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Behavioral Health Services Department
Certified Contract Provider Manual

COUNTY OF SANTA CLARA
Behavioral Health Services

Provider Services Business Office | www.bhsd.sccgov.org

The County of Santa Clara Behavioral Health Services Department Provider Manual covers the operations of Certified Contracting Providers.

Contents

Introduction to BHSD

County Health System, Behavioral Health Services Department

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

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

The BHSD believes without reservation that:

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

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

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

About this Provider Manual

This Behavioral Health Provider Manual (hereinafter, the "Manual") is a legal document incorporated by reference as part of each provider's Provider Services Agreement (Agreement) with BHSD.

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

Updates to the Provider Manual as referenced in the Agreement are posted on BHSD's website. BHSD provides notification to network providers at least 30 days prior to the effective date of any policy or procedural change that affects providers, such as modification in payment or covered services, unless the change is mandated sooner by state or federal requirements.

Quality Improvement Efforts Focus on Integrated Care

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

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

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

Network Operations

Network Operations

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

Contracting and Maintaining Network Participation

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

Practitioner Credentialing

Credentialing Scope

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

All licensed, waivered, registered, and certified practitioners that provide mental health and/or substance use disorder services under contract with the BHSD are required to be credentialed. It is the practitioner's responsibility to maintain current credentials. VHP conducts re-credentialing on behalf of the BHSD at a minimum of every three years (36 months) to ensure the quality of the BHSD network.

A practitioner's failure to maintain current credentials will result in the termination of privileges to render services and receive reimbursement for such services provided to Medi-Cal beneficiaries. Services rendered, prescribed, or ordered by a suspended Medi-Cal practitioner are not paid or reimbursed by Medi-Cal while the suspension is in effect.

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

BHSD reserves the right to review the credentialing of practitioners that do not meet one or more of the standards or requirements and will refer to the Credentialing Committee as a special consideration.

Delegation to Valley Health Plan

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

Credentialing Criteria and Basic Qualifications

1) All licensed practitioners must submit the most updated version of the application developed by the Council for Affordable Quality Healthcare (CAQH) and all applicable supplemental documents. Unlicensed practitioners must submit a completed, signed, and dated California Participating Practitioner Application (CPPA) and all applicable supplemental documents. *For Psychiatrists employed by the County, privileging will be completed by Valley Medical Center who will then coordinate credentialing with Valley Health Plan.*

2) All practitioners must complete a questionnaire attesting to the correctness and completeness of information included in the credentialing application. The attestation questionnaire includes:
    a. A minimum of five years' work history for new professional practitioners. If practitioner was licensed or completed training within the past five years, then the time frame begins at the completion of licensure or training. Employment gaps of six months or longer are researched and an explanation is required to be documented in VHP's permanent credentialing file by the credentialing staff. Gaps of one year or longer must be explained by the provider applicant in writing.
    b. Reasons for any inability to perform the essential functions of the position, with or without accommodation.
    c. Absence of current illegal drug use.
    d. History of loss of license, medical malpractice issues, or felony convictions.

e. History of loss or limitation of privileges or disciplinary actions.

3) Unlicensed practitioners must include a copy of a current Curriculum Vitae or complete work history with the California Participating Practitioner Application packet.

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

5) All participating practitioners must maintain the appropriate certification.

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

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

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

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

10) All participating practitioners are responsible for organizing a structure and plan for supportive health care resources and services, advice, and supervision seven days a week and 24 hours a day.

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

facility, if applicable.

All participating practitioners must be in good standing with the State and Federal health care program and not excluded from participation in Federal health care programs. The Office of Inspector General has the authority to exclude practitioners from Federally funded health care programs.

Insurance

1) All Participating Practitioners must furnish evidence of Professional Errors and Omissions Liability Insurance.
   a) Coverage shall be in an amount of not less than one million dollars ($1,000,000) per occurrence/aggregate.
   b) If coverage contains a deductible or self-retention, it shall not be greater than fifty thousand dollars ($50,000) per occurrence/event.
   c) Coverage as required herein shall be maintained for a minimum of two years following termination or completion of the Provider Agreement.

   **For County employees, send request for insurance certificate to BHSDBusinessOffice@hhs.sccgov.org*

2) The BHSD uses a third-party vendor to track and maintain contractual insurance compliance, currently Ebix, Inc. (Ebix). The initial application must include evidence of insurance. Any insurance thereafter would need to be submitted to Ebix.

   Certificates of Insurance can be sent directly to Ebix at:
   County of Santa Clara Insurance Compliance
   P.O. Box 100085 – ZB
   Duluth, GA 30096
   Email: countyofsc@ebix.com
   Fax: **1.770.238.1713**

   Certificates of Insurance can also be sent directly to VHP for transmittal to Ebix:
   Email: BHSDCredentialing@vhp.sccgov.org
   Attn: **VHP Credentialing Department**
   Fax: **1.408.885.7754**

3) All participating practitioners must report malpractice liability history, as applicable, determined to be acceptable by the VHP Credentialing Committee acting on behalf of BHSD. Malpractice liability history includes all legal actions involving claims of medical malpractice which have been initiated against the provider or practitioner. Any provider or practitioner with a malpractice history will be subject to review and approval by the Credentialing Committee.

4) Acceptance of malpractice history is based on the following guidelines:

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

Credentialing Request and Application

Prior to the provision of services, the Credentialing Request Form must be completed and submitted to VHP in order to begin the credentialing process. Alternatively, an email to begin the credentialing process may be submitted to BHSDCredentialing@vhp.sccgov.org

a. Licensed practitioners are required to submit a credentialing application by submitting through CAQH ProView. If licensed and eligible to use CAQH, provide CAQH number.
b. Unlicensed practitioners (i.e., paraprofessionals) are required to submit a credentialing application through the California Participating Practitioner Application (CPPA).
c. Supplemental documents may be submitted to BHSDcredentialing@vhp.sccgov.org

The CAQH ProView application collects the required credentialing documentation for licensed practitioners. The CAQH application is a secure web-based tool that collects and stores data related to the professional background of the licensed practitioner.

Practitioners who are not able to send secure emails may contact VHP's Credentialing Team at BHSDCredentialing@vhp.sccgov.org to arrange an alternate process for submission.

a. Licensed practitioners required to use the CAQH application are:
    - Medical Doctor (MD)
    - Professionals of the Healing Arts (PHA)
    - Alcohol/Drug Counselor (ADC)
    - Clinical Psychologist (CP)
    - Clinical Social Worker (CSW)
    - Marriage/Family Therapist (MFT)
    - Neuropsychologist (NEU)
    - Professional Counselor (PC)
    - Applied Behavioral Analyst (ABA)

b. Applications will require supporting documentation. Please see list of required documentation in CAQH ProView or in other relevant applications.

c. Applications will also include a signed and dated statement attesting to the following:

1. I do not have any limitations or inabilities that affect my capacity to perform any of the position's essential functions, with or without accommodation; and
2. I have never lost my license/credential or had a felony conviction; and
3. I have never lost or had any limitation of privileges or disciplinary action; and
4. I do not use illicit substances; and
5. I am not being investigated by or on the exclusionary list of the Office of Inspector General; and
6. I am not excluded from providing services to Medi-Cal or Medicare recipients; and
7. I attest to the accuracy and completeness of the information provided.

Upon receipt of an application, BHSD staff will review the application for completeness and any evident discrepancies.

Credentialing Committee

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

BHSD's Credentialing Committee consists of the CMO, or their designee, and at least three contracted provider practitioners representing multiple behavioral specialties or practice types. Credentialing Committee meetings shall be held at least monthly and more often as deemed necessary.

Practitioners are notified in writing of the Credentialing Committee's decision within 30 calendar days or as required by California law. Practitioners have the right to review information submitted with the credentialing application.

Notification of Credentialing Decision to Practitioners

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

If a practitioner's application is not approved, a denial letter is sent to the practitioner via certified mail that includes the reason for denial of participation, and a reminder of the practitioner's right to appeal.

Provisional Credentialing

Provisional credentialing is an optional process that the BHSD allows on an exception basis only pursuant to a specific request initiated by a Participating Provider. The

provisional process is a one-time exception for new practitioners to the network and practitioners must not have been previously credentialed by a delegate on behalf of BHSD. This process allows a Participating Provider to utilize a licensed, registered, waived, certified practitioner, and paraprofessional to deliver mental health and/or substance use disorder services prior to completion of the full credentialing process. Practitioners given provisional status will not be listed in the directory. The intention of provisional credentialing is to allow a Participating Provider to meet its client's needs for continuity, quality of care, or an immediate client need. The practitioner can only deliver care after completing the provisional credentialing process.

The Chief Medical Officer (CMO) or Credentialing Committee may provisionally credential a new applicant on a one-time basis. NCQA specifically requires that the following elements are obtained and appropriately verified:

- Current, valid California license, if applicable
- Past five years of malpractice history
- Current, signed application and attestation
- Not currently on the OIG or SAM.gov Exclusion Lists
- Not currently on the Medi-Cal Suspended and Ineligible Provider List

Provisional credentialing is only valid for 60 calendar days and generally will be completed within 14 calendar days of receipt of a credentialing application that is complete and ready for processing. By that time, BHSD will complete the full credentialing process using the CMO or Credentialing Committee review process, as appropriate.

Re-credentialing

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

In between credentialing cycles, BHSD may conduct ongoing or continuous monitoring activities of participating practitioners. This includes an inquiry to the appropriate and applicable regulatory agencies if/when BHSD identifies newly disciplined practitioners with a negative change in current licensure status. Additionally, BHSD reviews monthly reports released by the OIG and applicable sanction databases to identify network practitioners that have been newly sanctioned or excluded from participation in any state or federal health care program. If BHSD finds that a provider or practitioner has been identified by one of these sources, it is brought to the BHSD Credentialing Committee to discuss and decide on any action necessary up to and including termination from BHSD's service delivery network.

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

and requirements.

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

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

National Provider Identification and Taxonomy (NPI)

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

Protection of Practitioner Rights

Applicants have the following rights:

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

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

c. Receive the status of the credentialing or re-credentialing application, upon request.
    i. Applicants may call the Credentialing Department at (408) 885-2221 or

send a request to BHSDCredentialing@vhp.sccgov.org to receive information on the status of the application.

ii. Applicants are informed of their rights on page 8 of the California Participating Practitioner Application (CPPA) and page 18 of the CAQH Application.

iii. When signing the release and acknowledgements page of the Credentialing application, the practitioner consents to sharing information related to credentialing and qualifications.

Practitioner Suspension/Termination Procedure

Notification is promptly made to the practitioner by the BHSD, and/or designee, via certified mail regarding all actions made by the BHSD Credentialing Department that constitute grounds for a hearing.

The notice of action will include the action being proposed, the effective date of the action, a statement of reasons for the proposed action, notice that the practitioner has a right to request a hearing with the Credentialing Committee within 30 days, and a summary of the practitioner's rights in the hearing.

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

Right to Appeal

Practitioners may file an appeal for a hearing regarding actions of denial, termination, sanction, or reduction of participation when the cause of the action is related to clinical competency or professional conduct. Practitioners appealing a decision by the Credentialing Committee must submit documentation regarding the appeal.

Request for Hearing

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

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

Notification Requirements for Changes in Practitioner Status
Following the credentialing/re-credentialing process, the provider is required to notify VHP within five calendar days if any of the following circumstances arise:

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

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

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

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

Monthly Practitioner Roster Updates-TBD
The monthly update process requires the submission of any additional practitioners, removal of practitioners, and status changes to practitioner information using the inbound staff roster template. Completed rosters must be submitted to BHSDcredentialing@vhp.sccgov.org no later than three (3) days prior to the end of the current month.

Waiver Request Process

On occasions in which a practitioner possesses unique skills or abilities but does not meet the above credentialing criteria, a BHSD Waiver Request Form should be submitted. The completed form and supporting documentation can be submitted to BHSDCredentialing@vhp.sccgov.org. These waiver request forms will be reviewed by the BHSD Credentialing Committee, and practitioners will be notified of the outcome of the request.

Intern Waivers (BHSD)
Waivers for associate clinical social workers (ASW), marriage & family therapist interns (MFTi) psychologist intern and pre-licensed psychologist do not expire, but it is required that the applicants maintain registration with the California Board of Behavioral

Sciences (BBS). If BBS registration expires, the practitioner will no longer be considered waivered for the purposes of billing.

License Waivers (DHCS)

DHCS sets the maximum number of years of license waivers for unlicensed psychologists (5 years) and out-of-state licensed psychologists, clinical social workers, marriage & family therapists and licensed professional clinical counselors (3 years). During the credentialing process, VHP will submit a form to DHCS requesting a waiver approval.

Paraprofessionals

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

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

Mental Health Rehabilitation Specialists (MHRS)

Under Title 9, BHSD and the delegation to VHP is the designated body within County of Santa Clara authorized to evaluate materials for applicants who request to be identified as MHRS and to credential applicants who qualify. An MHRS must have the combined education and mental health experience required by state law. In all cases the experience must be: "in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment."

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

- A master's degree in a mental health related field plus two years of clinical experience in a mental health setting;
- A bachelor's degree plus four years of clinical experience in a mental health setting.

Up to two years of graduate professional education in a mental health or related field may be substituted for the experience requirement on a year-for-year basis; or

- An associate degree and six years of clinical experience in a mental health setting.

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

Completed form, application, and supporting documentation may be submitted to: BHSDCredentialing@vhp.sccgov.org

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

BHSD System Access Request Form (SARF)

Staff that require access to myAvatar and/or Unicare must complete and submit a BHSD SARF to the BHSD Business Office by email BHSDBusinessOffice@hhs.sccgov.org

For clinicians that require access to myAvatar and/or Unicare, the clinicians will need to complete the credentialing process with VHP prior to submitting BHSD SARF.

PAVE

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

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

Medi-Cal Site Certification

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

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

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

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

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

Drug Medi-Cal (DMC) Site Certification

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

DMC site certification requests for information and questions can be submitted by email to BHSDBusinessoffice@hhs.sccgov.org.

Encounter Data, Billing, and Claims

Claims Overview

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

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

BHSD wants to ensure that all providers understand and are aware of the guidelines that BHSD has in place for submitting a claim. BHSD or Designee will make training documentation available to Participating Providers upon request.

Adjudication Rules

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

a. The date of service needs to be within the authorization begin and end dates or the service will be denied.
b. Number of Services Per Claim is greater than one.
c. Date of Service Is Prior To BHSD Effective Date
d. In the Maximum Number of Days Prior to 'Date Claims Received' Date of Service is Permitted field, define the number of days a service can be included in a batch before a batch is created (Date Claims Received field, Batch Creation form).
    - Drug Medi-Cal is set to “150”
    - MHP is set to “335”
e. In the Maximum Number of Days Prior to Date Claims Received Date of Service is Permitted for Replacement Claims, enter the number of days a service would be denied
    - Drug Medi-Cal is set to “335”
    - MHP is set to “430”
f. Third Party Guarantor Does Not Exist
g. Maximum Units Per Day Exceeded.
h. Specified Diagnosis on Authorization is not a Medi-Cal Covered Diagnosis
i. Invalid Place of Service
j. Specified Duration is not valid for Procedure Code
k. Duplicate Service Parameters

l. Adjudication rule will be evaluated for all services that contain third party payments but are not fully covered by the identified authorization.
m. Participating Provider program does not match the contracting provider program for the selected authorization.

These rules apply to Drug Medi-Cal, Mental Health Plan and Substance Abuse Block Grant (SABG) claims.

Workflow

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

Electronic Billing Requirements

Providers must adhere to the following:

1. Ensure secure information exchanges and technologies employed by their agency for quality improvement, care coordination and claims submission methods meet HIPAA security and confidentiality requirements outlined in 45 CFR parts 160 and 164, and 42 CFR Part 2.
2. Is responsible for submitting any and all data and claims information that is required to obtain payment utilizing 837 files (for those connecting via Provider

Connect Enterprise; (PCE) or manually via Provider Connect (PCNX) (myAvatar portal) using standard code sets published by the BHSD and within the timeframes specified by the BHSD and the state:

   a. Submit claims for Specialty Mental Health Medi-Cal services up to 335 days from the date of service.
   b. Submit claims for Drug Medi-Cal services up to 150 days from the date of service.
   c. To receive timely reimbursement, Participating Provider's should elect to submit claims on a more frequent basis.

3. Will assume financial responsibility for claims that are inaccurate, invalid or lack supporting documentation or if any claims are denied or disallowed.
4. For PCE and PCNX, load all data regarding beneficiary record requirement into the BHSD health information system within seven (7) business days from the date services were rendered such as Beneficiary registration, financial eligibility, diagnosis, and discharge.
5. Work with identified staff to accurately enter data, to complete, clarify or addend claims returned.
6. Submit a void or void & replace via 837 or portal within sixty (60) calendar days of identification of payments more than amounts specified for reimbursement of Medi-Cal services.

Provider Connect Enterprise and Provider Connect (PCNX)

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

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

Coding

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

- PCE users (the CCPS converting to myAvatar) will have an 837 generated.

- Non-PCE (the CCPS who will use the PCNX portal rather than convert to myAvatar) will have their claims automatically entered into myAvatar with the PCNX portal and the claims will be processed as “Fast Service Entry”.

CCPs will be able to reference the 837/835 Companion Guide materials online.

Modifiers

Modifiers can reflect place of service, duplicate services or are used to make up specific code sets that are applied to identify services for correct payment.

Standard Code Sets

Refer to CPT Code Crosswalk

ICD-10 Compliance

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

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

Correcting Claims

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

Timely Filing Standards

For Medi-Cal claims, the primary claim must be received within 335 days from the date of services for Mental Health claims and 150 days from the date of service for DMC-ODS claims.

Original Claims

- If claims are received outside of the billing time limit, these claims will be denied for exceeding billing time limits.

- Claims outside the billing time limit can be submitted to the BHSD with proof that the claim was originally submitted within the billing time limits. These claims will be reviewed and if appropriate proof has been provided, claim will be reimbursed.

Claim Resubmissions

- For resubmission, the Participating Provider claim must be received within 430 days from the date of services for Mental Health claims and 150 days from the adjudication date for DMC-ODS claims.

Where to Send Invoices

All invoices should be sent to the BHSD Finance's email address. The subject line of the email should have the following information: Invoice-Agency-Month & Invoice Type.

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

A. Billing types are:
   1. Direct Service: Services that have the potential to earn MediCal if the client has MediCal as their payor. There are two types of clients receiving Direct Services; sponsored, and unsponsored. A sponsored client has MediCal coverage and an unsponsored client does not have MediCal coverage.
   2. Indirect Service: Indirect Services are Non-MediCal Eligible services, whether the client has MediCal or not.
      a. Outreach Services
      b. Dedicated Beds
      c. Any other non-Direct Service invoice
   3. Cost-Based Services: If allowed by the Behavioral Health Department and per the contract Agreement, programs not at or near full capacity may submit cost-based invoices for any expenses in excess of Direct Services and Outreach Services. An invoice itemizing labor, operating, and other costs must be provided. Total expenses less payments made from monthly Direct Services and Outreach Services Invoices will be paid up to the Maximum Financial Obligation (MFO) of the program. Supporting documentation such as payroll records, invoices, receipts, a trail balance, G&A overhead schedule, overhead schedule, and any other records necessary to support costs listed on the invoice should be submitted and copies retained for verification and reconciliation purposes. Start-Up Expenses – If allowed, claims for start-up and related expenses must be billed using the cost-based/cost reimbursement invoice. Supporting documentation for start-up expenses should be submitted and copies retained for verification and reconciliation purposes. Claims for client flex/housing support expenses will be invoiced using the cost-based invoice or client flex/housing invoice when allowed. Supporting documentations such as invoices, checks, receipts, and so forth are to be retained by the agency for purpose of verification

and reconciliation. In addition, a check/receipt register is to be provided for each invoice submitted.

a. Client Flex Support
b. Client Housing Support
c. Cost Reimbursement

Compensation

1. BHSD will compensate Participating Provider as detailed in each Agreement's Exhibit B for SD/MHSA Agreements. The BHSD will use the MFO to first match Federal Financial Participation for services to Medi-Cal beneficiaries and any remaining funds will pay for services to non-Medi-Cal Beneficiaries as defined in BHSD's policies, procedures, directives, and guidelines.
2. County and Participating Provider's compensation will be reduced by any penalties imposed by the Federal and/or State government(s) for the overestimation of costs.
3. Participating Provider's will be paid for claims considered valid and reimbursed by the State. Providers assume financial responsibility for rejected services, and must successfully replace or resubmit invalid, rejected, or void claims in order to receive reimbursement for them.
4. Providers must successfully replace or resubmit invalid, rejected, or void claims in order to receive reimbursement for them.
5. If third-party coverage is identified and a provider submits a charge that's greater than the fee table amount, the County will only pay the agreed fee (not the larger amount).

Reimbursement Policies

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

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

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

1. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.
2. The provided services was not within the scope of practice of the person delivering

the service.

3. There was no documentation date in the medical record.
4. Services provided by non-qualified individuals.
5. Providers are on the exclusion or sanction State or Federal list(s).

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

Overpayment

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

Recoupment and Withholding Compensation

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

Prohibition of Billing Beneficiaries

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

Provider Dispute Resolution for Claims

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

Contacts and Glossary of Terms

Contacts

Topic	Email	Phone
BHSD Documentation Correction	ccppcnxdoccorrection@hhs.sccgov.org – For help to process errors made in Avatar that county needs to support with	N/A
BHSD-TSS	support@tss.sccgov.org with "for HHS-BHS Triage" included in the subject line – For CCPs needing to open tickets with Netsmart	N/A
Credentialing	BHSDCredentialing@vhp.sccgov.org	(408) 885-2221
DMC Site Certification	BHSDBusinessOffice@hhs.sccgov.org	N/A
HIMS	HHS-HHSHIMBHSD@hhs.sccgov.org – For CCPs that see multiple MRNs for a single client and need to determine which MRN needs to be used	N/A
Invoices (Direct, Indirect, Cost-Based)	BHSD-Finance@hhs.sccgov.org	N/A
MyAvatar Claiming (PCE and PCNX)	CSCCCPClaimsGroup@hhs.sccgov.org	N/A
PAVE	BHSDBusinessOffice@hhs.sccgov.org	N/A
Provider Manual	BHSDBusinessOffice@hhs.sccgov.org	N/A
Reporting Support	bhsd.reporting@hhs.sccgov.org	N/A
Short Doyle/Medi-Cal Site Certification	BHSDSiteCert@hhs.sccgov.org	N/A
System Access Request	BHSDBusinessOffice@hhs.sccgov.org	N/A
Other inquiries	BHSDBusinessOffice@hhs.sccgov.org	N/A

Glossary of Terms

270	The 270 transaction is a request for eligibility information. A provider submits a 270 transaction for a Beneficiary to a payer/insurance to find out the Beneficiary's eligibility information. Participating Providers are required to review real-time to determine eligibility.
271	The 271 transaction is the reply to the 270 eligibility inquiry. It transmits eligibility information to the requester.
837P	A standard format for all claim data. The 837 is a HIPAA compliant electronic submission of health care claim data. CCP's can submit their claim data via 837 and the Plan will submit eligible claims to the State via 837.
Abuse	Provider practices that are inconsistent with the sound fiscal business or medical practices, and result in an unnecessary cost to the Medi-Cal Program or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medi-Cal Program.
Adjusted Claim	1. Request for payment reconsideration for a paid or denied claim. 2. Any claim for which a Remittance Advice (RA) was issued that was not paid appropriately or denied.
Administrative Review	If a claim under dispute was originally denied, underpaid, or overpaid based on non-medical criteria. The Claims Processor determines based on the contested claim criteria and any additional information presented by the provider whether the claim was incorrectly processed.
Adverse Benefit Determination	Means any of the following actions taken by a Plan: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of grievances and appeals. 6. The denial of a Beneficiary's request to dispute financial liability.
Amended Provider Dispute	Information not requested by BHSD but sent by provider. A provider submits an amended Provider Dispute within thirty (30) working days of the Date of Receipt of a closed Provider Dispute.

Appeal	An Appeal is a Plan review of a Notice of Adverse Benefit Determination (NOABD). A request for review of an Action, in response to a problem, such as denial or changes to services a Beneficiary believes they need. The Appeal may be filed in person, on the phone, or in writing. However, Appeals must be signed by the Beneficiary or by the Participating Provider on behalf of the Beneficiary. A process to have an authorization decision that adversely affects services provided to an individual, or involves denial of services to an individual, reviewed by a licensed professional to evaluate the medical needs or the individual and not in the original denial decision, to evaluate the medical needs of the individual for possible decision reversal.
Authorization	Approval from Plan prior to the Beneficiaries receiving services. Remittance Advice is a statement sent to a provider by Plan listing services provided, amount billed, payment made and/or the reason for the denial of services. Unbundling is the practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.
Beneficiary	A person seeking or receiving behavioral health services from BHSD that is either a person certified as eligible for Medi-Cal or Medicare services, or someone for whom there is no third-party payor who may become responsible for paying all or part of the person's medically necessary behavioral health services.
Bundled Claims	A Provider Dispute request with multiple claims that are similar in nature on a single document. The request is for more than one (1) member and/or more than one (1) claim number.
Calendar Days	Means 365 days of the year.
California Department of Public Health (CDPH)	The state department responsible for public health in California. It is a subdivision of the California Health and Human Services Agency. It enforces some of the laws in the California Health and Safety Codes, notably the licensing of some types of healthcare facilities.
Capitation payment	A payment the State makes periodically to the Participating Provider on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The State makes the payment regardless of whether the Beneficiary receives services during the period covered by the payment.
Claim	A bill that providers submit to a Beneficiary's insurance provider. This bill contains unique medical codes detailing the care administered during a Beneficiary visit. The medical codes describe any service that a provider used to render care,

	including: • A diagnosis • A procedure • Medical supplies • Medical devices • Pharmaceuticals • Medical transportation When a provider submits a claim, they include all relevant medical codes and the charges for that visit. Insurance providers, or payers, assess the medical codes to determine how they will reimburse a provider for their services.
Claims Acknowledgement (CA277)	An electronic transaction format file that allows payers of health care claims to provide notification to the trading partner of all accepted and rejected claims. 837 is an electronic transaction format file that allows health care providers, both professional and institutional, to submit their claims for payment to health care payers.
Complaint	A Complaint is the same as a formal Grievance. A Complaint shall be considered a Grievance unless it meets the definition of an “Adverse Benefit Determination.”
Complete Claim, clean claim	Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. 42 CFR § 447.45
Contested Claim Criteria	Non-medical criteria used to guide the reconsideration of all disputes.
Corrected Claims	Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original claim number. Corrected claims are considered new Claims for processing purposes. Corrected Claims must be submitted within the timelines outlined in this Policy.
Corrective Action Plan (CAP)	A corrective action plan (CAP) is a step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to: • Identify the most cost-effective actions that can be implemented to correct error causes • Develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient • Achieve measurable improvement in the highest priority areas • Eliminate repeated deficient practices.

Cost-Based Services	If allowed by the Behavioral Health Department and per the contract Agreement, programs not at or near full capacity may submit cost-based invoices for any expenses in excess of Direct Services and Outreach Services. An invoice itemizing labor, operating, and other costs must be provided. Total expenses less payments made from monthly Direct Services and Outreach Services Invoices will be paid up to the Maximum Financial Obligation (MFO) of the program. Supporting documentation such as payroll records, invoices, receipts, a trial balance, G&A overhead schedule, overhead schedule, and any other records necessary to support costs listed on the invoice should be submitted and copies retained for verification and reconciliation purposes
County or Certified Contracted Providers	BHSD internal programs and Certified Contracted Provider (CCPs) that agree to provide covered specialty mental health services and/or substance use treatment services to Beneficiaries, or any other organization or person who agrees to perform any administrative function or service for BHSD specifically related to securing or fulfilling its obligations to the DHCS under the terms of their existing contracts.
Covered Diagnoses	A mental health or substance use disorder that qualifies for Medi-Cal reimbursement as identified in the California Code of Regulations and ASAM Criteria.
Credentialing	Credentialing is a uniform process for verifying, through Primary Source, the education, training, experience, licensure and overall qualifications of behavioral health and substance use disorder services Participating Provider's.
Credentialling Attestation	For all network Participating Providers who deliver covered services, the Participating Provider must include a signed and dated statement attesting to the following: a. Any limitations or inabilities that affect the Participating Provider's ability to perform any of the position's essential functions, with or without accommodation. b. A history of loss of license or felony conviction. c. A history of loss or limitation of privileges or disciplinary activity. d. A lack of present illegal drug use. e. The application's accuracy and completeness. Credentialing Attestations must be completed at start of contract, at hire and minimally, every three (3) years thereafter.
Date of Determination	Date on Provider Dispute or Amended Provider Dispute Determination letter delivered by physical or electronic means to the claimant's office or other address of record.
Date of Receipt	The working day when the provider dispute, amended provider dispute or additional information is received by Plan.

Date of Service	For the purposes of evaluating claims submission and payment requirements under these regulations, means: 1. For outpatient services and all emergency services and care, the date upon which the provider delivered separately billable health care services to the enrollee. 2. For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a Plan and a Plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.
Denial	A determination that a specific service is not medically/clinically appropriate, necessary to meet needs, consistent with the person's diagnosis, symptoms and functional impairments, the most cost-effective option in the least restrictive environment, and/or consistent with clinical standards of care and/or per policy and contractual requirements.
Denied Claims	A claim will be denied if Medi-Cal does not cover the service rendered, if it is a duplicate of a prior claim, if the required Prior Approval is not obtained, or if the data is invalid or logically inconsistent. Please refer to the Billing Section of your Provider Manual for details. Providers should review the denied claim on their remittance advice (RA) statement and resubmit on a new claim.
Department of Health Care Services (DHCS)	Department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal, which provides health care services to low-income people.
Direct Service	Services that have the potential to earn Medi-Cal if the client has Medi-Cal as their payor. There are two types of clients receiving Direct Services: sponsored, and unsponsored. A sponsored client has Medi-Cal coverage, and an unsponsored client does not have Medi-Cal coverage.
Disclosing Entity	A Medi-Cal provider (other than an individual practitioner or group of practitioners). For example, a health plan.
Electronic Data Interchange (EDI)	The electronic interchange of business information using a standardized format; a process which allows one company to send information to another company electronically rather than with paper. Business entities conducting business electronically are called trading partners.
Excluded Party Database Attestation	A mechanism or form used by Participating Provider's or designee(s) to demonstrate they have conducted monthly required database checks to ensure its Practitioners are in good standing and not listed on any of the excluded party databases.
Expedited Requests	An Expedited Request occurs when the standard process could jeopardize the Beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. If the Beneficiary or

	Provider expedited hearing request is approved, a decision will be issued within three (3) working days of the date of the request. Expedited Requests may include Grievances, Appeals and State Fair Hearings. Expedited Requests must be resolved within seventy-two (72) hours of receipt of the request.
Fee Table	The fee table consists of a direct, indirect and cost based statement and Director approved advanced payment provisions that the Plan has agreed to pay to the CCP for services rendered during the course of the services agreement. The fee table describes the funding sources, populations to be served, the rates per service items and total number of units allowed. The fee table outlines the Plan's Maximum Financial Obligation (MFO).
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself, or some other person. It includes any act that constitutes fraud under applicable federal or state law.
Goodwill Payment	Goodwill payment is a payment being made as a gesture of goodwill where the original decision to deny the claim is not being overturned. BHSD will pay the claim in order to maintain the established relationship. Goodwill payments are not required to include interest and penalties if they are paid late.
Grievance	An expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Beneficiary's rights regardless of whether remedial action is requested. Grievance includes a Beneficiary's right to dispute an Extension of time proposed by BHSD to make an authorization decision. There is no distinction between an informal and formal Grievance.
Healthcare Access Program (HAP)	The State required annual amount that is based on household size, income, assets, and allowed expenses. 203..
HealthCare Common Procedural Coding System (HCPCS)	A Center for Medicare and Medicaid Services (CMS) uniform coding system consisting of descriptive terms and codes used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.
Holiday	An event of any duration where the office will not be open during regular hours for Beneficiary services, such a Labor Day, Thanksgiving, or staff training days. The CCP is expected to maintain at minimal a skeleton crew that will facilitate the processing of referrals coming from the BHSD Call Center or

	24-Hour Care unit.
Indirect Service	Indirect Services are Non-Medi-Cal Eligible services, whether the client has Medi-Cal or not: o Outreach Services o Dedicated Beds o Any other non-Direct Service invoice
Ineligible Person	Is an individual or entity who: 1. Is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal or state health care program or in federal or state procurement or non-procurement programs; or 2. Has been convicted of a criminal offense that falls within scope of 42 U.S.C. §§ 1320a-7a or similar state statute, but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.
Information Necessary to Determine Payer Liability	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claim's adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Interest on Late Claim Payment	Interest accrued on a claim that is processed and paid past the regulatory requirements of forty-five (45) working days. Calculation of interest is based on the daily interest rate. The formula is as follows: divide the interest rate of 15 % by 365 days, multiply the number of delayed days by the allowed amount of the claim and then multiply by daily interest rate.
International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)	A medical classification list by the World Health Organization (WHO) used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. Maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
Medical Necessity Criteria	A determination that a specific service is clinically appropriate, necessary to meet the person's needs, consistent with the person's diagnosis, symptoms and functional impairments, is the most cost-effective option in the least restrictive setting and is consistent with the BHSD's medical necessity criteria and service selection guidelines.
MyAvatar 835	The 835 transaction is an electronic remittance advice that explains claims that have not passed adjudication rules in MSO.

Notice of Adverse Benefit Determination (NOABD)	Informs the Beneficiary of a denial or change to their SMHS or DMC-ODS services. It also notifies the Beneficiary of the right to request an appeal if the Beneficiary does not agree with BHSD's decision. The NOABD outlines the delays in resolving grievances, appeals, providing services in a timely manner, delays in authorization, or to dispute financial liability.
Organizational Provider	Refers to facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. This element applies to all organizational providers with which the organization contracts (e.g., telemedicine providers, urgent care centers).
Original Claim	A professional or institutional medical claim that was initially submitted by provider to BHSD for processing.
Participating Provider	A County, Individual Provider or Contracted Certified Provider (CCP) that has agreed to contract with the BHSD Plan to provide eligible services to Beneficiaries covered by its plan.
Payment Authorization	Payment Authorization" means the written, electronic or verbal authorization given by a Plan to a provider for reimbursement of specialty mental health services or DMC-ODS services provided to a beneficiary.
Pended Claims	A pended claim is one in which the Claims Processor cannot make a final determination without further review or investigation. A claim may be pended if it contains erroneous information, does not match state insurance information, or requires manual review to be resolved. The Claims Processor will review the pended claim. Any claim pended during the current payment cycle will appear on the remittance advice statement with a descriptive message about why the claim was pended. Pended claims may ultimately be approved for payment, reduced or denied. Some common reasons to pend a claim are listed in the Adjudication Rules section of this policy.
Plan	BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).
Practitioner	Workforce Members who are providing direct Beneficiary care services, are licensed, registered, waivered, certified or meet criteria as a paraprofessional.
Primary Source	Refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
Prior Authorization	The process of obtaining approval or authorization to perform a covered service in advance of its delivery. Required for Adult Residential, Therapeutic Behavioral Services, Treatment Foster Care and planned psychiatric hospitalization. The Plan will make authorization decisions within five (5) business days of receipt of request.

Proof of Timely Filing	Documents from the provider and/or the facility that shows the original claim submission date. Must show the member's name, date of service billed, and date claim was submitted to the Plan.
Provider Services Agreement	This Service Provider Agreement serves to record the agreement between the parties and to regulate all aspects of the services and/or products to be supplied by the Service Provider and the general business relationship between the parties.
Provisional Credentialing	An optional process that the Plan may incorporate into its credentialing policy. This process provides BHSD with the ability to add practitioners to its network prior to completing the full credentialing process.
Reasonably Relevant Information	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of Plan's or Plan's capitated provider's liability, if any, and to comply with any governmental information requirements.204
Reconsideration	Review of a previously denied, underpaid, or overpaid claim where provider presents additional information to explain why the claim should be paid.
Re-Credentialing	The process of credential verification every three (3) years that a Participating Provider continues to meet Plan Credentialing requirements.
Remittance Advice (RA)	A written explanation sent to the provider of service on how the claim was processed by Plan. The RA includes information as the member's name, date of service, claim number, amount submitted by provider, amount paid by Plan and reason for either payment or denial. The RA is mailed with the payment to the provider.
Representative	A person who is authorized by the Beneficiary to act on behalf of or assisting a Beneficiary, and may include, but is not limited to, a family member, a friend, a BHSD or provider employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.
Resolution	Means the Grievance or Appeal has reached a final disposition with respect to the Beneficiary's submitted Grievance or Appeal. BHSD Grievance will send the Notification of Grievance Resolution (NGR) to notify Beneficiaries of the results of the Grievance Resolution. The NGR shall contain a clear and concise explanation of the BHSD Provider or Plan's decision.
Resolution Final Determination	Resolution and a written determination must be completed within forty-five (45) working days after the date of receipt of the

	provider dispute or the amended provider dispute. Determination letter must list pertinent facts and reason as to dispute decision including any goodwill payments.
Sanction	An action deemed necessary taken by to act upon an outstanding deficiency to promptly ensure contract and performance compliance. Sanctions may include but are not limited to: a. Delay payments until deficiency is addressed. b. Deny a portion of requested payments for activities not in compliance. c. Suspend services or new referrals. d. Reduced contract funding in the next FY. e. Termination the practitioner, contracted program or the entire contract. f. Decline to renew contracted program at the end of the current contract cycle. g. Initiate Federal suspension or debarment proceedings. h. Other legally available actions.
Start-Up Expenses	If allowed, claims for start-up and related expenses must be billed using the cost-based/cost reimbursement invoice. Supporting documentation for start-up expenses should be submitted and copies retained for verification and reconciliation purposes.
State 835	Is an electronic Remittance Advice coming from the State that details what claims were paid and what claims were denied.
State Fair Hearing	A State Fair Hearing is an independent review conducted by the California Department of Social Services (CDSS) to ensure that Beneficiaries receive behavioral health services to which they are entitled under the Medi-Cal program. A Beneficiary may request a State Hearing to resolve appeals related to denial, termination or modification of existing services or unreasonable delay in receiving services. a. The hearing must be requested by the Beneficiary within mandated timelines.
Termination	County or Certified Contracted Provider voluntarily ended employment or contract; or BHSD ended the County Provider's employment or the Certified Contracting Provider's contract, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal Program.
Timely Filing	The time frame in which the provider/facility must submit the original (initial) claims to BHSD.
Workforce Member	Employees, residents, students, volunteers, interns, and other persons whose conduct, in performance of work for a covered entity, is under the direct control of the covered entity, whether or not they are paid by the covered entity.