional Authorization**

During the initial authorization period, the Network Provider and client collaborate to develop a Client Care Plan. The Network Provider faxes it to Managed Care at (805) 781-4176. The original is mailed to Managed Care at:

San Luis Obispo County Behavioral Health  
Attention: Managed Care  
2945 McMillan Ave, Suite 136  
San Luis Obispo, CA 93401-4535

The Managed Care Team will review the Client Care Plan at a weekly Site Authorization Meeting. Up to fifteen (15) Individual or Family Therapy sessions will be authorized for a six (6) month period, based on the documentation of medical necessity in the Client Care Plan. Network Providers will be notified of the Managed Care Team's decision within ten (10) working days of receipt of the Client Care Plan. If services are authorized, the Network

Provider will receive a written authorization. The authorization ends when the authorized visits have been completed or the six (6) month period has elapsed, whichever comes first.

Occasionally, an additional set of sessions may be approved (based on the availability of other resources, client need or other individual considerations). The Network Provider requests additional sessions by completing a second Client Care Plan prior to the expiration of the previous authorization period.

### **Payment Policies and Procedures**

All non-emergency services must be preauthorized by the MHP. Preauthorization is obtained by contacting Managed Care at 800-838-1381. ***Payment for unauthorized, non-emergency services will be denied.***

Requests for additional sessions may be denied or modified if the Managed Care Team determines medical necessity criteria are not met or if the client's condition requires services other than those requested. The MHP will mail a Notice of Adverse Benefit Determination to the Network Provider and to the client when payment authorization requests are denied or modified.

Managed Care verifies current Medi-Cal eligibility at Initial and Subsequent Authorization. Continued Medi-Cal eligibility is a condition of treatment with a Network Provider.

Payment by the MHP to the Network Provider is considered payment in full. Network Providers **may not** charge or collect additional fees from a client.

**The MHP does not reimburse Network Providers for no-shows or cancellations; providers may not bill clients directly for cancellations or no-shows.**

Submit claims for payment on a completed CMS 1500 form to the following address:

San Luis Obispo County Behavioral Health  
Attention: Managed Care,  
2180 Johnson Avenue, 2<sup>nd</sup> Floor  
San Luis Obispo, CA 93401-4535

All claims must be submitted within ninety (90) days of service delivery. Payment will be made within thirty (30) days of the receipt of the claim.

## **Documentation Standards**

### **Client Care Plans must:**

- Identify the qualifying diagnoses using the most current DSM/ICD approved by the MHP and resulting functional impairment(s)
- Identify specific observable and/or quantifiable goals and objectives
- Identify the proposed type(s), frequency, and duration of proposed intervention(s)
- Identify intervention(s) which are consistent with the objective(s); objective(s) must target the impairment(s); impairment(s) must be consistent with the qualifying diagnoses.
- Be legible. Typed Client Care Plans are strongly preferred.
- Document client/parent/legally responsible person participation in and agreement with the plan, as evidenced by client/parent/legally responsible person signature.

### **Progress Notes must:**

1. Be signed (with licensure noted) and dated by the Network Provider.
2. Be legible. Typed Progress Notes are strongly preferred.
3. Each client contact must be documented in a Progress Note, which must include:
  - A description of how the service reduced symptoms, restored functioning, or prevented deterioration in an important area of functioning identified in the Client Care Plan.
  - A description of the interventions used.
  - A description of clinical decisions, referrals, or follow up needed.
  - The date and duration of the service.

## **Medical Necessity Criteria**

<b>Medical Necessity Criteria for Outpatient Specialty Mental Health Services</b>
1. The client must have an included mental health diagnosis*
2. Impairment Criteria (As a result of the included diagnosis, at least one of the following must be true):
A. Significant impairment in an important area of life functioning
B. Probability of significant deterioration in an important area of life functioning
C. Under 21: Reasonable probability child will not progress developmentally as individually appropriate without the proposed mental health service
3. Intervention Criteria (A, B and C must all be yes):
A. The focus of the proposed intervention is to address the included diagnosis.

B. Will the intervention ( <i>at least one of the following must be yes</i> ):
<ul style="list-style-type: none"> <li>• Significantly diminish the impairment?</li> </ul>
<ul style="list-style-type: none"> <li>• Prevent significant deterioration in functioning?</li> </ul>
<ul style="list-style-type: none"> <li>• Allow the child to progress developmentally as appropriate?</li> </ul>
C. The condition would <b>not</b> be responsive to physical health care based treatment.

**\* Included ICD 10 Diagnoses**

- Pervasive Developmental Disorders, except Autistic Disorder, which is excluded
- Attention Deficit and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders, except Substance Induced Mood Disorders, which are excluded
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, except Antisocial Personality Disorder, which is excluded
- Medication-Induced Movement Disorders

**Quality Improvement:**

Managed Care monitors the quality of service delivery by:

- Weekly multidisciplinary review of Client Care Plans
- Quarterly review of Progress Notes
- Quarterly report of client and Network Provider complaints and appeals to the Quality Support Team Committee
- Periodic consumer and Network Provider satisfaction surveys
- Prompt follow up of any concerns identified above (See Problem Resolution and Appeal sections below)

## **Client Problem Resolution Processes**

### **Informal Problem Resolution**

Every effort will be made by the MHP to resolve problems or complaints at an informal level. If a client has a complaint, an attempt will be made to resolve the problem through discussion with the Managed Care staff within two (2) working days. A second opinion will be arranged whenever requested by the client at no cost to the client.

In the event these efforts do not satisfactorily resolve the issue, the Patients' Rights Advocate is available to assist the client and identify any other needed resources.

### **Grievance Process**

If the complaint is not resolved at an informal level or if the client chooses to forego the informal process, the client has the right to file a grievance. A grievance will be directed to the Patients' Rights Advocate, who will enter the grievance into the Consumer Request Log. The Patients' Rights Advocate will:

- Complete a Consumer Request Form to initiate the formal complaint process and to describe the client's desired result(s).
- Assist the client and/or the provider in resolving the complaint/grievance within sixty (60) calendar days.

### **Appeal Process**

If the client's complaint is related to an action (denial, reduction, suspension, or limitation of services; failure to provide timely service) by the MHP, the client may file an appeal within ninety (90) days of receipt of the Notice of Action. The Patient's Rights Advocate is available to help the client complete the process. The client and/or a representative may present information regarding the appeal, which will be reviewed by MHP staff not involved in the action that triggered the appeal. Following the completion of the Appeal, the client is informed of the findings and the resolution date in writing.

### **State Fair Hearings**

A State Fair Hearing may be requested by a Medi-Cal beneficiary **at any time** when there has been an action (denial, reduction, suspension, or limitation of services; failure to provide timely service) by the MHP. The beneficiary may contact the Patients' Rights



Advocate for assistance in this process or may authorize another person to act on his/her behalf. The State Fair Hearings Division issues a decision after hearing information from both the MHP and the client regarding the issue in dispute.

## **Provider Problem Resolution Processes**

### **Informal Provider Problem Resolution**

A Network Provider may contact Managed Care staff during regular business hours to discuss concerns with billing or authorization. Every effort will be made to resolve the issue at this level. A formal appeal process may be initiated by the Network Provider at any time before, during or after the Informal Provider Problem Resolution process. Managed Care will not discriminate or penalize the Network Provider for utilizing the problem resolution or appeals processes.

### **Formal Provider Appeal Process**

If a Network Provider's request for authorization (before the service is provided) or request for payment (after a service is provided) is denied, modified, or not acted upon and the provider wishes to appeal, the provider must send a written appeal to the Managed Care Program Supervisor within ninety (90) days of receiving the denial.

- The Network Provider's appeal will be evaluated by personnel not involved in the initial denial decision within 60 calendar days of receipt of the appeal.
- If the provider appeal is upheld or partial payment is approved, the MHP will have fifteen (15) working days to process the provider claim for payment.
- If the provider appeal is not approved in full, the Managed Care Program Supervisor will inform the provider of this decision and the reasons for the decision in writing. The appeal decision will include information about how the provider can appeal to the State pursuant to CCR, Title 9, §1850.320.

A log of all Formal Problem Resolution Requests and decisions will be submitted to the Quality Support Team Committee on a quarterly basis. Information documented in the log will include: name of provider, date request was received, nature of the problem, time period allowed for resolution, person responsible for addressing the problem, and date for resolution or disposition of the problem. The log will document either the resolution of the problem or why the problem could not be resolved.

**SERVICE DIRECTORY**

Managed Care (Main):	(800) 838-1381	Fax: 781-1177
Health Information Technician:	(805) 781-1566	Fax: 781-4176
Provider Payments/Claims/Credentialing:	(805) 781-1559	Fax: 781-4176
Program Supervisor:	(805) 781-4881	Fax: 781-1177
Patient's Rights Advocate	(805) 781-4738	