Health Care Agency (HCA) – Behavioral Health Services Annual Provider Training

1. Welcome

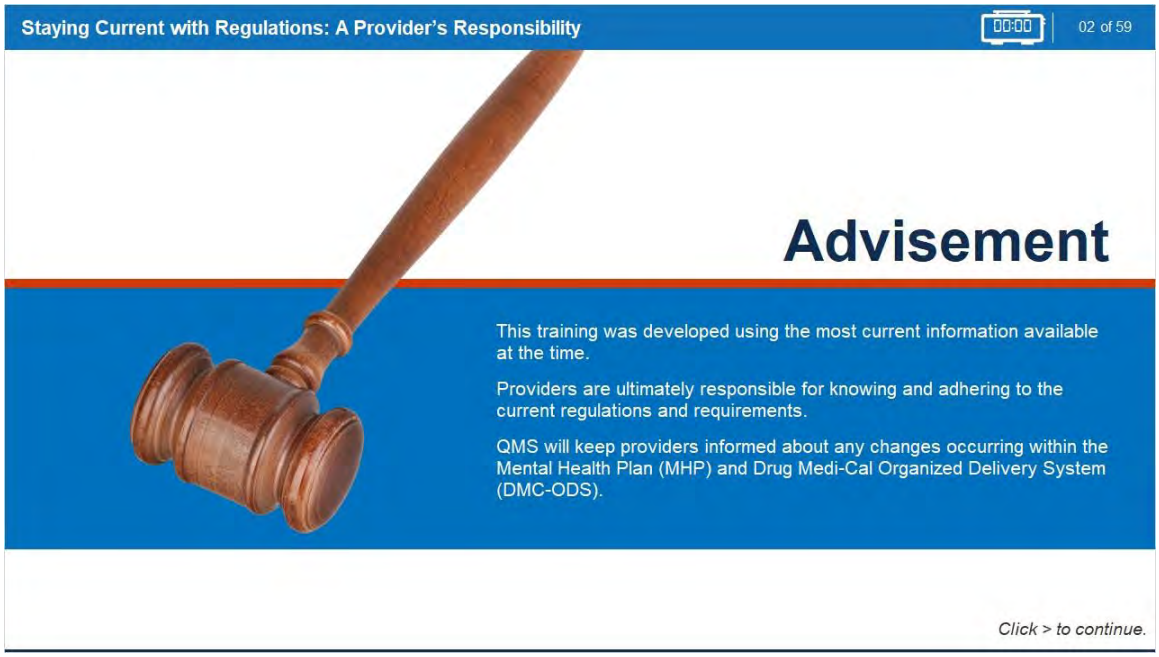
1.1 Welcome

Notes:

Welcome to the 'Health Care Agency - Behavioral Health Services Annual Provider Training'.

Click 'Help' to learn how to navigate through the module. You can proceed directly if you've been here before.

1.2 Staying Current with Regulations: A Provider's Responsibility



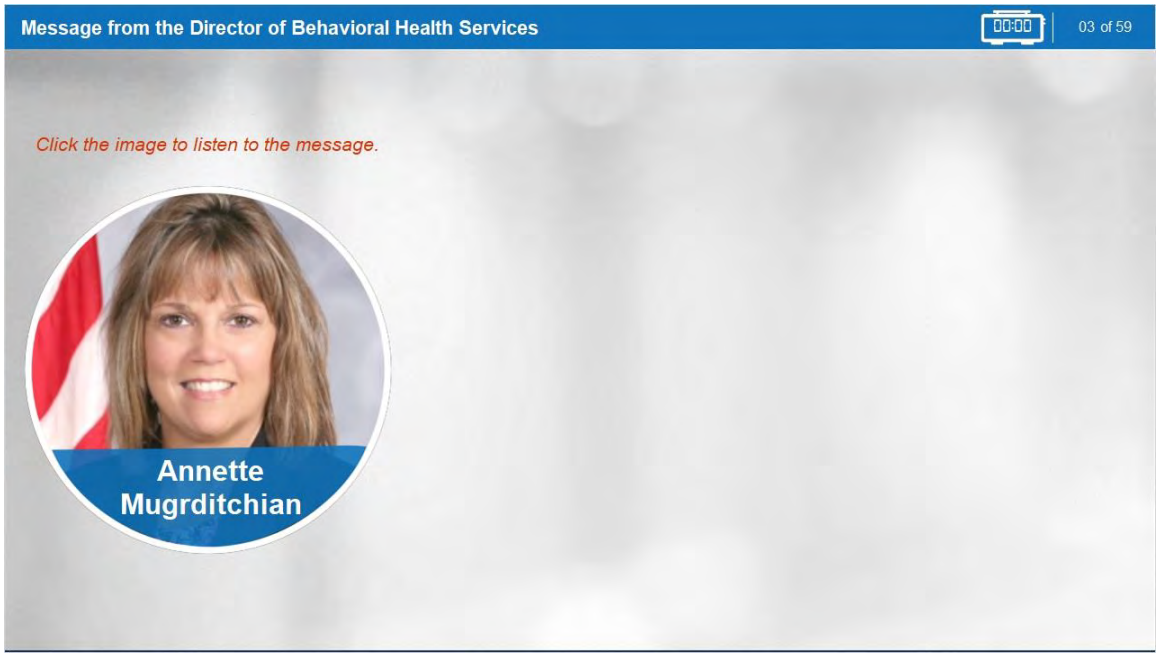
Notes:

This training was developed using the most current information available at the time. Providers are ultimately responsible for knowing and adhering to the current regulations and requirements.

If you have any doubts about the current requirements, please consult with your Supervisor, Contract Monitor, or Quality Management Services (QMS).

QMS will keep providers informed about any changes occurring within the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).

1.3 Message from the Director of Behavioral Health Services



Notes:

Before we delve into the module, let's have a look at the message from Annette Mugrditchian, interim Director of Behavioral Health Services.

Hello. I'm Annette Mugrditchian, interim Director of Behavioral Health Services. I'd like to welcome you all to this year's Annual Provider Training. We value you for being an essential part of the Behavioral Health Services team that is committed to providing the best care to our communities.

This training is provided to fulfill our mission in accordance with State and Federal requirements. We've seen a number of important regulatory changes over the past several years with much more to come as we move into CalAIM, California Advancing and Innovating Medi-Cal.

This training is both a reminder of our obligations, and of course, incorporates new requirements into the current training. Our goal this year, as always, is to prepare and equip our community partners to implement best practices to promote health and wellness and improve the overall quality of life for individuals, families, and communities in Orange County.

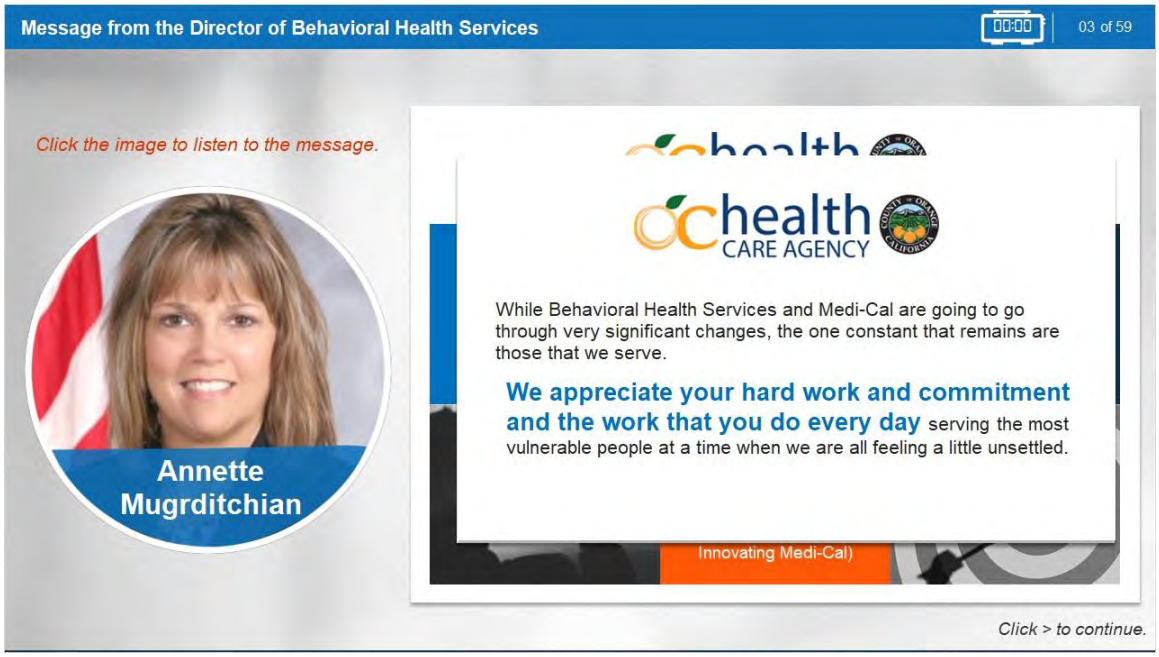
This year's annual provider training will highlight the changes that have occurred over the past few years and prepare all of you so our system can meet the State and Federal regulatory requirements of our agreements with the State Department of Health Care Services.

Many changes are just over the horizon and that will mean more flexibility and grace from Behavioral Health Services staff and contracted providers. These changes may result in more meetings -I apologize ahead of time for that- but definitely in more communication, and that communication will flow both ways.

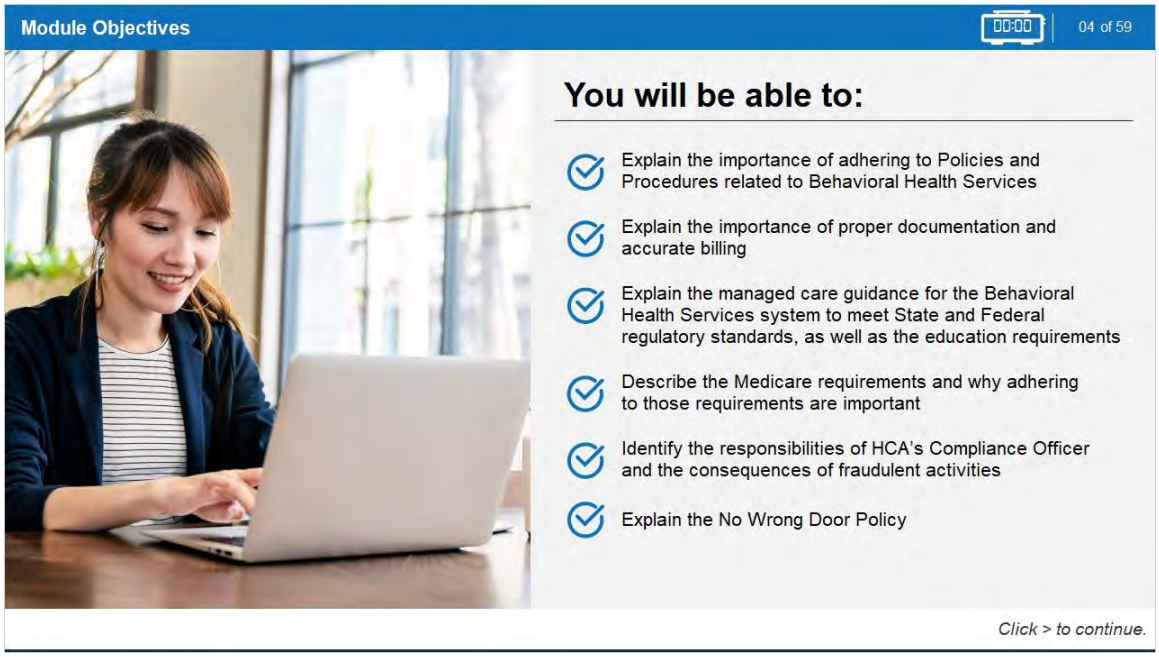
And while Behavioral Health Services and Medi-Cal as we know it are going to go through very significant changes, the one constant that remains are those that we serve. We appreciate your hard work and commitment and the work that you do every day serving the most vulnerable people at a time when we are all feeling a little unsettled.

Once again, we thank you for all that you do for Orange County.

audio (Slide Layer)



1.4 Module Objectives

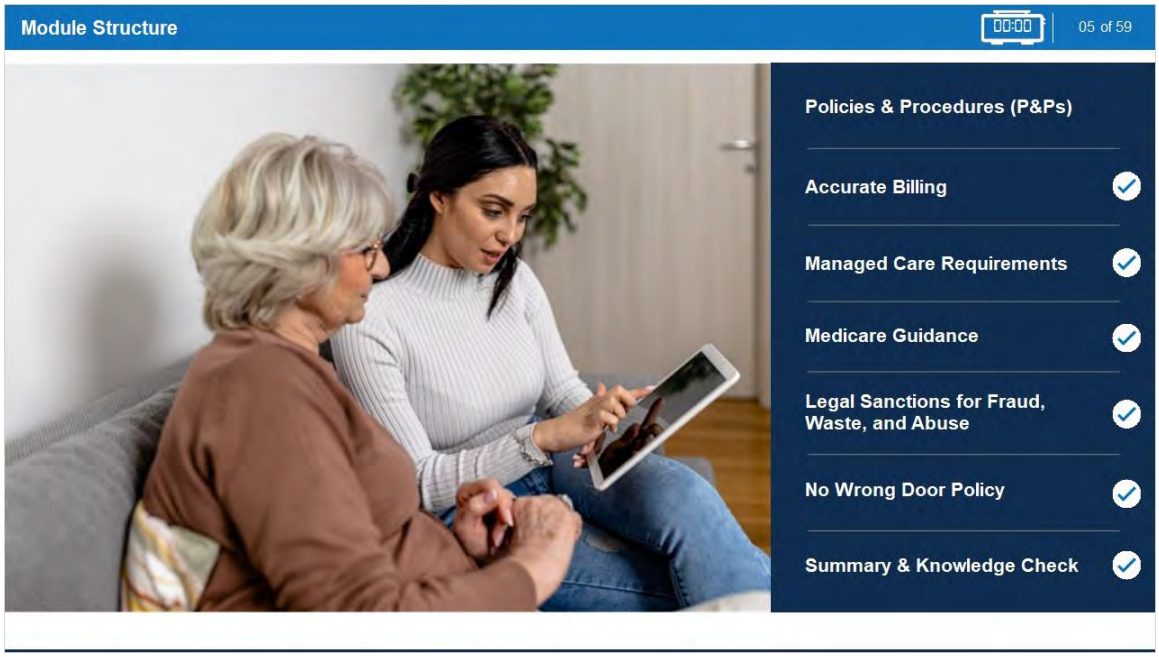


Notes:

So…what can you expect out of this module?

By the end of this module, you will be able to explain the importance of adhering to Policies and Procedures related to Behavioral Health Services, explain the importance of proper documentation and accurate billing, explain the managed care guidance for the Behavioral Health Services system to meet State and Federal regulatory standards, as well as the education requirements, describe the Medicare requirements and why adhering to those requirements are important, identify the responsibilities of HCA's Compliance Officer and the consequences of fraudulent activities, and explain the No Wrong Door Policy.

1.5 Module Structure



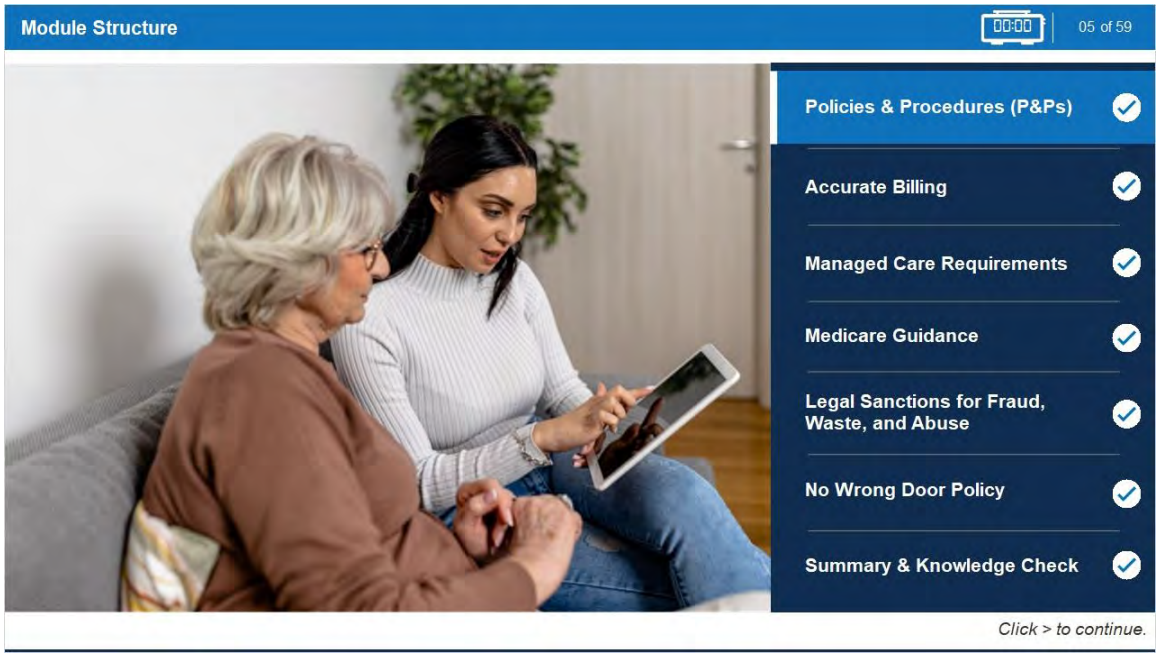
Notes:

The General Training module of the Annual Provider Training is divided into 7 units.

- Policies & Procedures (P&Ps),
- Accurate Billing,
- Managed Care Requirements,
- Medicare Guidance,
- Legal Sanctions for Fraud, Waste, and Abuse,
- No Wrong Door Policy, and
- Summary & Knowledge Check.

2. Policies and Procedures (P&Ps)

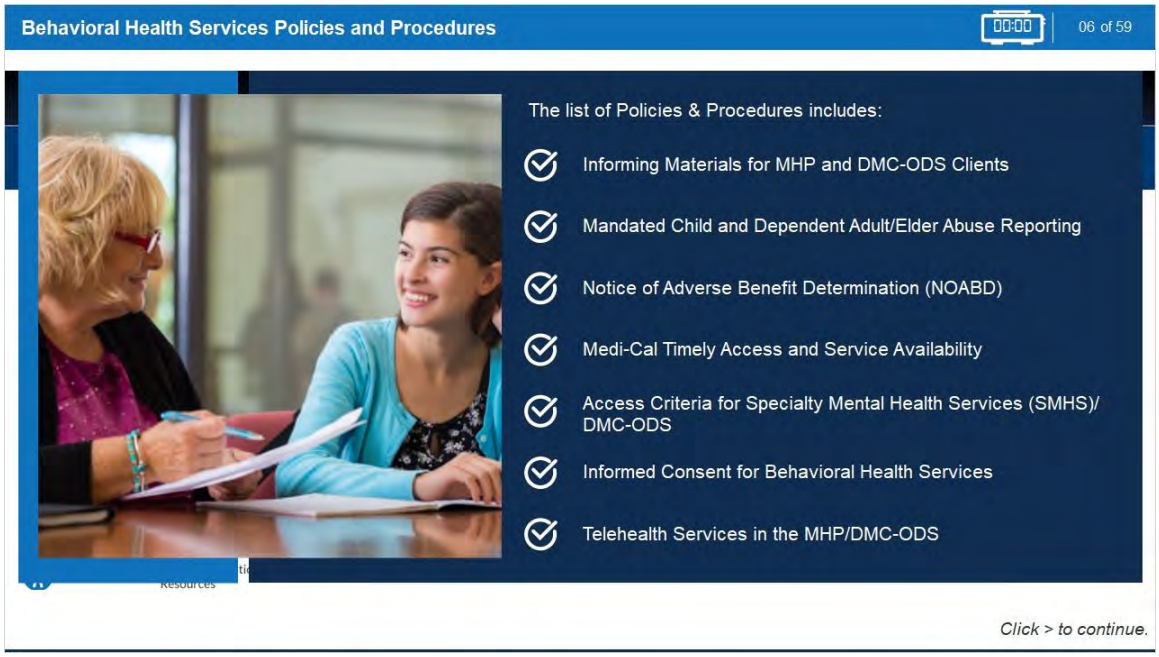
2.1 Module Structure



Notes:

Let's start with the Policies & Procedures.

2.2 Behavioral Health Services Policies and Procedures



Notes:

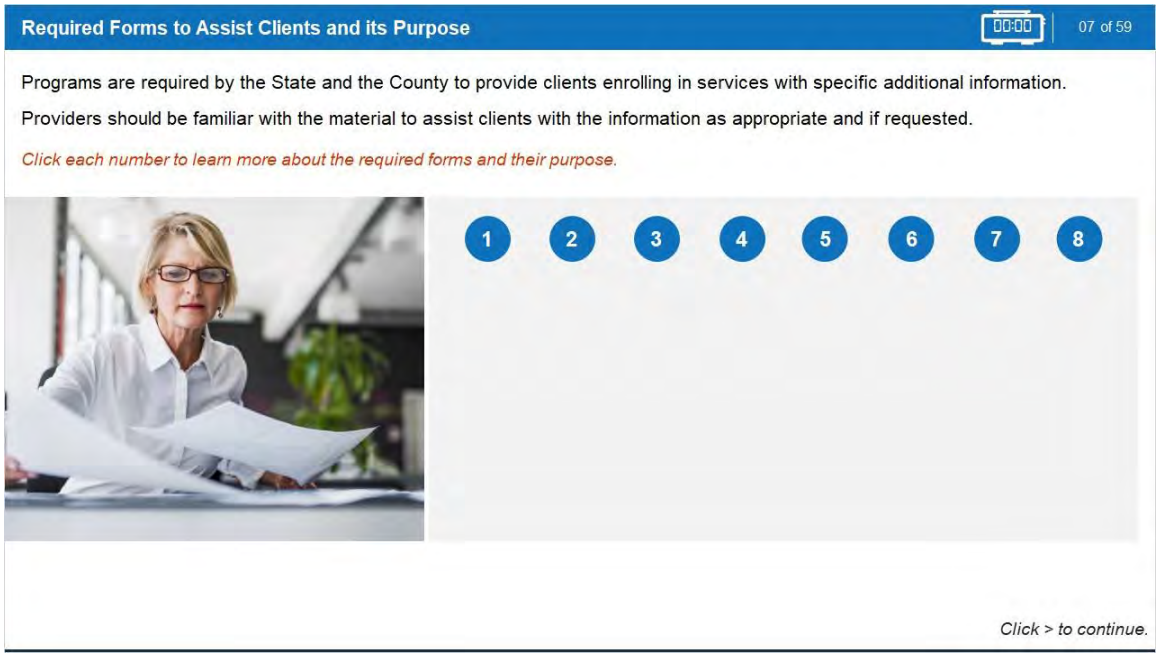
BHS P&Ps are available to all providers via the County website or from Contract Monitors. P&Ps explain the requirements for conducting business within the MHP and DMC-ODS behavioral health plans.

P&Ps are reviewed, developed, and updated as necessary. The reasons for editing P&Ps include changes in business practices, client and agency needs, and laws and regulations.

Providers are expected to review P&Ps and be familiar with those that directly impact operations specific to one's role within the agency.

A list of P&P's is displayed here, and you will learn about them in the next slides.

2.3 Required Forms to Assist Clients and its Purpose



Notes:

Now that you're aware of the BHS policies and procedures, let's now learn about the forms to assist clients.

Programs are required by the State and the County to provide clients enrolling in services with specific additional information.

Providers should be familiar with the material so that they can assist clients with the information as appropriate and if requested.

Voter Registration Form is to increase voter registration. The client must attest to the accuracy of the information with their signature.

Providers are required to sign if they helped the client complete the form and are not permitted to screen for voter eligibility in any way.

Notice of Privacy Practices is to inform the client about use, access, and disclosure of PHI, the complaint process, and other privacy rights.

Car Seat Safety Law is to inform clients about the benefits and use of child safety seats.

The Advance Directive Information Sheet is to inform the client of the importance of having an Advance Directive in the event the client becomes incapacitated.

Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Client Handbooks are to inform clients about available Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services, respectively, and how to access them.

The MHP & DMC-ODS Provider Directory is to inform clients about the MHP and DMC-ODS provider networks. This includes:

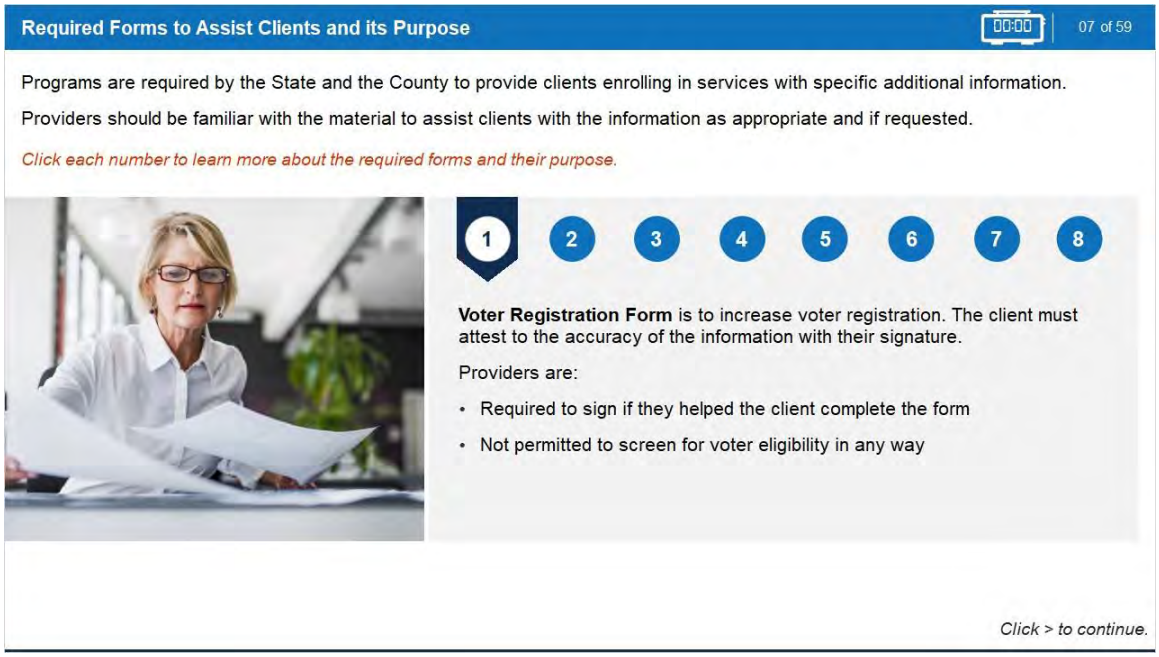
- County-operated and contracted organizational providers,
- Provider groups, and
- Individual practitioners.

The MHP/DMC-ODS Advisement Checklist is to document that the previously mentioned informing materials were reviewed with the client.

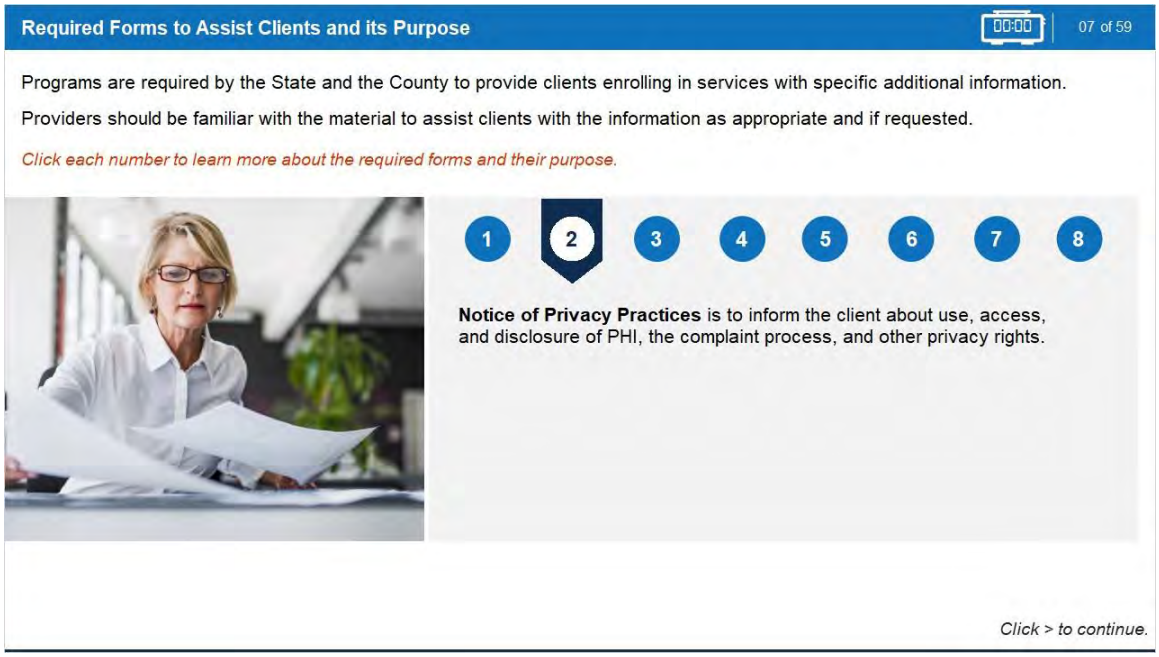
Trafficking Victims Protection Act (TVPA) information is to inform clients about protections afforded to victims of trafficking and violence.

This form is applicable for SUD programs only.

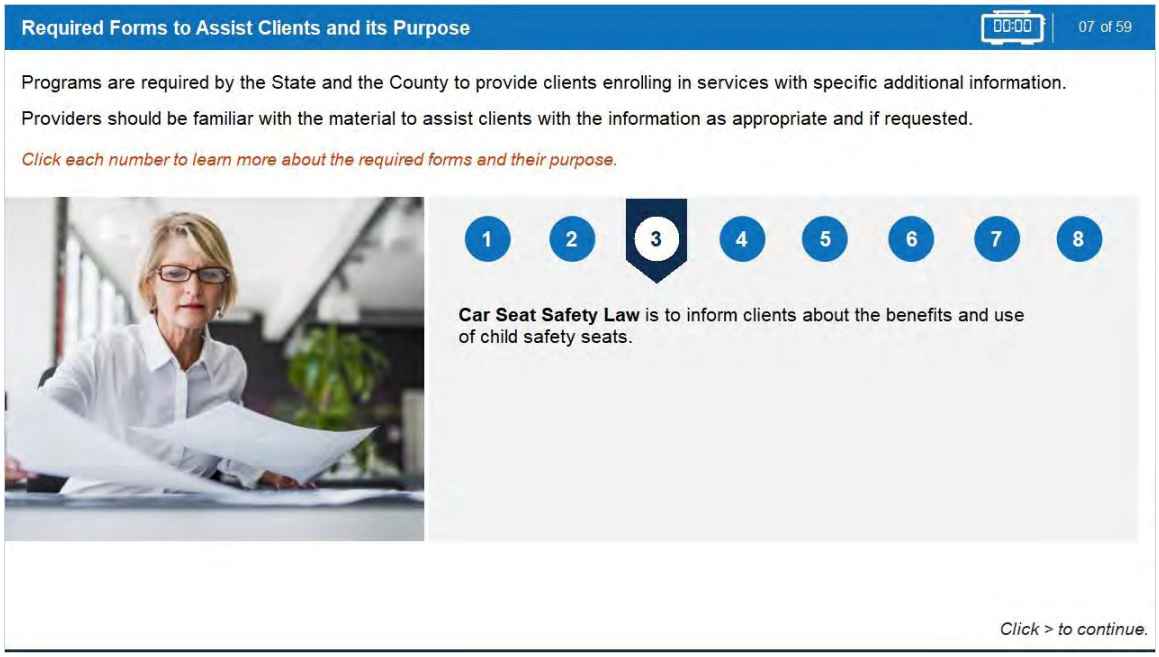
T1 (Slide Layer)



T2 (Slide Layer)



T3 (Slide Layer)



T4 (Slide Layer)

Required Forms to Assist Clients and its Purpose 07 of 59

Programs are required by the State and the County to provide clients enrolling in services with specific additional information.

Providers should be familiar with the material to assist clients with the information as appropriate and if requested.

Click each number to learn more about the required forms and their purpose.

1 2 3 4 5 6 7 8

The Advance Directive Information Sheet is to inform the client of the importance of having an Advance Directive in the event the client becomes incapacitated.

Click > to continue.

T5 (Slide Layer)

Required Forms to Assist Clients and its Purpose 07 of 59

Programs are required by the State and the County to provide clients enrolling in services with specific additional information.

Providers should be familiar with the material to assist clients with the information as appropriate and if requested.

Click each number to learn more about the required forms and their purpose.

1 2 3 4 5 6 7 8

Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Client Handbooks are to inform clients about available Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services, respectively, and how to access them.

Click > to continue.

T6 (Slide Layer)

Required Forms to Assist Clients and its Purpose 07 of 59

Programs are required by the State and the County to provide clients enrolling in services with specific additional information.

Providers should be familiar with the material to assist clients with the information as appropriate and if requested.

Click each number to learn more about the required forms and their purpose.

1 2 3 4 5 6 7 8

The MHP & DMC-ODS Provider Directory is to inform clients about the MHP and DMC-ODS provider networks. This includes:

- County-operated and contracted organizational providers
- Provider groups
- Individual practitioners

The web link to both the MHP/DMC-ODS Client Handbooks and the MHP & DMC-ODS Provider Directory is provided to the client and posted in the providers' lobby. Hard copies are available upon request.

Click > to continue.

T7 (Slide Layer)

Required Forms to Assist Clients and its Purpose 07 of 59

Programs are required by the State and the County to provide clients enrolling in services with specific additional information.

Providers should be familiar with the material to assist clients with the information as appropriate and if requested.

Click each number to learn more about the required forms and their purpose.

1 2 3 4 5 6 7 8

The MHP/DMC-ODS Advisement Checklist is to document that the previously mentioned informing materials were reviewed with the client.

Click > to continue.

T8 (Slide Layer)

Required Forms to Assist Clients and its Purpose 07 of 59

Programs are required by the State and the County to provide clients enrolling in services with specific additional information.

Providers should be familiar with the material to assist clients with the information as appropriate and if requested.

Click each number to learn more about the required forms and their purpose.

1 2 3 4 5 6 7 8

Trafficking Victims Protection Act (TVPA) information is to inform clients about protections afforded to victims of trafficking and violence.

This form is applicable for SUD programs only.

Click > to continue.

2.4 Mandated Reporting of Abuse

Mandated Reporting of Abuse 08 of 59

Under California law, mandated reporters are required to report known or suspected cases of **elder, dependent adult**, and **child abuse**. Failure to report can lead to fines and imprisonment.

Reporting is an individual responsibility, and Supervisors cannot legally prevent clinicians from reporting. Similarly, mandated reporters cannot delegate this authority to others.

Note: Any mandated reporting should never disclose the identity of individuals receiving SUD services.

Click each image to learn more.

Reporting of Known or Suspected Elder or Dependent Adult Abuse

Reporting of Known or Suspected Child Abuse

Click > to continue.

Notes:

Under California law, mandated reporters are required to report known or suspected cases of elder, dependent

adult, and child abuse.

Failure to report can lead to fines and imprisonment. Reporting is an individual responsibility, and Supervisors cannot legally prevent clinicians from reporting. Similarly, mandated reporters cannot delegate this authority to others.

However, 42 CFR Part 2 introduces additional barriers to meeting this mandate. Consult with your Supervisor or the Office of Compliance for further guidance. It's important to remember that any mandated reporting should never disclose the identity of individuals receiving SUD services.

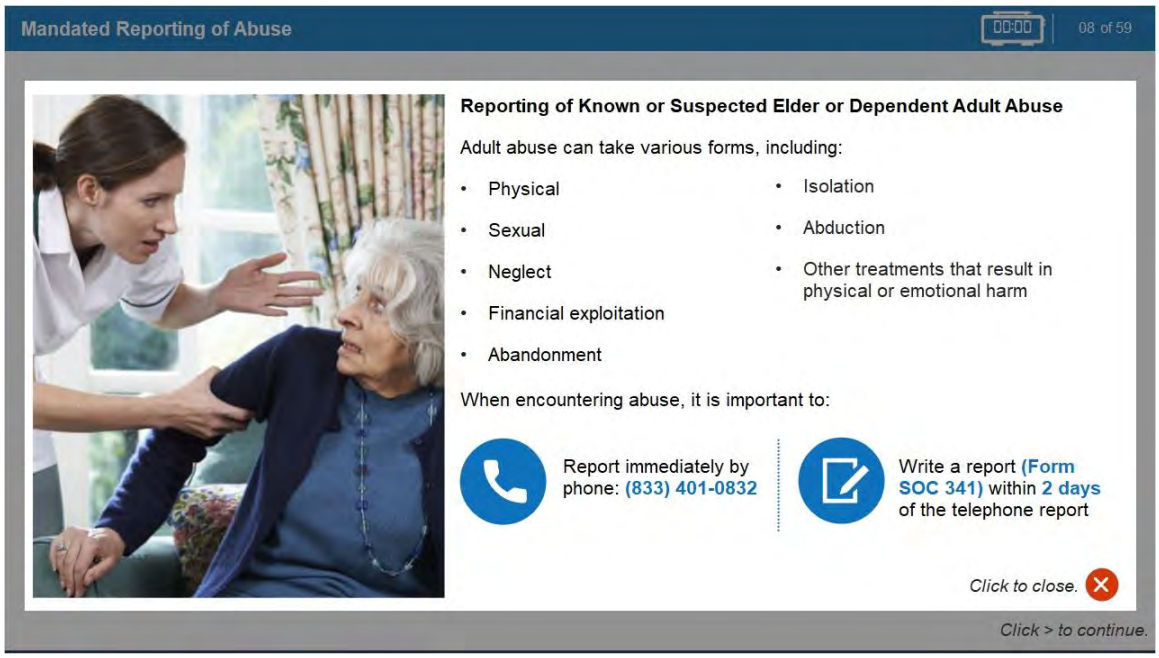
Adult abuse can take various forms, including physical, sexual, neglect, financial exploitation, abandonment, isolation, abduction, and other treatments that result in physical or emotional harm. It may also involve depriving one of goods or services necessary to avoid physical harm or mental suffering.

When encountering abuse, it is important to report immediately by phone as soon as possible and write a report within 2 days of the telephone report. For victims in long-term care facilities, reports must be filed with as many as four different agencies/entities, depending on the situation.

Child abuse is legally defined as a non-accidental physical injury inflicted upon a child by another person, sexual abuse, willful cruelty or unjustifiable punishment of a child, cruel or inhuman corporal punishment, and neglect.

When encountering abuse, it is important to report immediately by phone as soon as possible and write a report within 36 hours of the telephone report.

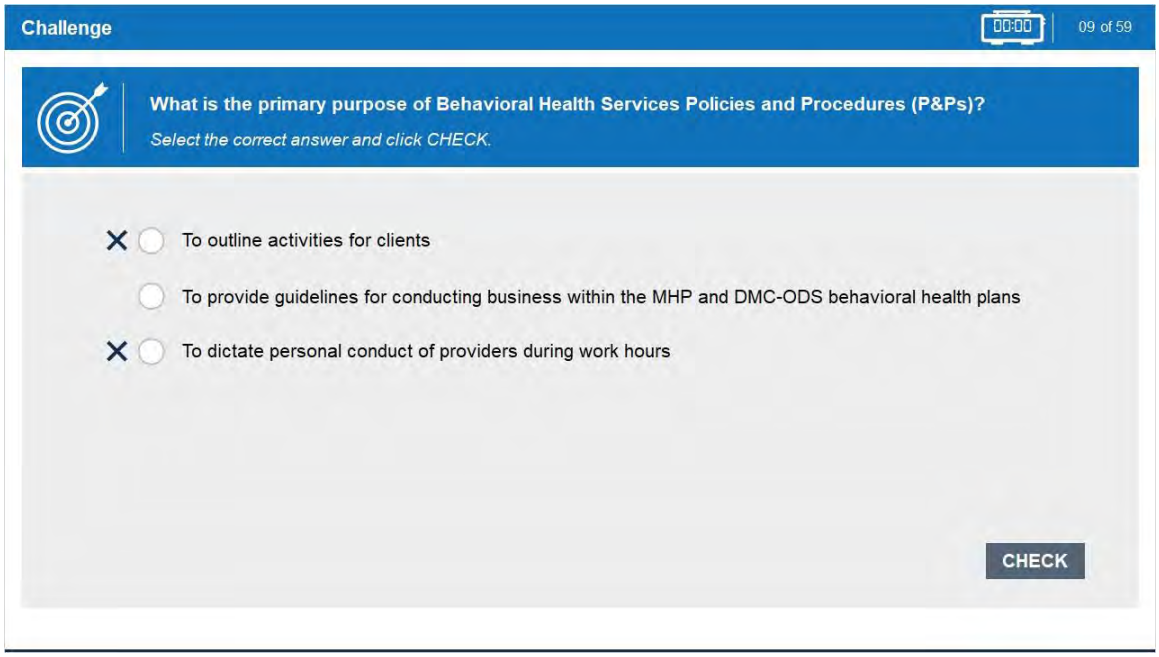
Suspected Elder (Slide Layer)



Suspected Child (Slide Layer)

2.5 Challenge

(Pick One, 10 points, 1 attempt permitted)



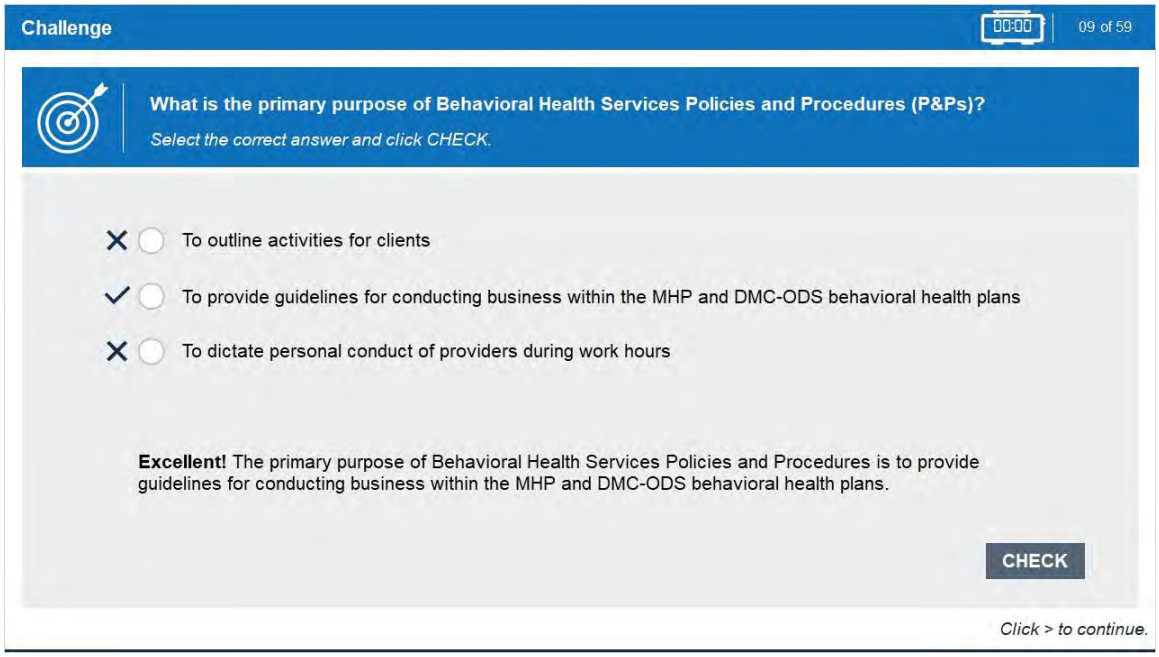
Correct	Choice
	To outline activities for clients
X	To provide guidelines for conducting business within the MHP and DMC-ODS behavioral health plans
	To dictate personal conduct of providers during work hours

Notes:

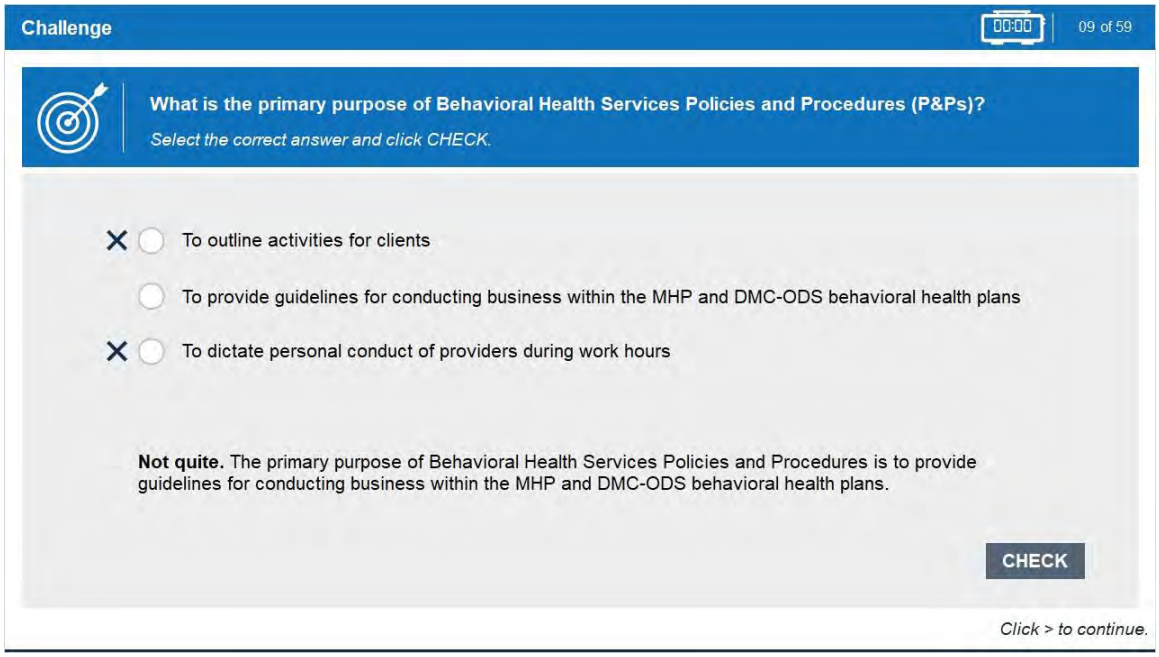
It's time for an activity.

What is the primary purpose of Behavioral Health Services Policies and Procedures?

Correct (Slide Layer)

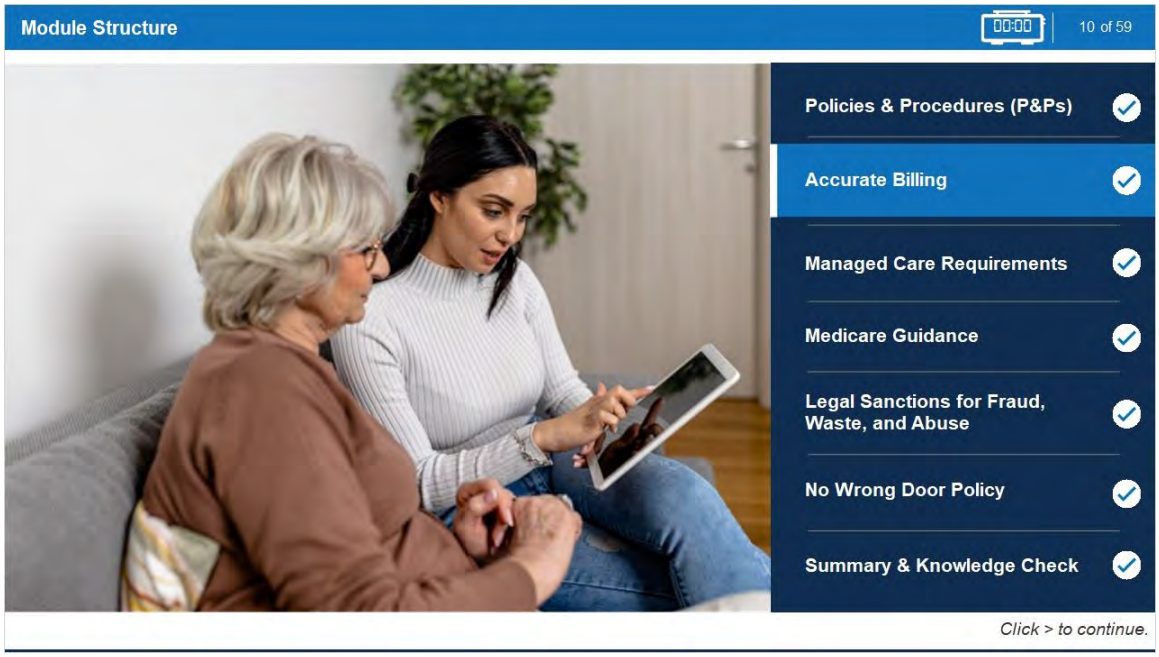


Incorrect (Slide Layer)



3. Accurate Billing

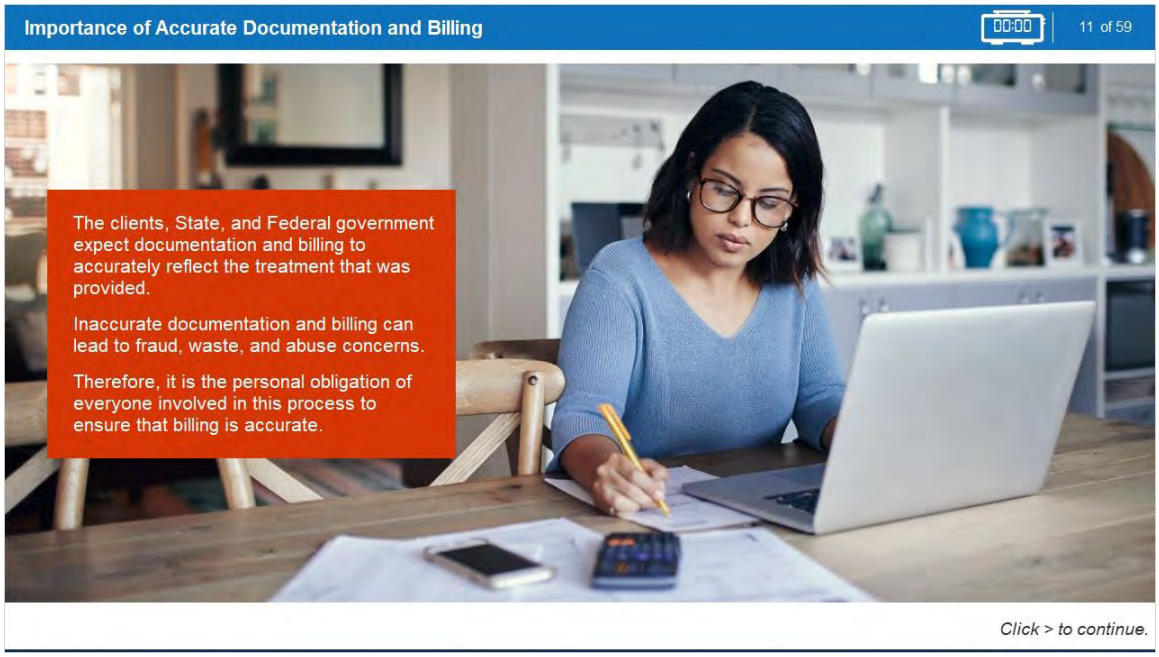
3.1 Module Structure



Notes:

Now that we've gone through Policies & Procedures (P&Ps), let's move on to Accurate Billing.

3.2 Importance of Accurate Documentation and Billing



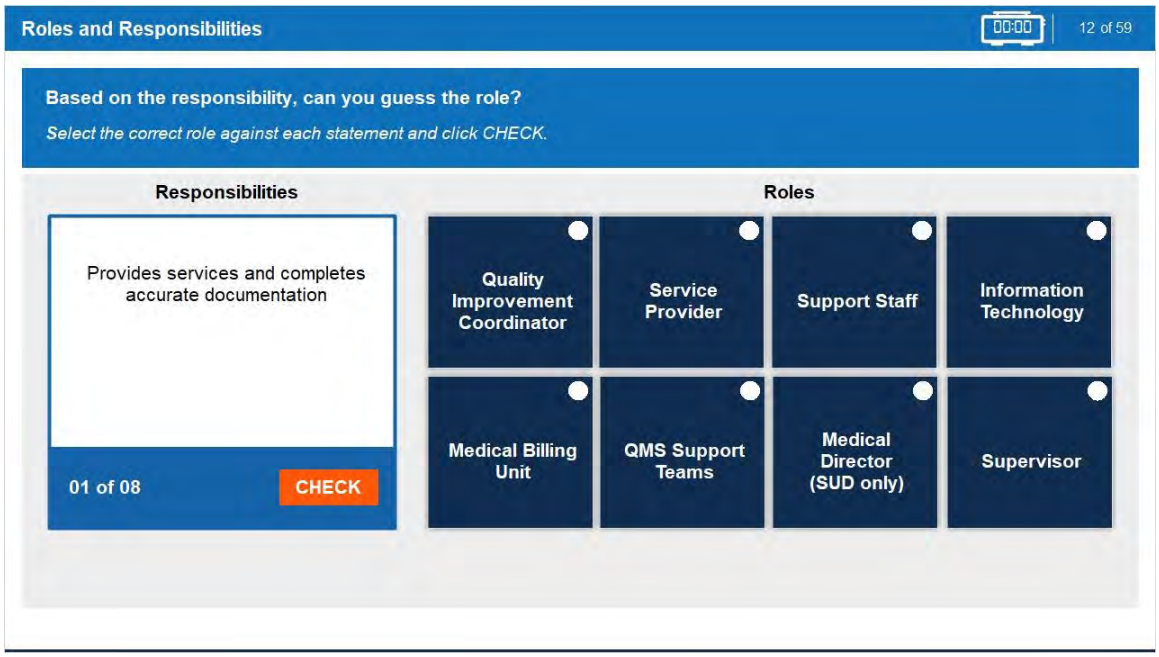
Notes:

The clients, State, and Federal government expect documentation and billing to accurately reflect the treatment that was provided. Inaccurate documentation and billing can lead to fraud, waste, and abuse concerns.

Therefore, it is the personal obligation of everyone involved in this process to ensure that billing is accurate.

3.3 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
X	Service Provider
	Support Staff
	Information Technology
	Medical Billing Unit
	QMS Support Teams
	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

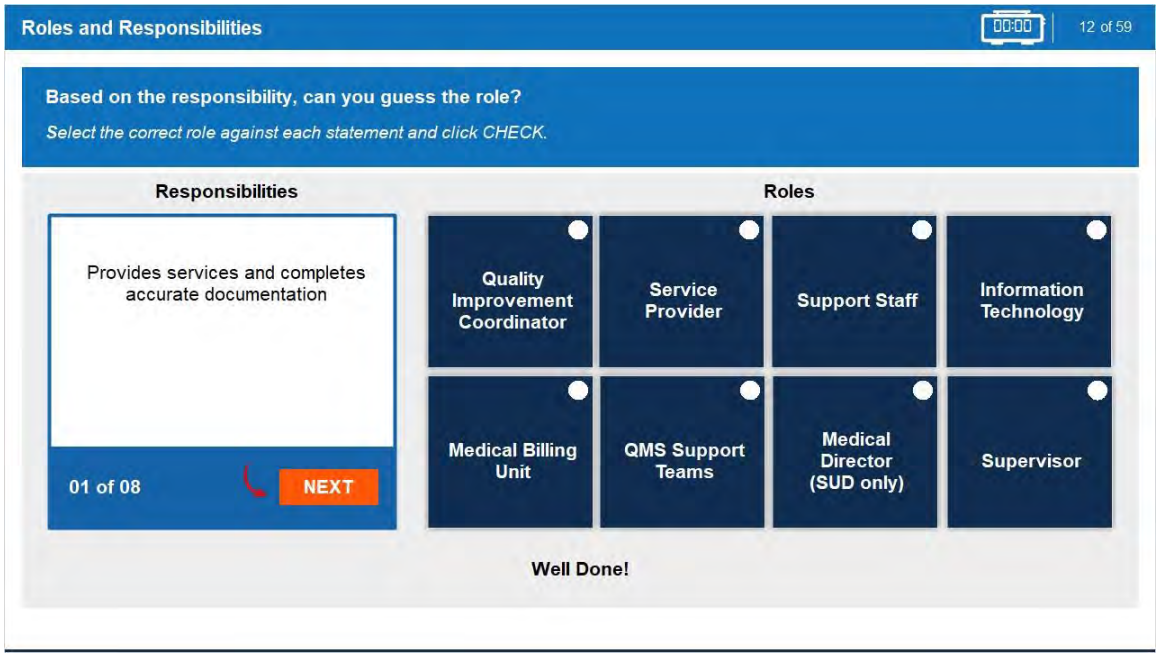
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

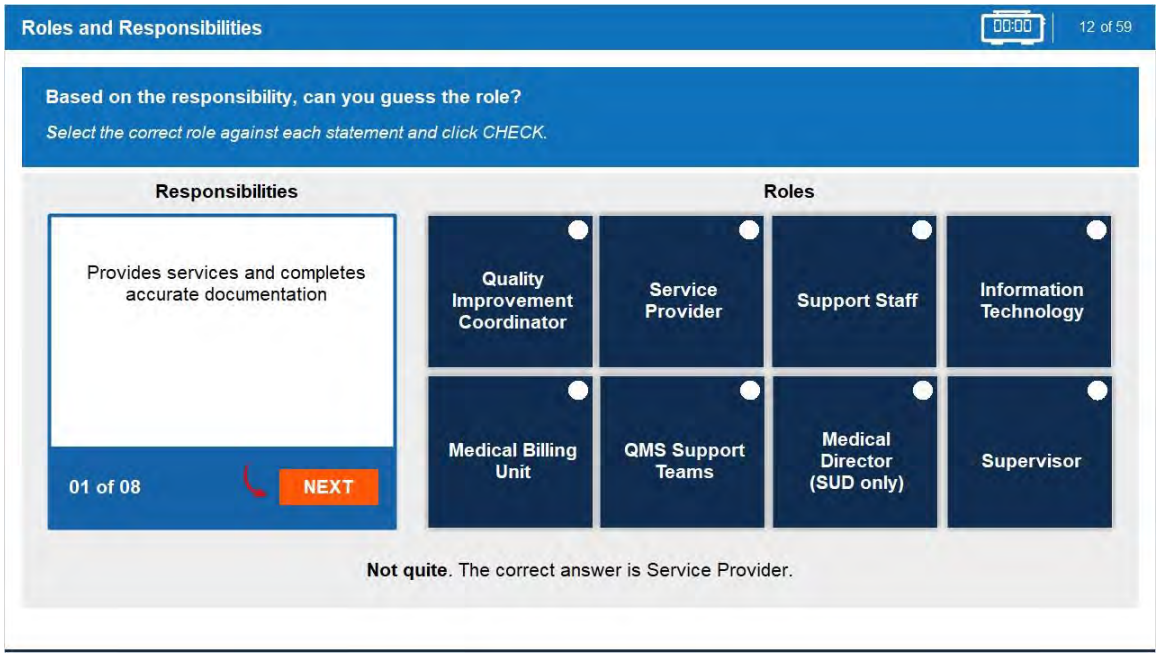
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

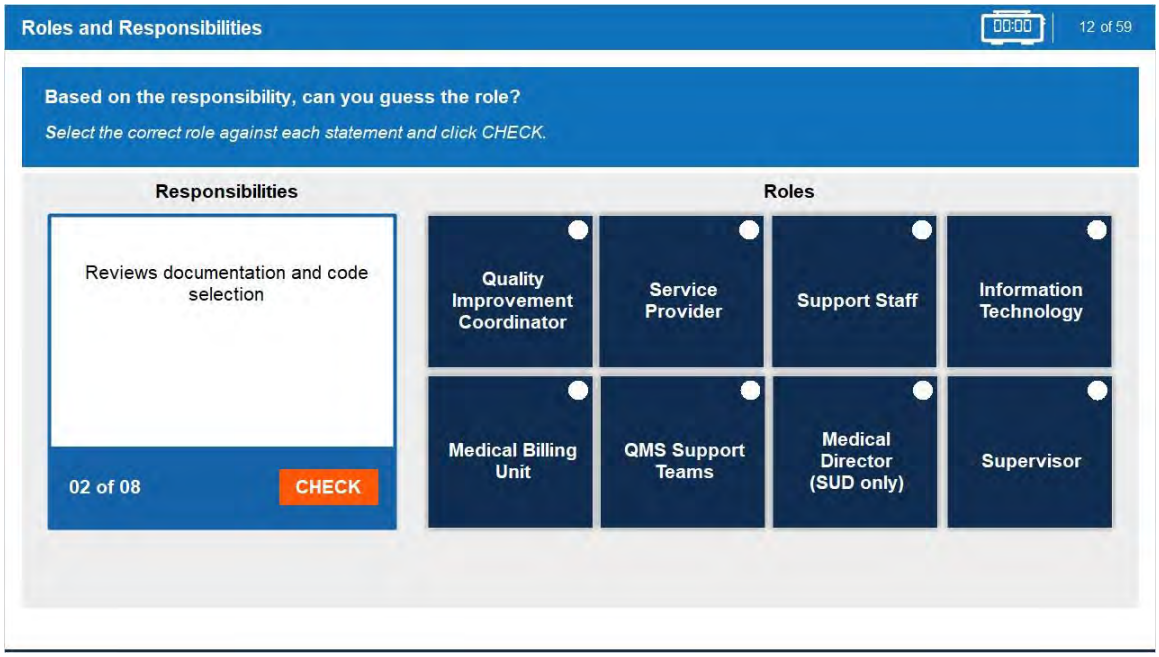


Not quite. The correct answer is Service Provider. (Slide Layer)



3.4 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
	Service Provider
	Support Staff
	Information Technology
	Medical Billing Unit
	QMS Support Teams
	Medical Director (SUD only)
X	Supervisor

Notes:

Here is a quick activity.

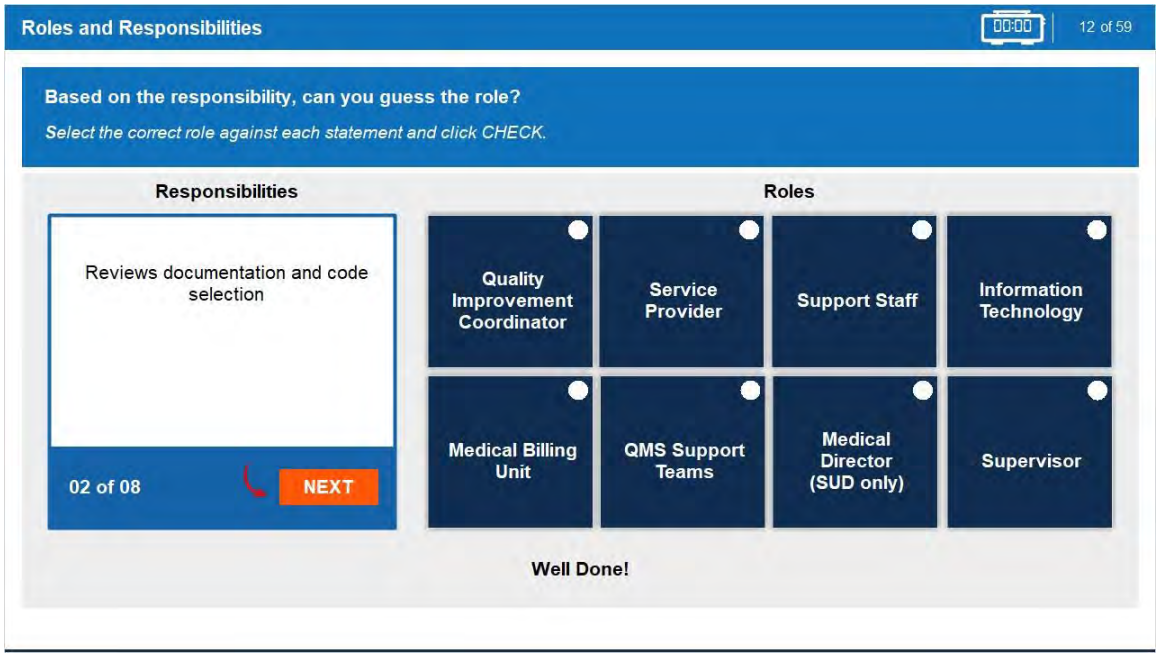
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

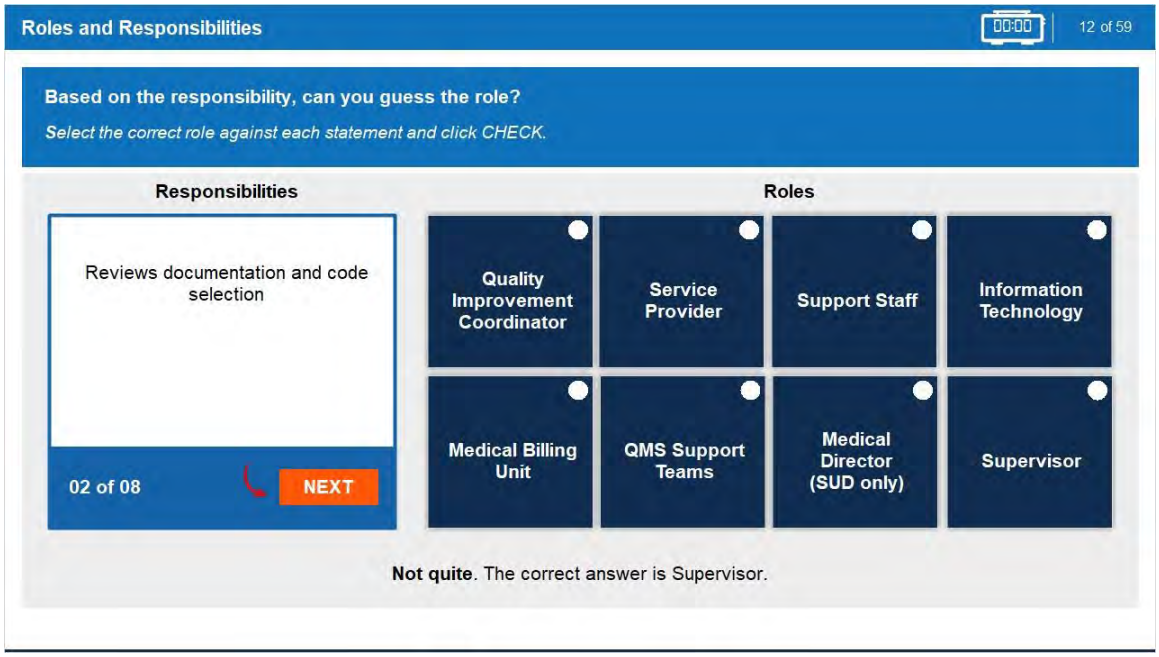
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

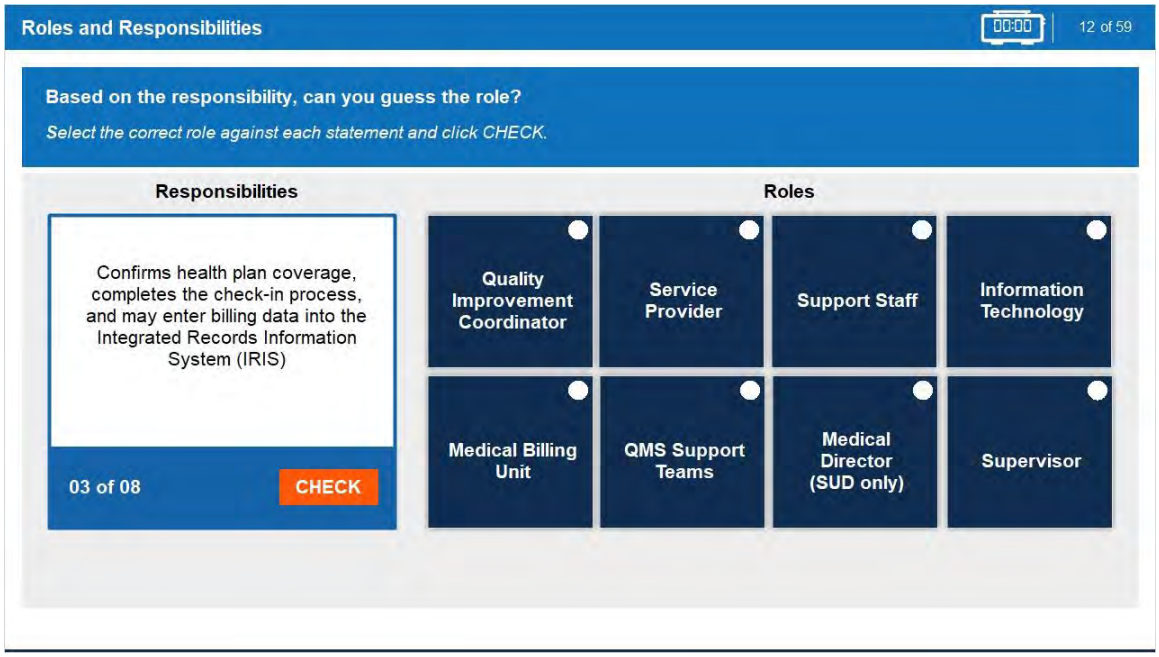


Not quite. The correct answer is Supervisor. (Slide Layer)



3.5 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
	Service Provider
X	Support Staff
	Information Technology
	Medical Billing Unit
	QMS Support Teams
	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

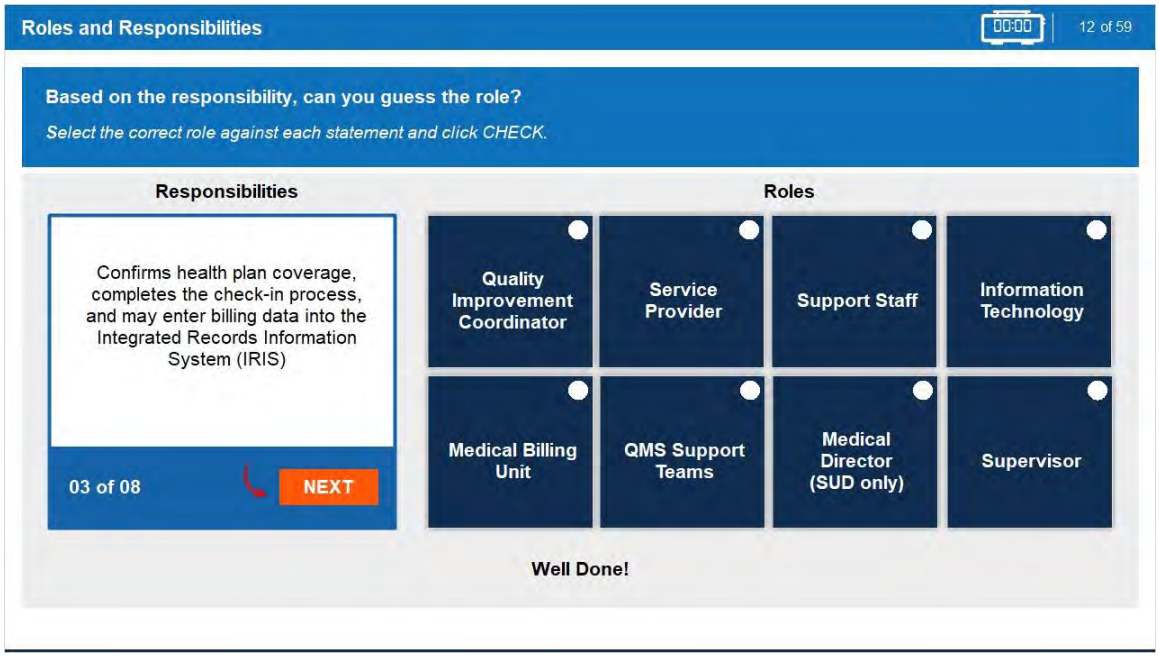
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

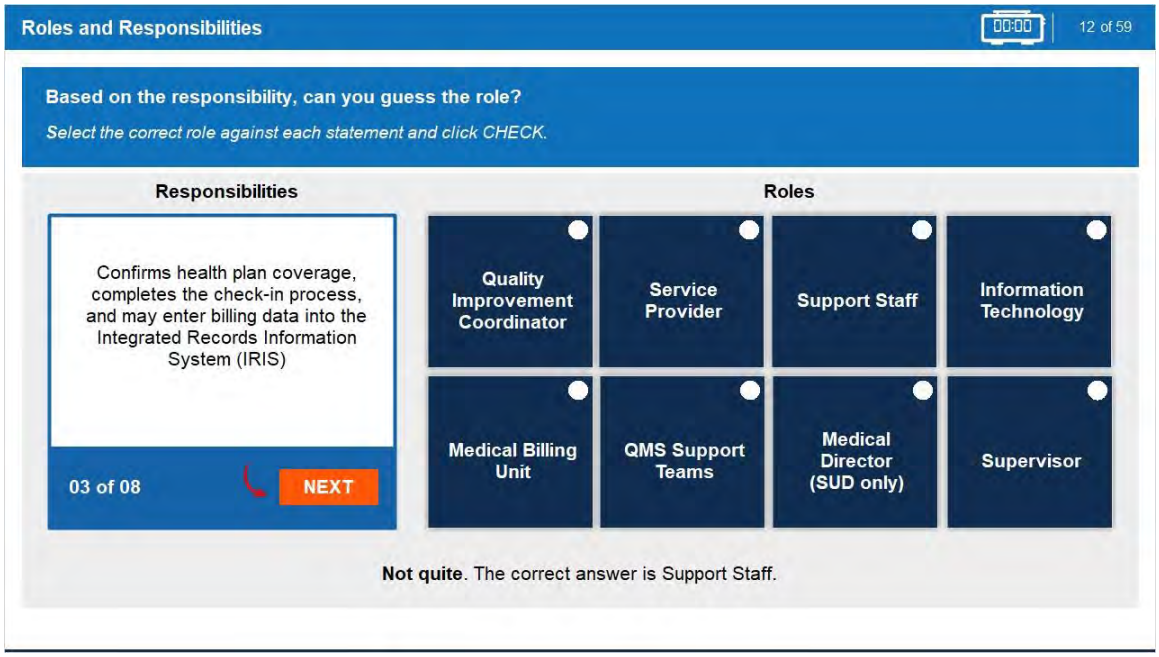
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

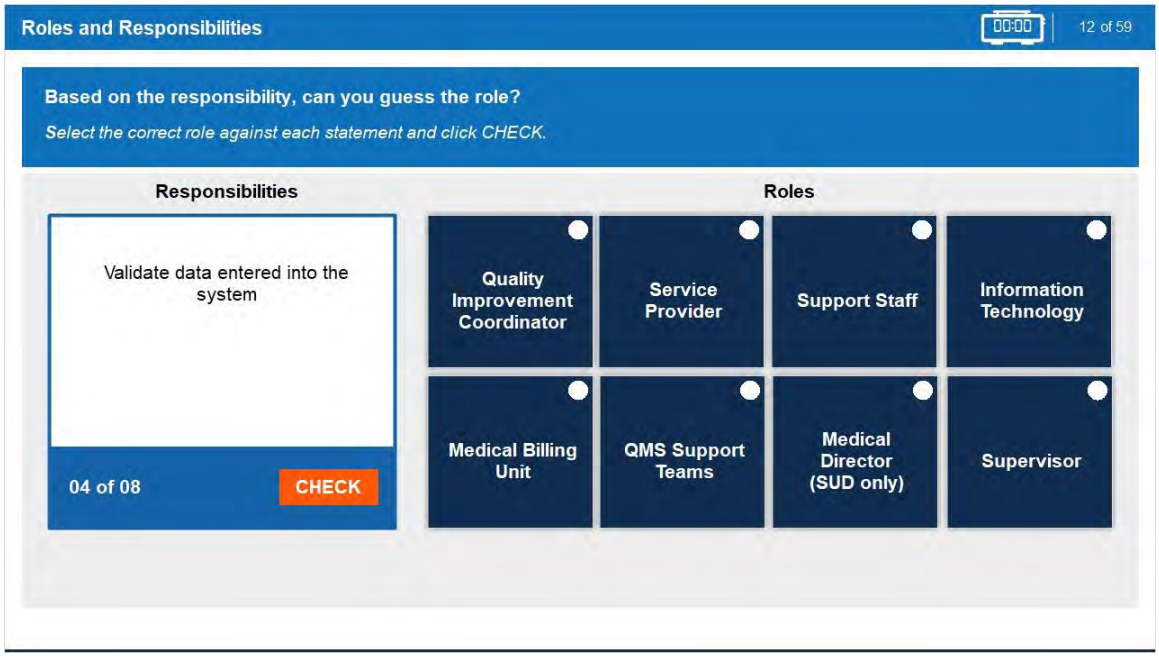


Not quite. The correct answer is Support Staff. (Slide Layer)



3.6 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
	Service Provider
	Support Staff
X	Information Technology
	Medical Billing Unit
	QMS Support Teams
	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

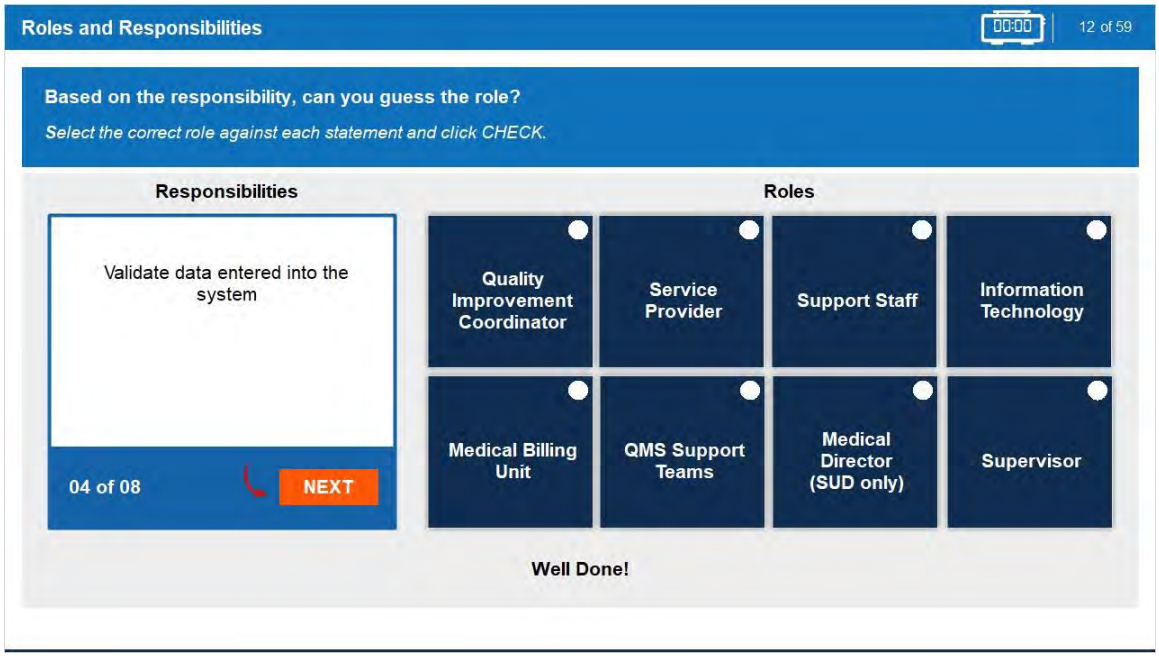
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

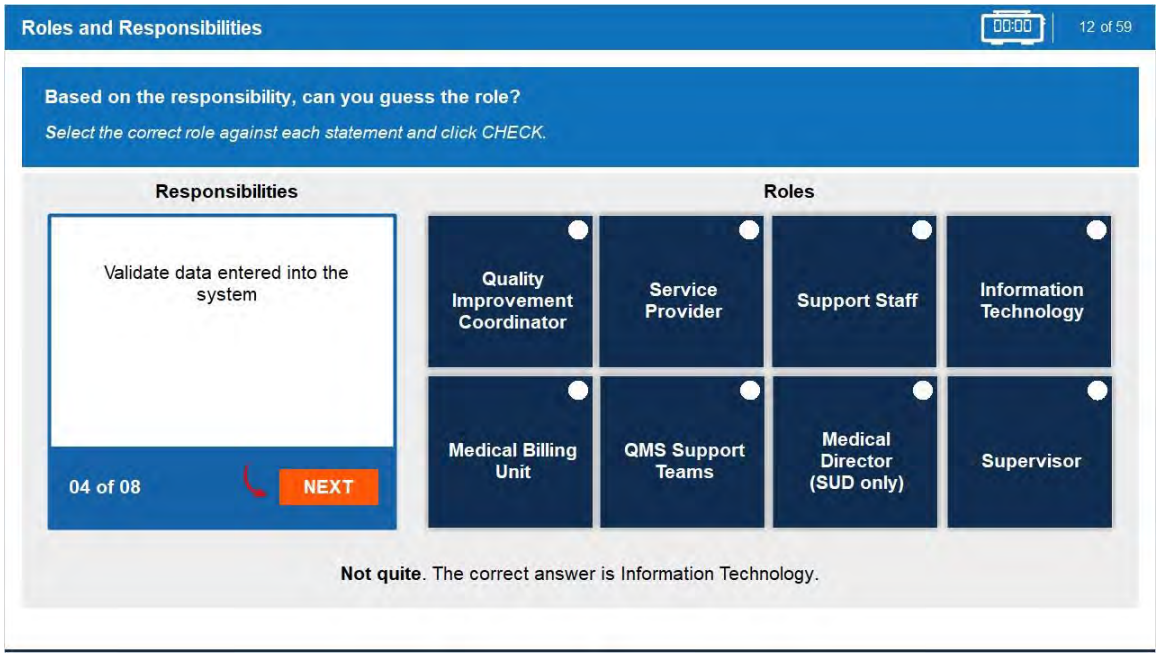
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

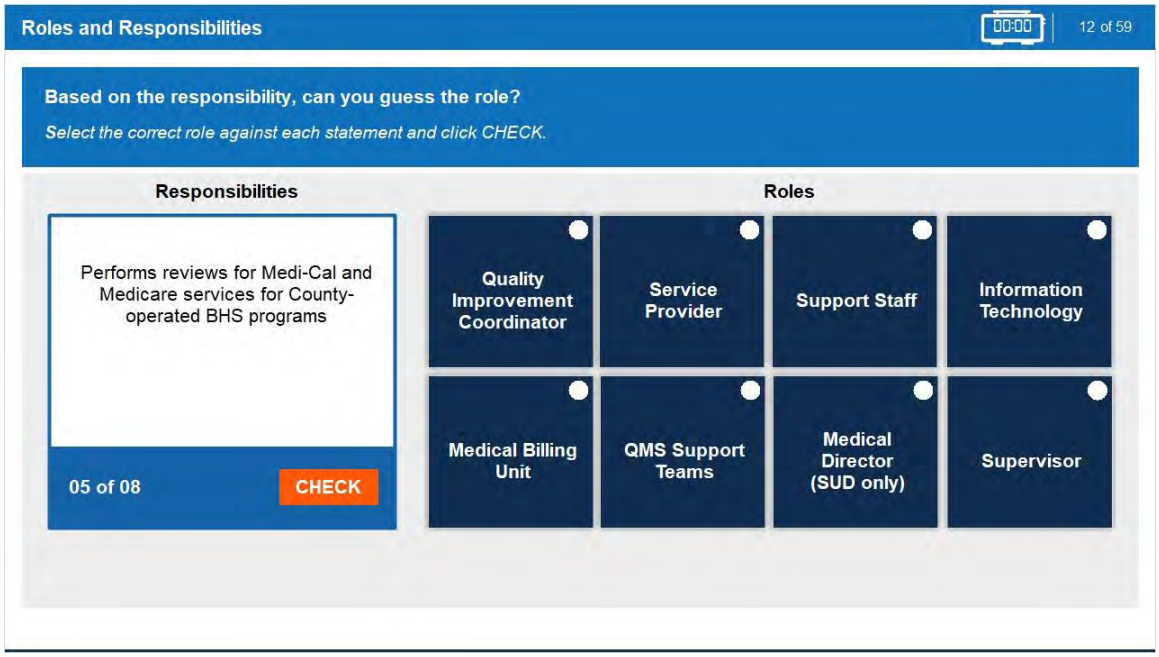


Not quite. The correct answer is Information Technology. (Slide Layer)



3.7 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
	Service Provider
	Support Staff
	Information Technology
X	Medical Billing Unit
	QMS Support Teams
	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

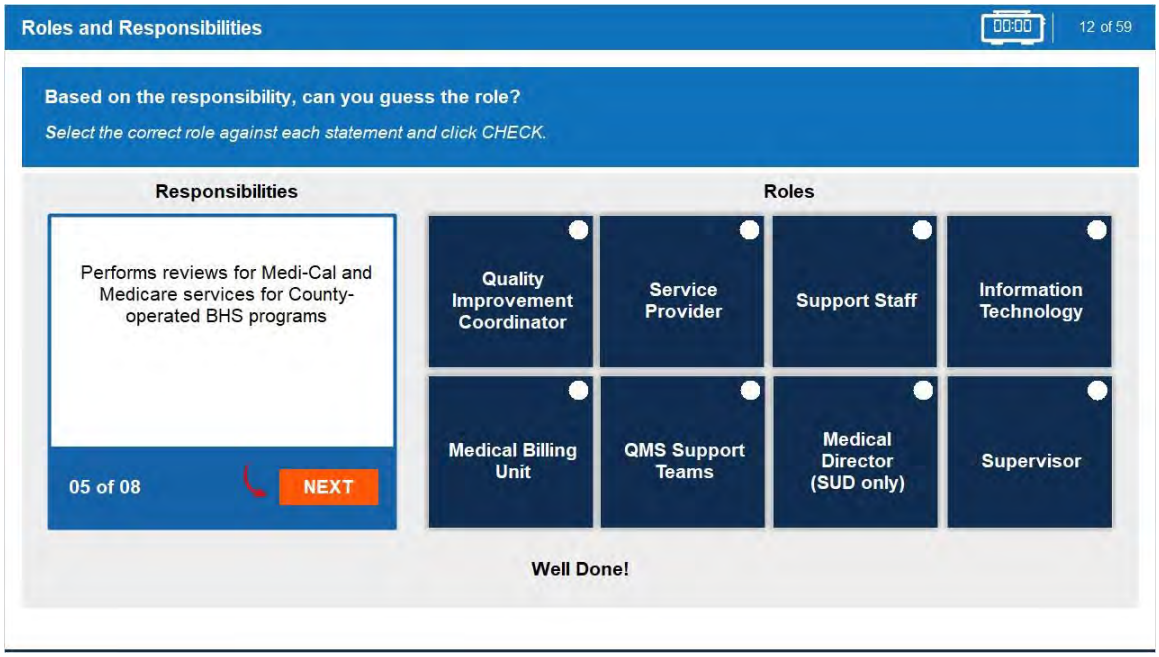
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

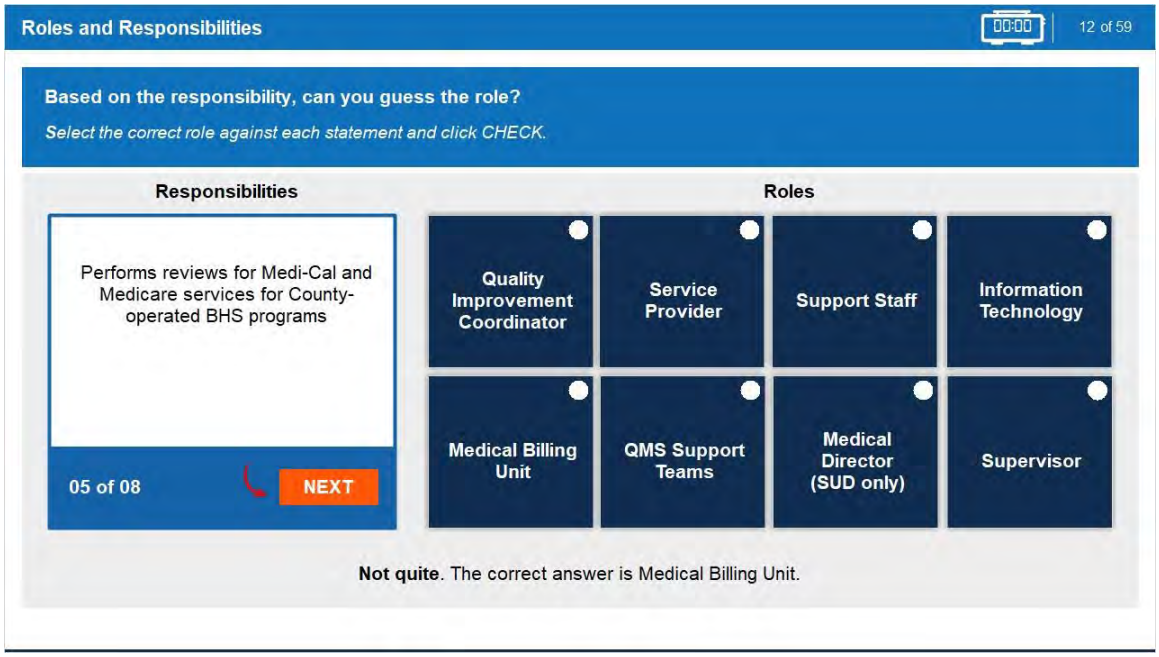
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

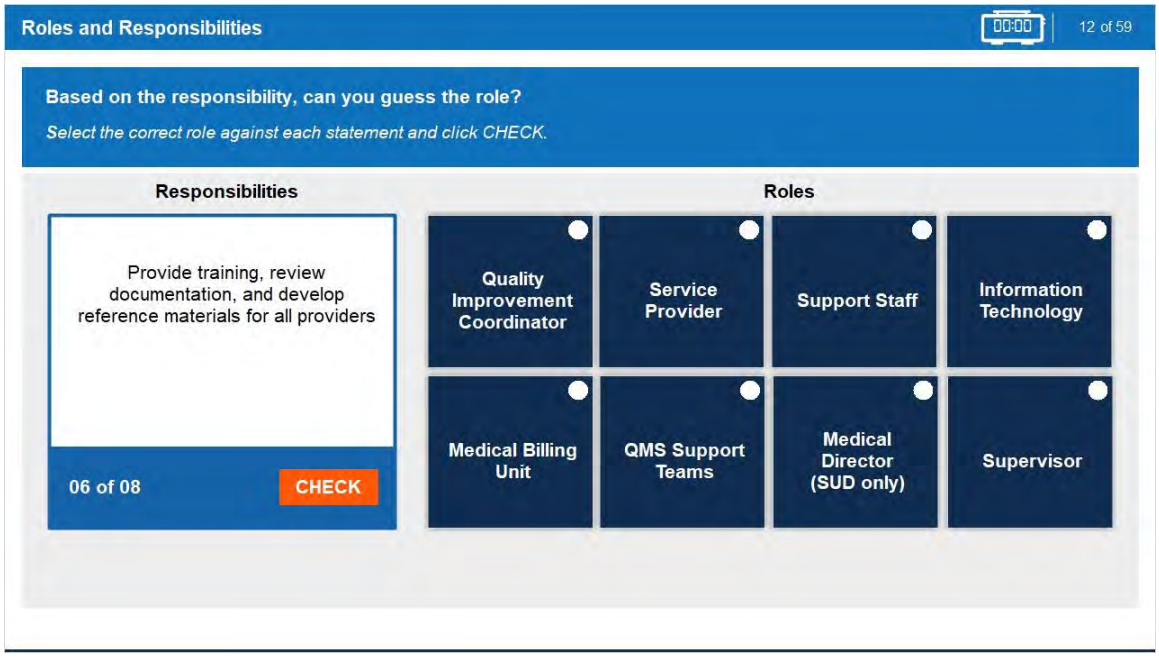


Not quite. The correct answer is Medical Billing Unit. (Slide Layer)



3.8 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
	Service Provider
	Support Staff
	Information Technology
	Medical Billing Unit
X	QMS Support Teams
	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

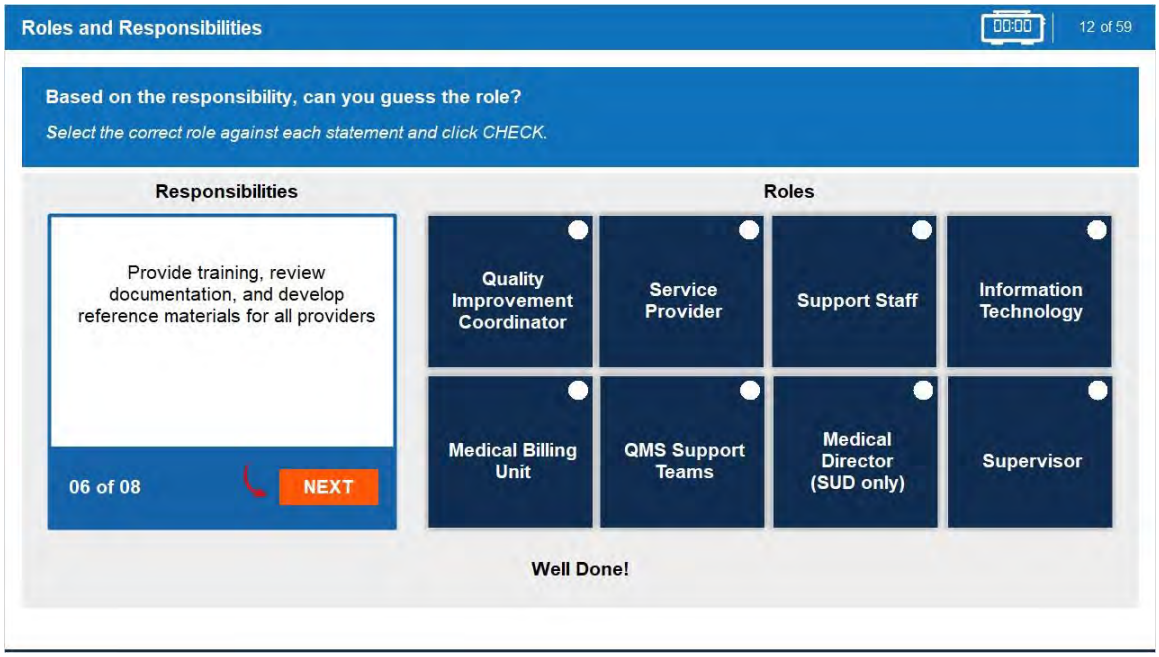
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

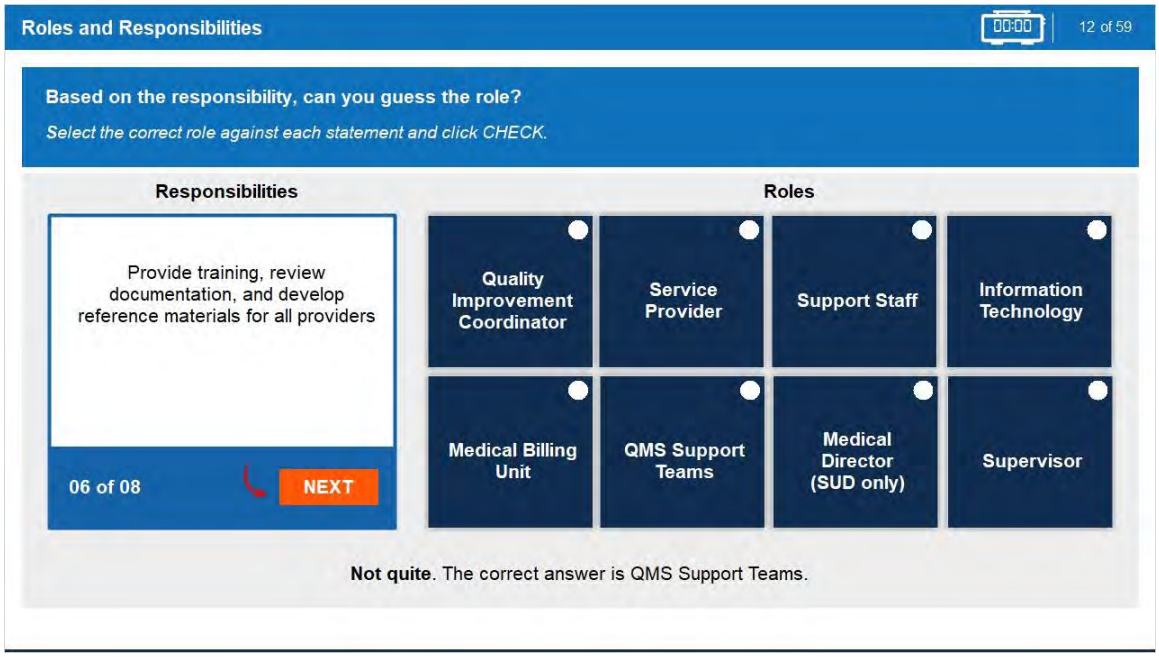
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

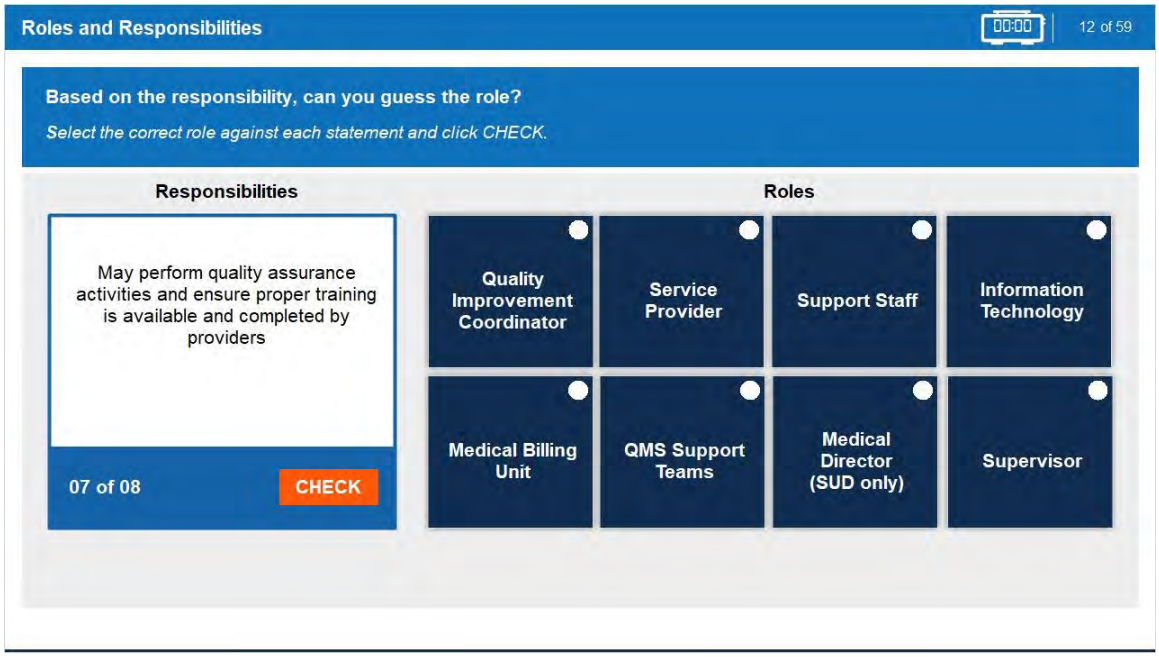


Not quite. The correct answer is QMS Support Teams. (Slide Layer)



3.9 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
X	Quality Improvement Coordinator
	Service Provider
	Support Staff
	Information Technology
	Medical Billing Unit
	QMS Support Teams
	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

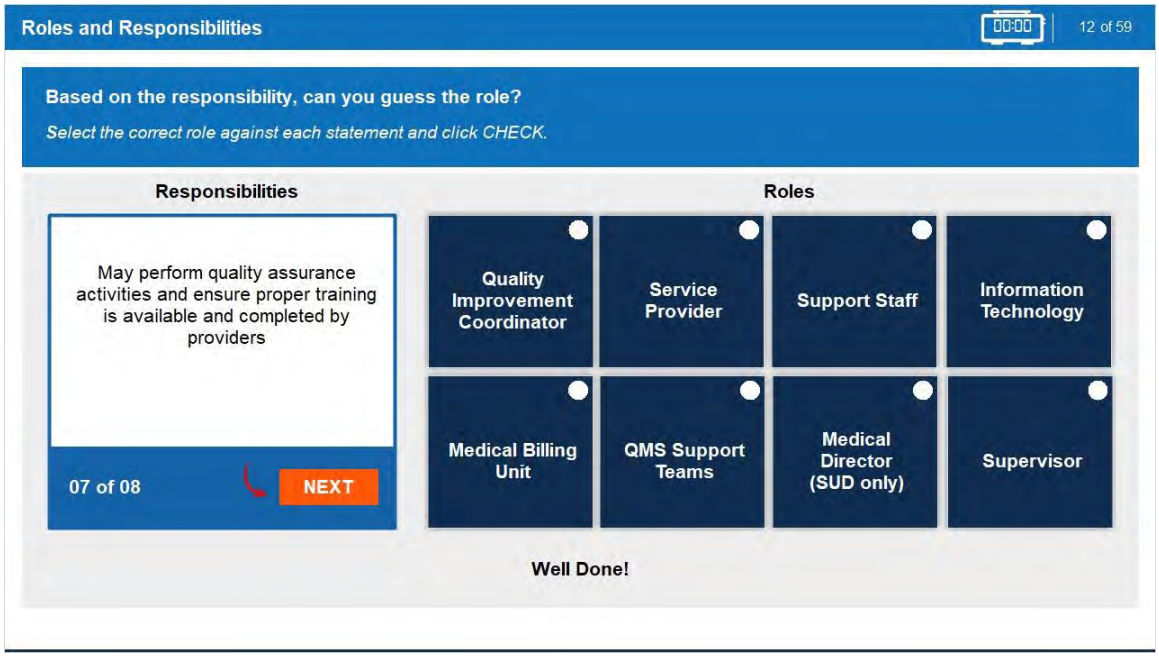
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

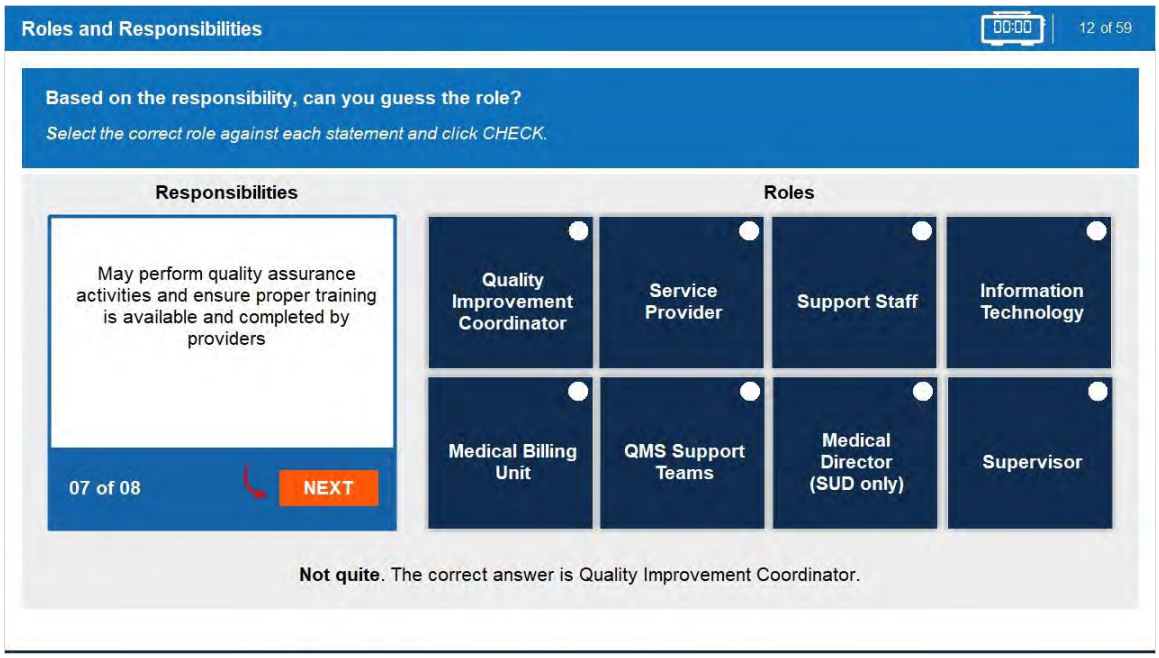
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

Well Done! (Slide Layer)

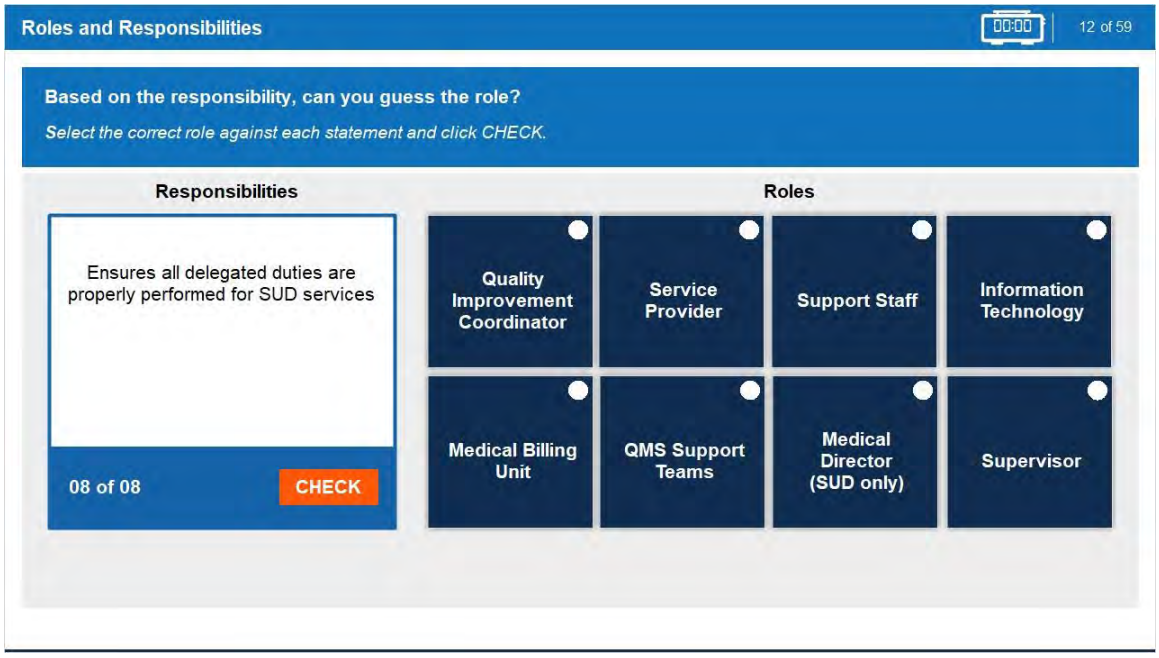


Not quite. The correct answer is Quality Improvement Coordinator. (Slide Layer)



3.10 Roles and Responsibilities

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Quality Improvement Coordinator
	Service Provider
	Support Staff
	Information Technology
	Medical Billing Unit
	QMS Support Teams
X	Medical Director (SUD only)
	Supervisor

Notes:

Here is a quick activity.

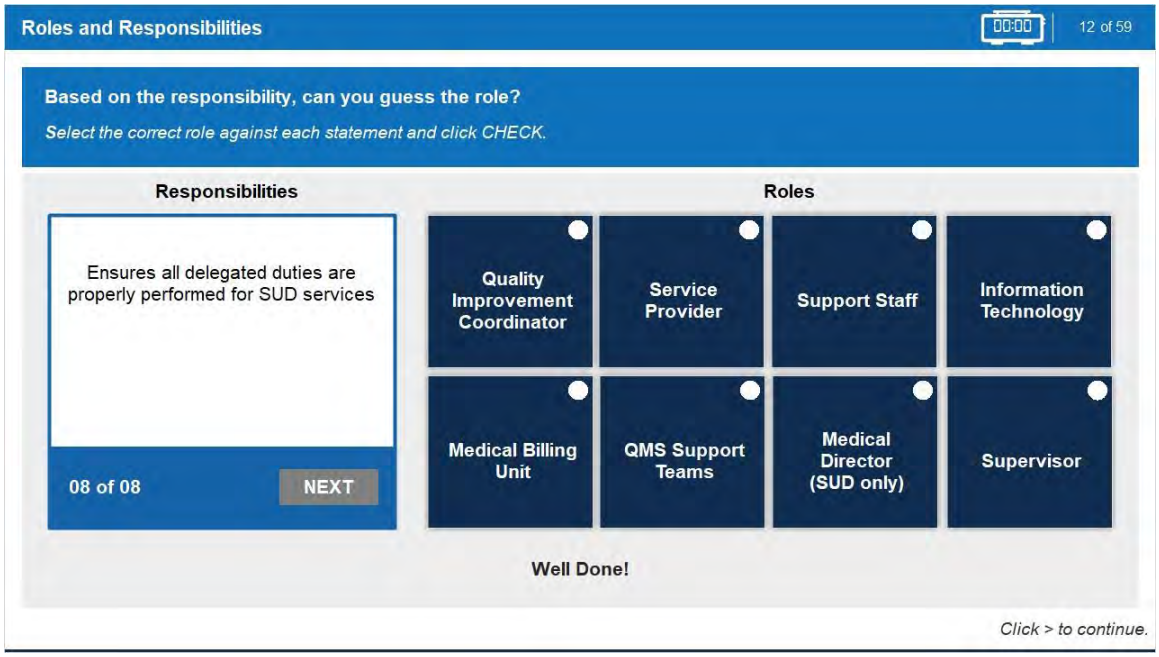
Let's see if you can guess the role based on their responsibility.

You will be given a series of statements that represent the various responsibilities.

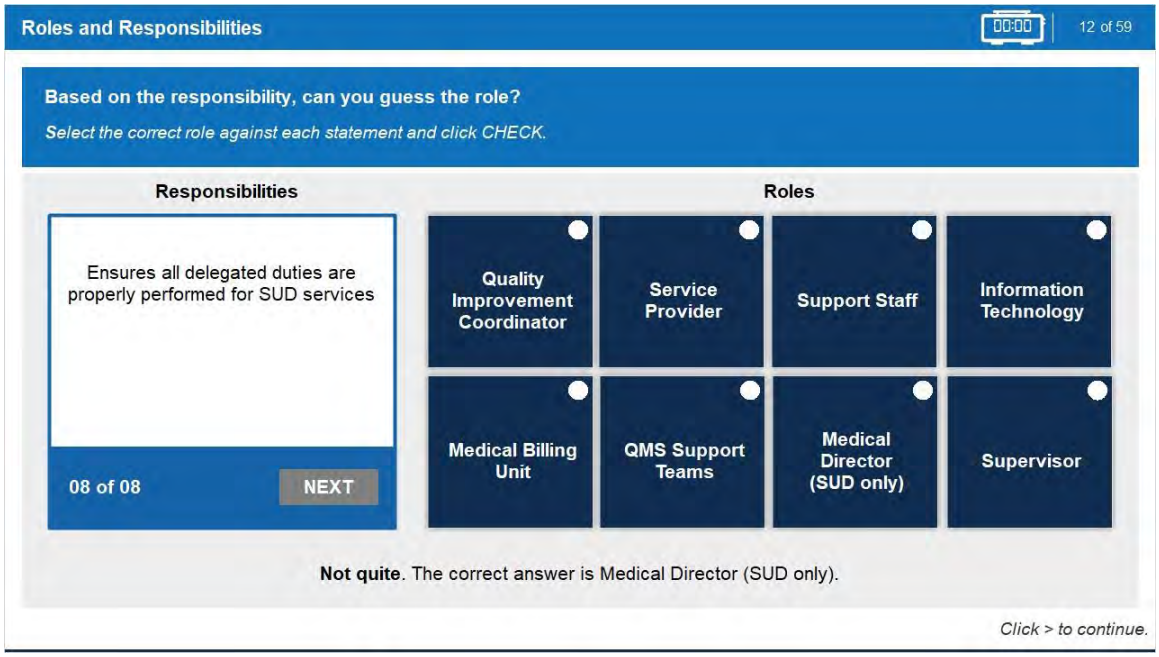
All you need to do is select the correct role against each statement and click CHECK.

Please note that there is no audio narration for the series of statements.

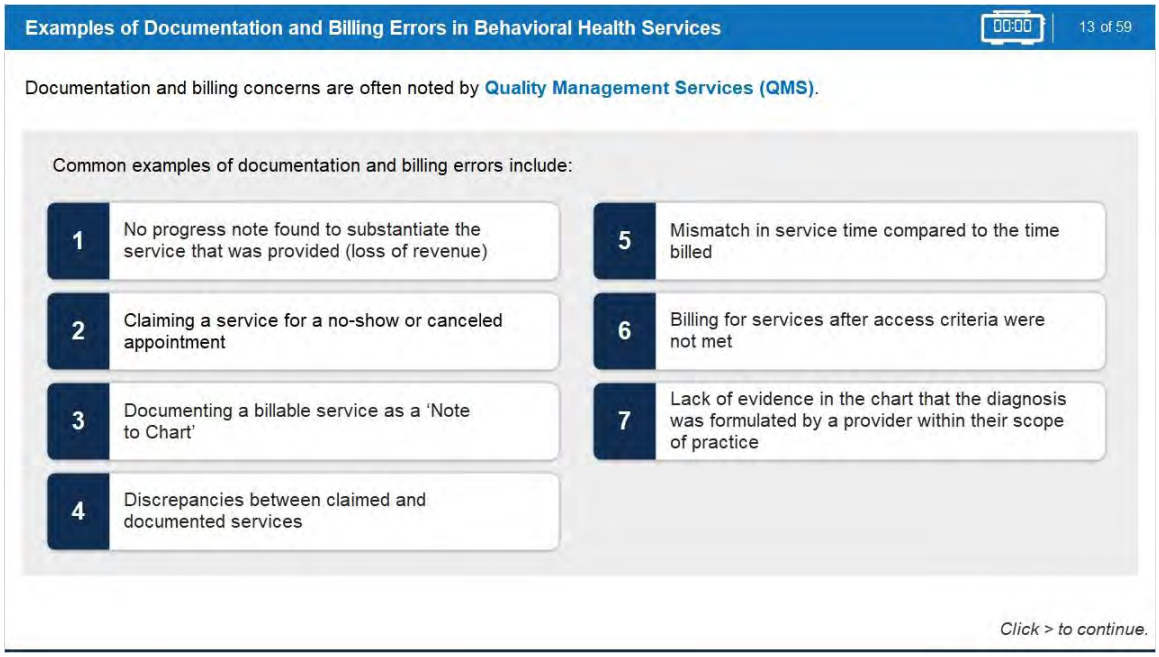
Well Done! (Slide Layer)



Not quite. The correct answer is Medical Director (SUD only). (Slide Layer)



3.11 Examples of Documentation and Billing Errors in Behavioral Health Services



Notes:

Now that you've gone through the roles and responsibilities, let's now explore some examples of billing errors.

Documentation and billing concerns are often noted by Quality Management Services (QMS).

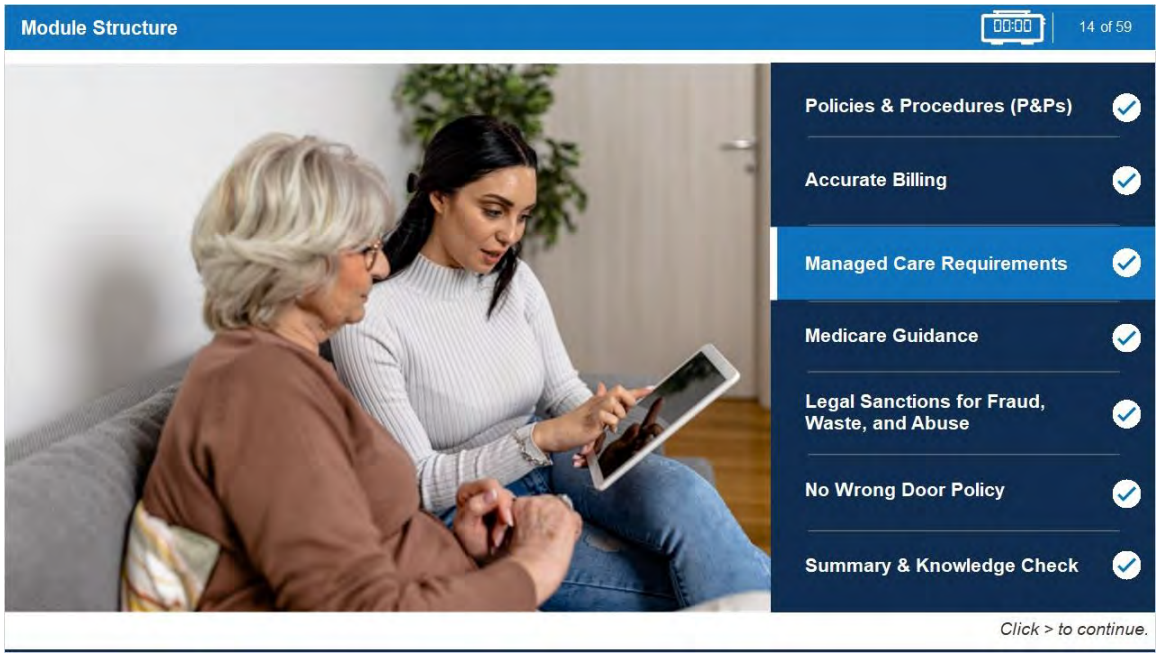
Common examples of documentation and billing errors include:

- No progress note found to substantiate the service that was provided,
- Claiming a service for a no-show or canceled appointment,
- Documenting a billable service as a 'Note to Chart',
- Discrepancies between claimed and documented services,
- Mismatch in service time compared to the time billed,
- Billing for services after access criteria were not met, and
- Lack of evidence in the chart that the diagnosis was formulated by a provider within their scope of practice.

Providers who continue to struggle with maintaining documentation standards can discuss training opportunities with their Supervisors to improve adherence to the guidelines and requirements.

4. Managed Care Requirements

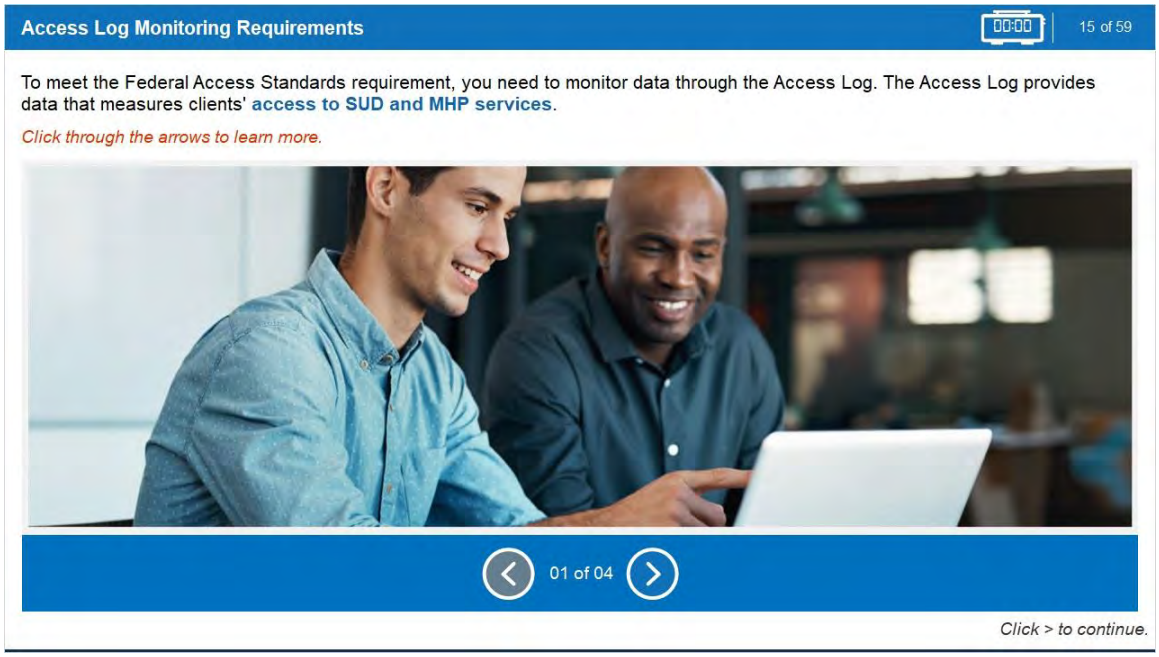
4.1 Module Structure



Notes:

That was about Accurate Billing. Let's now move on to Managed Care Requirements.

4.2 Access Log Monitoring Requirements



Notes:

To meet the Federal Access Standards requirement, you need to monitor data through the Access Log. The Access Log provides data that measures clients' access to SUD and MHP services.

From the Access Log entry, the network can determine the availability of 24/7 access to services, number of days between a client's request for services and first service date, the date of the initial offered appointment, and the date of the accepted appointment.

Additionally, the Access Log data captures information about the type of service requested, the level of need for the service, the request for services in non-English languages, and, of course, the number of service requests.

The Access Log serves as a tool to demonstrate how efficiently you can initially provide needed services to your clients.

Every clinic that serves as an access point should complete an Access Log entry for all new requests to start services with the MHP or DMC-ODS.

If a client can access services through a specific place or program, then that “place” qualifies as an access point.

Transitions along the continuum of care do not need to be entered into the Access Log. If a client is simply moving from one program type to another within the same program, or if a client is moving from one provider to another within the same plan, it is not considered an initial access request.

If a client has a history within the MHP and/or DMC-ODS network but is not currently open in the network, an Access Log entry is required.

For example, if a client leaves the Orange County system altogether and then returns (case closed or new admission), an Access Log entry is necessary.

If a client is currently open with the MHP and becomes a “new” client with DMC-ODS (or vice versa), an Access Log entry is required because the two health plans are different and distinct from each other.

If you have any questions about the Access Log, please reach out to the Managed Care Support Team (MCST) for guidance.

Tab 01 (Slide Layer)

Access Log Monitoring Requirements 15 of 59

To meet the Federal Access Standards requirement, you need to monitor data through the Access Log. The Access Log provides data that measures clients' **access to SUD and MHP services**.

Click through the arrows to learn more.

From the Access Log entry, the network can determine the:

- Availability of 24/7 access to services
- Number of days between a client's request for services and first service date
- Date of the initial offered appointment
- Date of the accepted appointment
- Type of service requested (e.g., outpatient or residential)
- Level of need for the service
- Request for services in non-English languages
- Number of service requests

02 of 04

Click > to continue.

Tab 02 (Slide Layer)

Access Log Monitoring Requirements 15 of 59

To meet the Federal Access Standards requirement, you need to monitor data through the Access Log. The Access Log provides data that measures clients' **access to SUD and MHP services**.

Click through the arrows to learn more.

Every clinic that serves as an access point should complete an Access Log entry for all new requests to start services with the MHP or DMC-ODS.

If a client can access services through a specific place or program, then that "place" qualifies as an access point.

Transitions along the continuum of care do not need to be entered into the Access Log (e.g., clinic to PACT; SUD residential to SUD outpatient).

03 of 04

Click > to continue.

Tab 03 (Slide Layer)

Access Log Monitoring Requirements 15 of 59

To meet the Federal Access Standards requirement, you need to monitor data through the Access Log. The Access Log provides data that measures clients' **access to SUD and MHP services**.

Click through the arrows to learn more.

If a client has a history within the MHP and/or DMC-ODS network but is not currently open in the network, an Access Log entry is required.

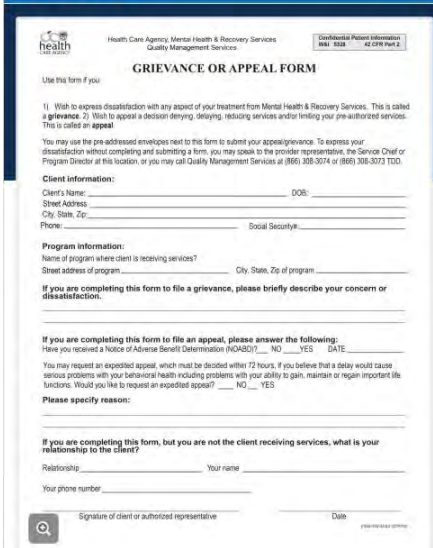
If a client is currently open with the MHP and becomes a "new" client with DMC-ODS, an Access Log entry is required because the two health plans are different and distinct from each other.

04 of 04

Click > to continue.

4.3 Grievances

Grievances 16 of 59



Health Care Agency, Mental Health & Recovery Services
Quality Management Services

Confidential Patient Information
HIPAA 5328 42 CFR Part 2

GRIEVANCE OR APPEAL FORM

Use this form if you:

1) Wish to express dissatisfaction with any aspect of your treatment from Mental Health & Recovery Services. This is called a **grievance**. 2) Wish to appeal a decision denying, delaying, reducing services and/or limiting your pre-authorized services. This is called an **appeal**.

You may use the pre-addressed envelopes next to this form to submit your appeal/grievance. To express your dissatisfaction without completing and submitting a form, you may speak to the provider representative, the Service Chief or Program Director at this location, or you may call Quality Management Services at (866) 308-3074 or (866) 308-3073 TDD.

Client information:

Client's Name: _____ DOB: _____
Street Address: _____
City, State, Zip: _____
Phone: _____ Social Security#: _____

Program information:

Name of program where client is receiving services?
Street address of program _____ City, State, Zip of program _____

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

If you are completing this form to file an appeal, please answer the following:
Have you received a Notice of Adverse Benefit Determination (NOABD)?___ NO ___YES DATE _____

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? ____ NO ___ YES

Please specify reason:

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

Relationship _____ Your name _____

Your phone number _____

Signature of client or authorized representative _____ Date _____

When a client **expresses dissatisfaction** with the MHP or DMC-ODS regarding any matter related to the provision of Medi-Cal services.

Clients have the right to file grievances whenever they are dissatisfied with any aspect of the services they receive.

In managed care, grievances may include:

- 01 — Quality of care or services provided
- 02 — Interpersonal relationships
- 03 — Failure to respect Medi-Cal client rights
- 04 — Right to dispute an extension of time proposed by the Plan

Click > to continue.

Notes:

When a client expresses dissatisfaction with the MHP or DMC-ODS, either in person or over the phone, regarding

any matter related to the provision of Medi-Cal services.

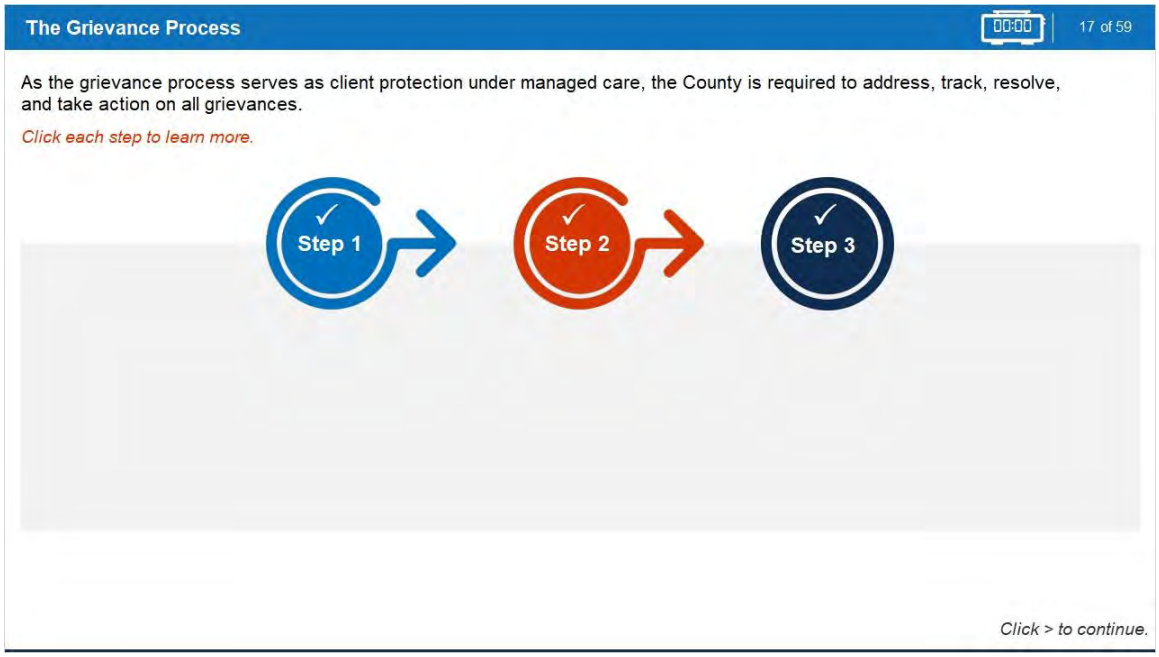
Clients have the right to file grievances whenever they are dissatisfied with any aspect of the services they receive.

If a complaint is attached to an Notice of Adverse Benefit Determination (NOABD), it results in an appeal rather than a grievance.

In managed care, grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships (such as rudeness), failure to respect Medi-Cal client rights (regardless of whether remedial action is requested), and the client's right to dispute an extension of time proposed by the Plan for making an authorization decision.

Furthermore, the definition of a grievance has expanded to encompass "any expression of dissatisfaction" with the services received by a Medi-Cal client.

4.4 The Grievance Process



Notes:

As the grievance process serves as client protection under managed care, the County is required to address, track, resolve, and take action on all grievances. There are strict timelines about what must occur when you receive a grievance.

Whenever a plan representative hears or receives an expression of dissatisfaction from a client, it must be treated as a grievance.

Consequently, programs should be prepared to provide clients with a grievance form or assist them in completing the form if requested on behalf of the client.

All grievance forms should be sent to the Managed Care Support Team, along with a Grievance Tracking Form (if the client has Medi-Cal).

The Managed Care Support Team uses the additional tracking form to log and monitor all grievances.

The tracking form provides the Managed Care Support Team with additional information that is needed to log, investigate, and report on grievances to DHCS.

The Managed Care Support Team promptly acknowledges receipt of the grievance by sending a letter within 5 business days.

Subsequently, the Managed Care Support Team investigates the grievance, which may include interviewing those involved in the case and reviewing the case file, among other activities.

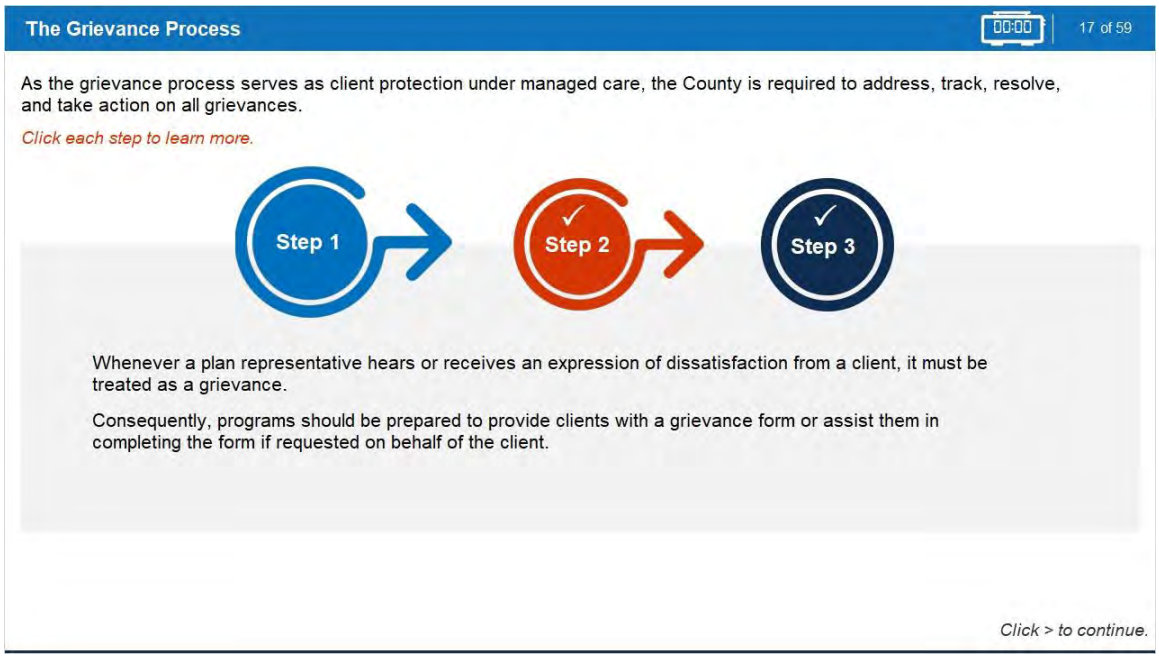
Because strict timelines must be met to comply with the grievance resolution requirements, the Managed Care Support Team needs your help sending the grievance and tracking forms immediately if you are the recipient of a grievance.

The Managed Care Support Team oversees, tracks, and monitors all grievances. As part of this monitoring, corrective action plans are issued to providers who have received three or more substantiated grievances in a quarter.

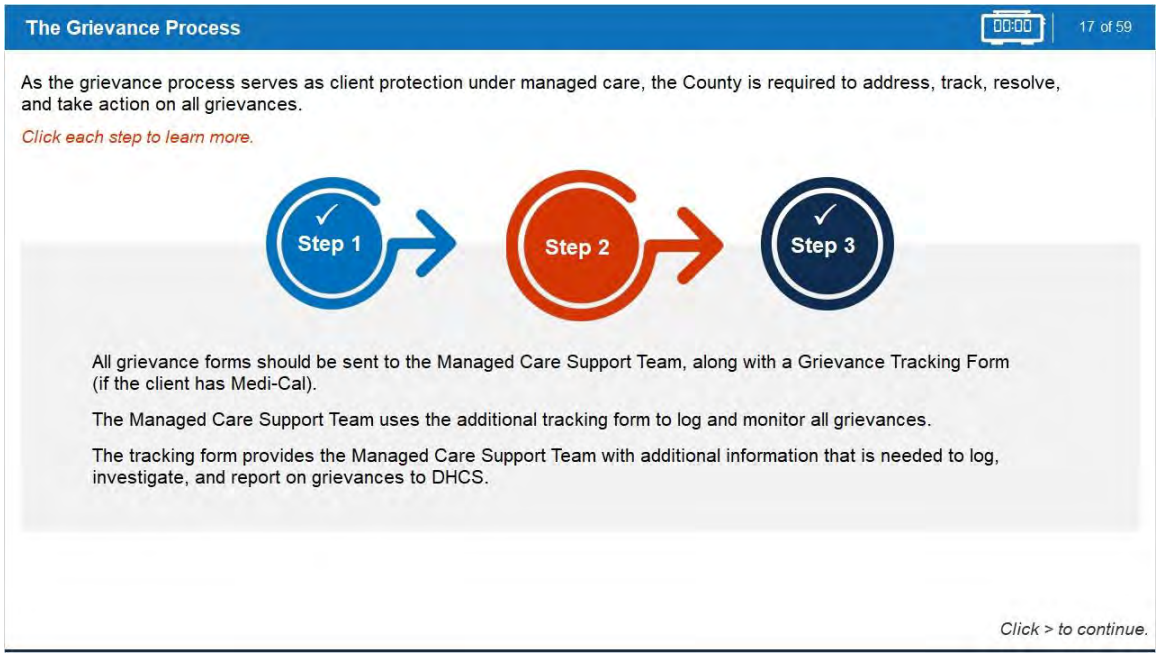
If you have further questions or need additional details about the grievance process, refer to the training materials or reach out to the Managed Care Support Team.

Displayed here is a Grievance Tracking Form. You need to complete and send the Grievance or Appeal Form along with the Grievance Tracking Form via email by the end of the next business day.

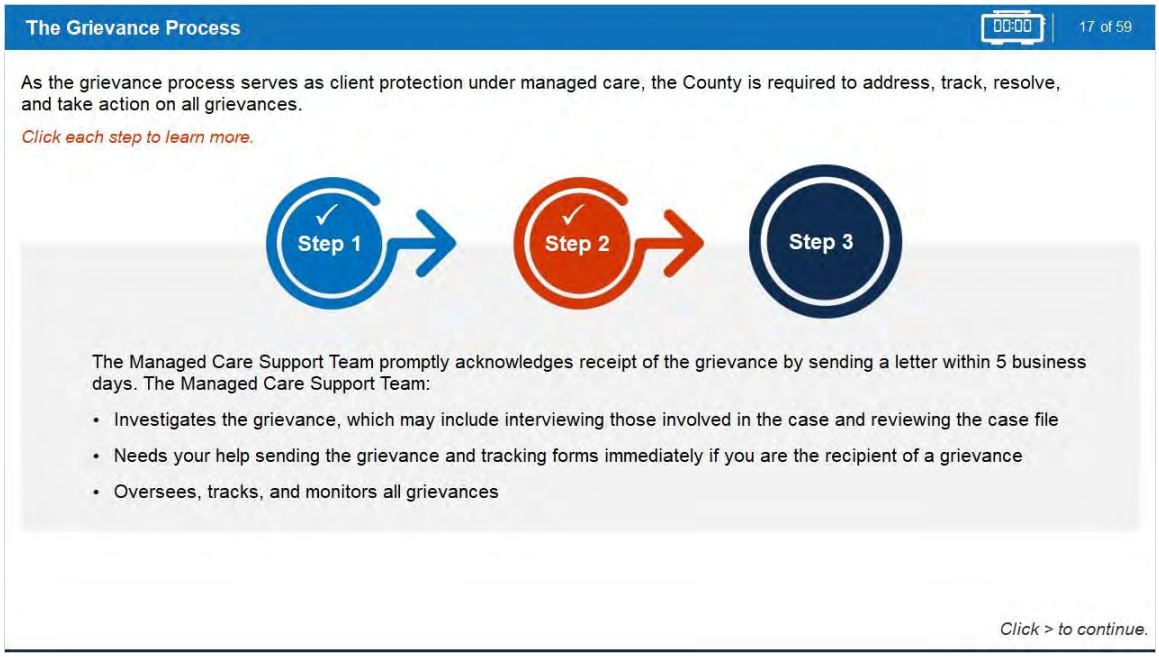
Step 1 (Slide Layer)



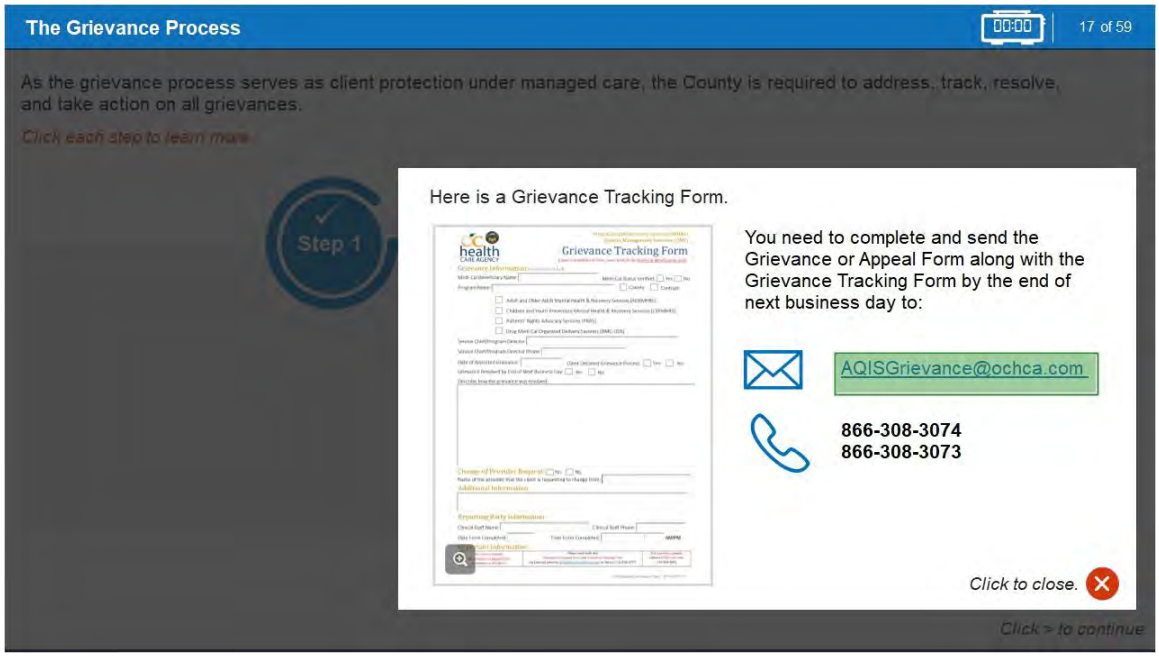
Step 2 (Slide Layer)



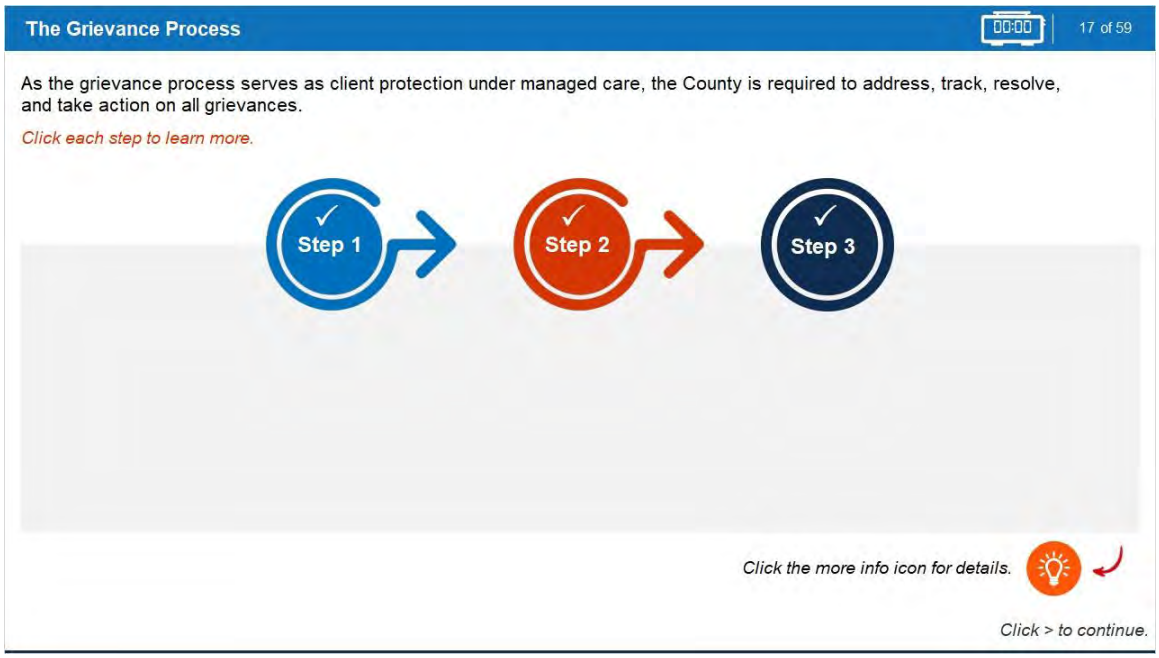
Step 3 (Slide Layer)



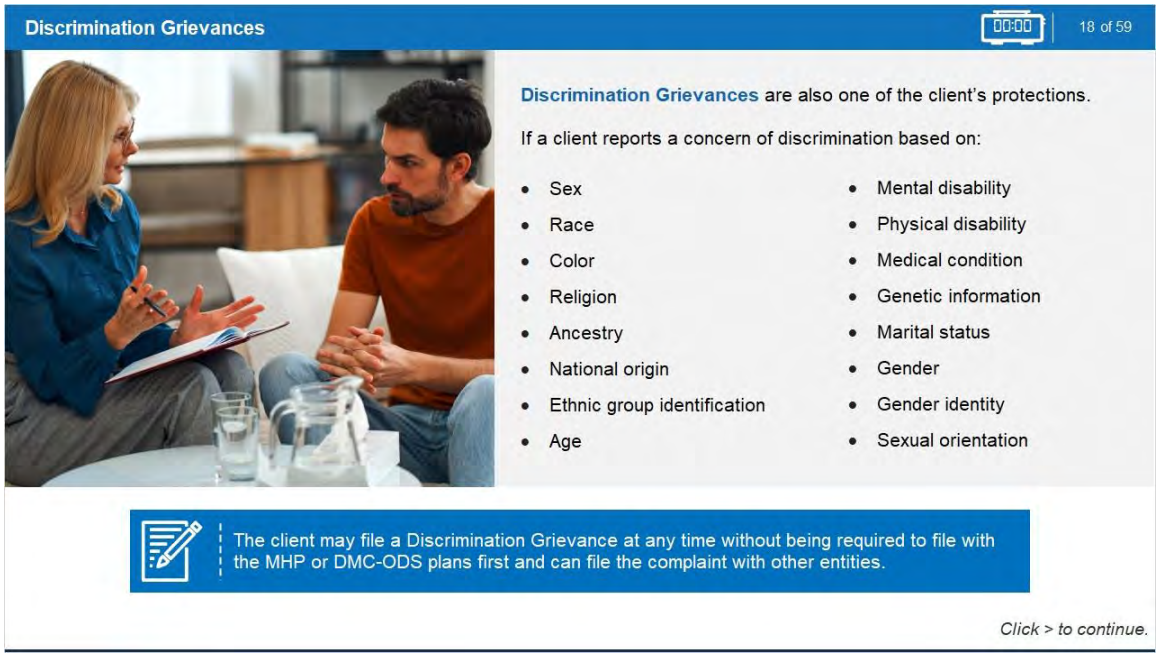
More Info (Slide Layer)



Last Audio (Slide Layer)



4.5 Discrimination Grievances



Notes:

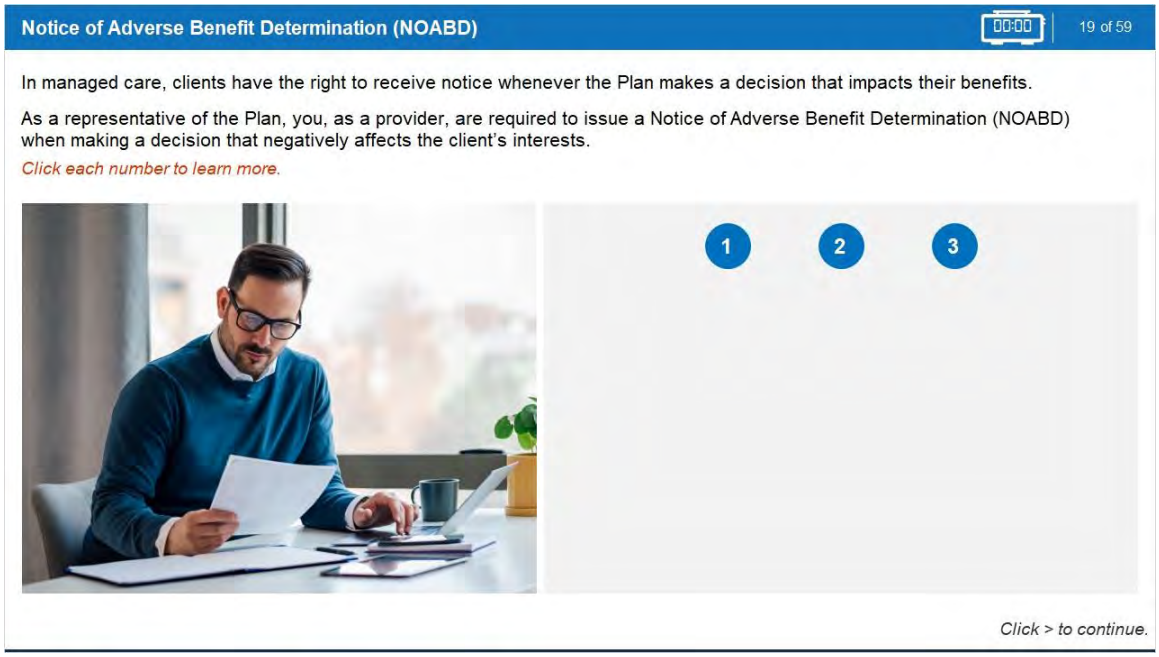
Now that you're aware of the grievances process, let's now learn about Discrimination Grievances.

Discrimination Grievances are also one of the client's protections. If a client reports a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, we are required to address the Discrimination Grievances, track them, and resolve them.

The client may file a Discrimination Grievance at any time without being required to file with the MHP or DMC-ODS plans first and can file the complaint with other entities.

With this type of grievance, the Managed Care Support Team works in collaboration with the Office of Compliance County Civil Rights Coordinator to complete the investigation and report it to DHCS.

4.6 Notice of Adverse Benefit Determination (NOABD)



Notes:

In managed care, clients have the right to receive notice whenever the Plan makes a decision that impacts their benefits. As a representative of the Plan, you, as a provider, are required to issue a Notice of Adverse Benefit Determination (NOABD) when making a decision that negatively affects the client's interests.

The treatment provider should either hand-deliver or mail the original completed NOABD to the Medi-Cal client within a specified timeframe. This notice must be accompanied by three enclosure documents: "Your Rights," Language Assistance Taglines, and the Notice of Non-Discrimination.

All NOABDs must be forwarded to the Managed Care Support Team for tracking and logging. NOABDS must be sent with a cover sheet that includes elements the Managed Care Support Team needs to track elements that are not included in the NOABD itself, such as who issued the notice and how.

Your direct Supervisor or Quality Improvement Coordinator can assist you if you have questions about when or how to issue a NOABD. While you are the first person to write the NOABD, the notice must be reviewed and approved by your direct Supervisor or Quality Improvement Coordinator before it is sent out.

Please note that NOABDs are issued to Medi-Cal clients only. For non-Medi-Cal clients, please consult your Supervisor.

T1 (Slide Layer)

Notice of Adverse Benefit Determination (NOABD) 00:00 19 of 59

In managed care, clients have the right to receive notice whenever the Plan makes a decision that impacts their benefits.

As a representative of the Plan, you, as a provider, are required to issue a Notice of Adverse Benefit Determination (NOABD) when making a decision that negatively affects the client's interests.

Click each number to learn more.

1 2 3

The treatment provider should either hand-deliver or mail the original completed NOABD to the Medi-Cal client within a specified timeframe.

This notice must be accompanied by three enclosure documents:

- Your Rights
- Language Assistance Taglines
- Notice of Non-Discrimination

Click > to continue.

T2 (Slide Layer)

Notice of Adverse Benefit Determination (NOABD) 00:00 19 of 59

In managed care, clients have the right to receive notice whenever the Plan makes a decision that impacts their benefits.

As a representative of the Plan, you, as a provider, are required to issue a Notice of Adverse Benefit Determination (NOABD) when making a decision that negatively affects the client's interests.

Click each number to learn more.

1 2 3

All NOABDs must be forwarded to the Managed Care Support Team for tracking and logging.

NOABDS must be sent with a cover sheet that includes elements the Managed Care Support Team needs to track elements that are not included in the NOABD itself.

Click > to continue.

T3 (Slide Layer)

Notice of Adverse Benefit Determination (NOABD) 19 of 59

In managed care, clients have the right to receive notice whenever the Plan makes a decision that impacts their benefits.

As a representative of the Plan, you, as a provider, are required to issue a Notice of Adverse Benefit Determination (NOABD) when making a decision that negatively affects the client's interests.

Click each number to learn more.

1 2 3

Your direct Supervisor or Quality Improvement Coordinator can assist you if you have questions about when or how to issue a NOABD.

While you are the first person to write the NOABD, the notice must be reviewed and approved by your direct Supervisor or Quality Improvement Coordinator before it is sent out.

Click > to continue.

4.7 Types of NOABDs

Types of NOABDs 20 of 59

The different types of NOABDs include:

Click each type of NOABD to learn more.

- NOABD – Delivery System (MHP Only)
- NOABD – Denial of Authorization for Requested Services
- NOABD – Timely Access
- NOABD – Termination
- NOABD – Modification
- NOABD – Authorization Delay

Click > to continue.

Notes:

The different types of NOABDs include:

- Delivery System,
- Denial of Authorization for Requested Services,
- Timely Access,
- Termination,
- Modification, and
- Authorization Delay.

NOABD – Delivery System

The NOABD Delivery System is issued to the Medi-Cal client when it is determined that the client's mental health condition does not meet the medical necessity criteria for Specialty Mental Health Services (SMHS) during the initial assessment period.

The NOABD is typically issued after the completion of the 7-Domain Assessment, but in rare cases, it may occur during the intake appointment.

DMC-ODS does not use the NOABD "Delivery System." If a program determines that there is no medical necessity or that the DMC-ODS is not the right system for a client, then the provider would issue the NOABD "Denial."

The NOABD must be hand-delivered or mailed at least two business days after the decision.

NOABD – Denial of Authorization for Requested Services

The NOABD Denial shall be issued when the Medi-Cal client is being denied the requested services. The NOABD must indicate the clinical reasons for the decision regarding medical necessity or residential authorization request. It should explicitly state why the services have been denied and why the Medi-Cal client's condition does not meet SMHS or DMC-ODS medical necessity criteria.

For the MHP, the NOABD shall explicitly state why the Medi-Cal client's condition can continue being treated with the current treatment modality.

For the DMC-ODS, the provider shall list on the NOABD Denial a referral for the Medi-Cal client to receive non-DMC-ODS services (that is MHP, CalOptima Behavioral Health for mild or moderate symptoms, The Regional Center, and Primary Care Physician). Denials include determinations based on the level of service type, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

The NOABD must be hand-delivered or mailed within two business days after the decision.

If you believe you need to issue a Denial NOABD, please contact the Managed Care Support Team for consultation before issuing it.

NOABD – Timely Access

The NOABD Timely Access is issued when there is a delay in providing the client with timely services, as required by the timely access standards applicable to the delayed service. This type of NOABD is typically generated at access points, for example:

- 24/7 Access Line/Beneficiary Access Line,
- Community providers partner with outpatient clinics, and
- County operated outpatient clinics.

The NOABD must be hand-delivered or mailed within two business days after the decision.

Please consult with the Managed Care Support Team prior to issuing a NOABD Timely Access. The Managed Care Support Team needs to ensure that all resources within the Plan have been exhausted before a NOABD for timely access can be issued.

NOABD – Termination

The NOABD Termination is issued once the client is in treatment and an action is taken by either the provider or the client that results in the termination of treatment services. The NOABD must be issued when the provider has lost

contact with the client, and therefore the client cannot agree nor disagree with the decision that the provider is making to terminate services.

There can be different reasons for issuing the NOABD termination. Some examples include when the client has not participated in services or contacted the program (60 days for the MHP and 30 days for the DMC-ODS), when a client is deceased, or when a client is admitted to an institution where they are ineligible for further services (such as jail or a long-term hospital).

Even when a client decides to end treatment voluntarily, a NOABD is still required if this occurs before completion of treatment, as such action is considered to be against the provider's advice and therefore "adverse."

The only time we do NOT issue a NOABD termination is when the client agrees and successfully completes their treatment services.

The treatment provider shall hand-deliver or mail the original, completed NOABD Termination to the Medi-Cal client at least 10 days before the proposed action or when a client submits a written statement to the program asking to discontinue services and states that it is understood that this will result in termination on the same day.

For all the rules, exceptions, and timelines of NOABDs, please contact the Managed Care Support Team and ask to speak to the NOABD Leads for guidance.

NOABD – Modification

The NOABD Modification is issued to the Medi-Cal client whenever the Plan modifies or limits a provider's request for a service while in treatment, provided that the client is NOT in agreement. This includes reductions in frequency and/or duration of services, as well as the approval of alternative treatments and services while in treatment.

For example: If a provider authorizes one individual therapy session per week, but the client prefers two individual therapy sessions instead, an NOABD modification is necessary.

Similarly, if the provider authorizes Dialectical Behavior Therapy (DBT), but the client disagrees with receiving this alternative treatment, an NOABD modification should be issued.

The NOABD must be hand-delivered or mailed within two business days after the decision.

Before issuing a NOABD modification, please consult with the Managed Care Support Team.

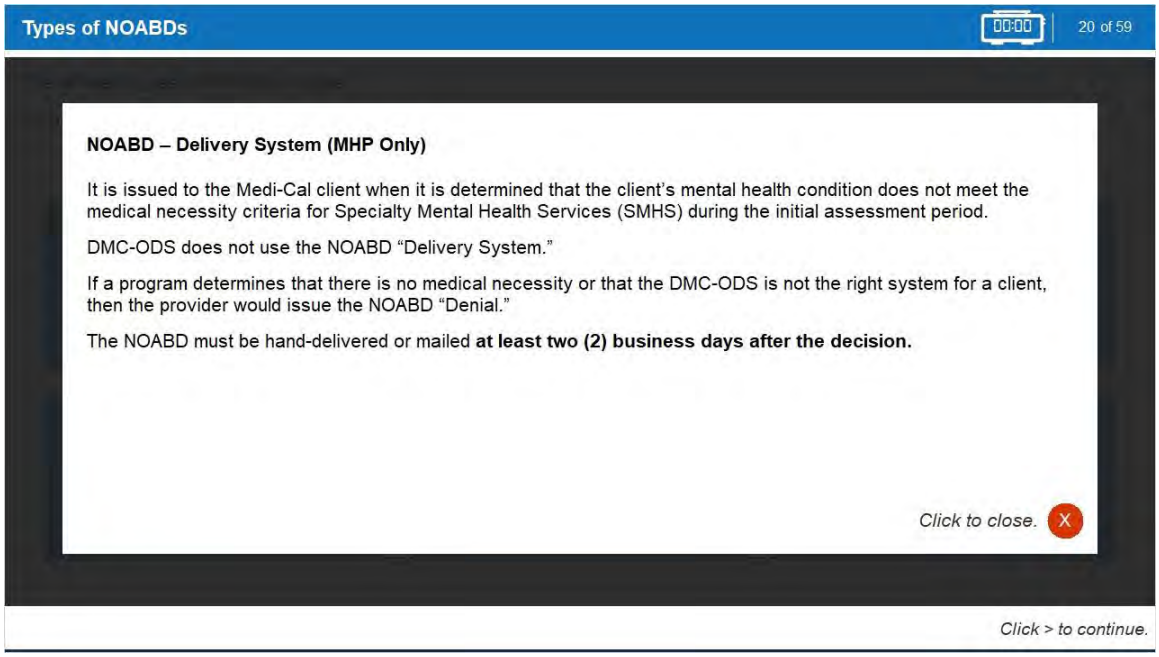
NOABD – Authorization Delay

The NOABD Authorization Delay should be issued when additional time is required to process a provider's request for authorization of SUD residential services and certain Specialty Mental Health Services, including out-of-network Behavioral Health Services.

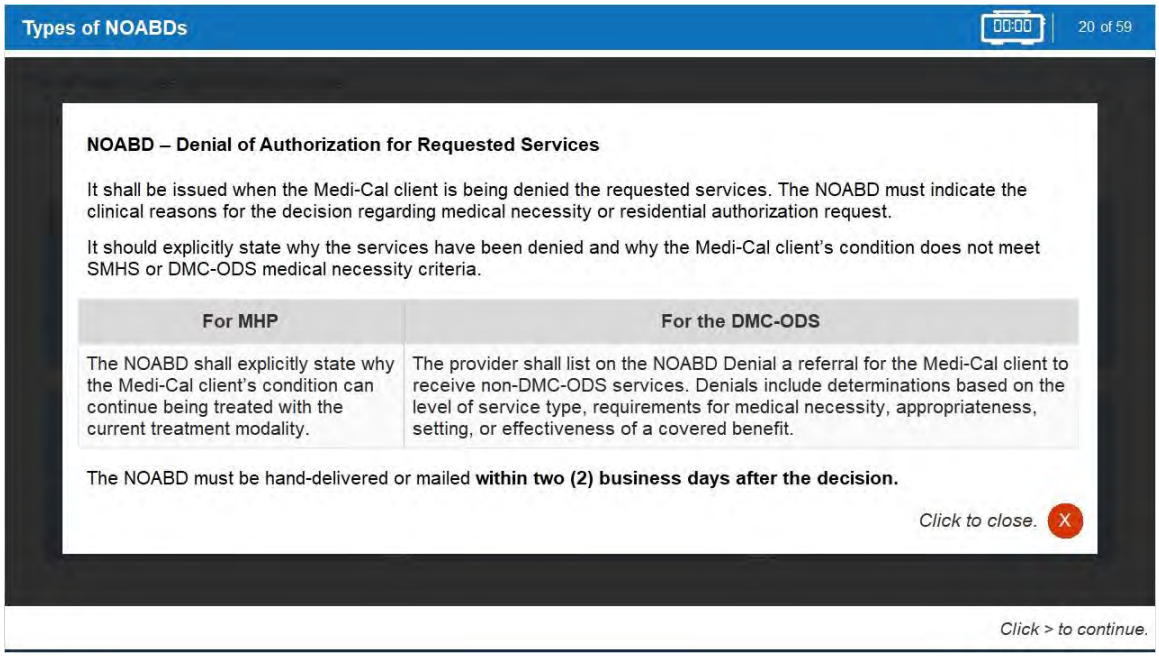
This NOABD can be utilized once for the request. It includes an extension granted at the request of the client or provider, as well as those granted when there is a need for additional information from the client or provider, provided that the extension is in the client's interest.

Currently, the Authorization of Residential Treatment (ART) team for DMC-ODS and the QMS for the MHP are responsible for handling requests related to issuing these NOABDs.

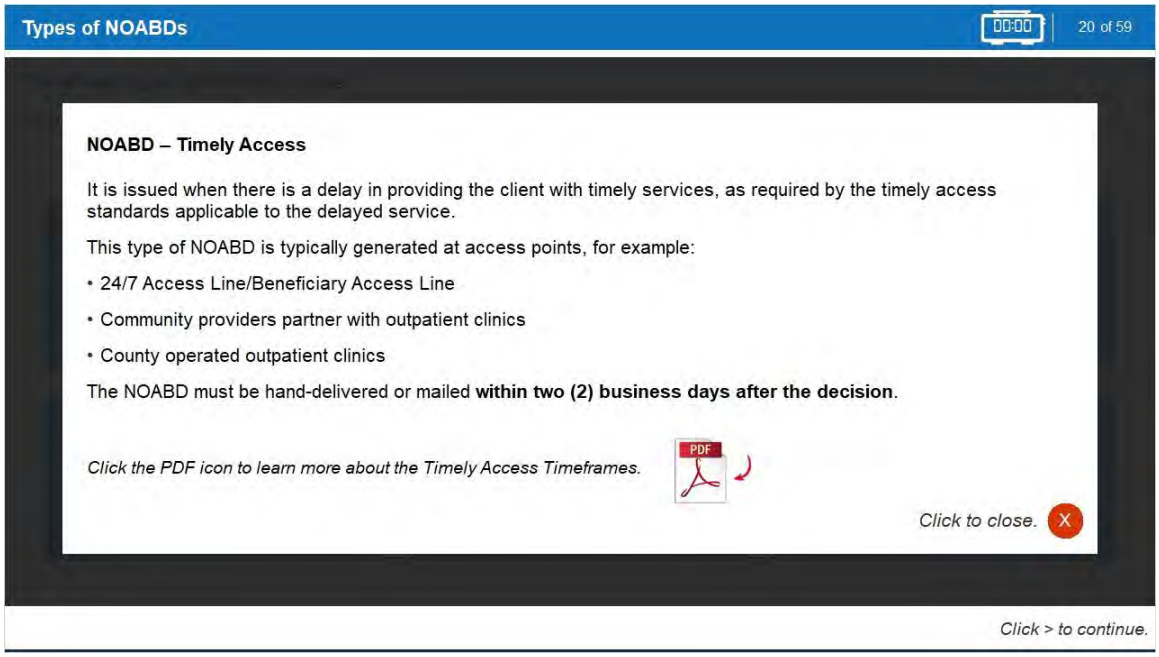
T1 (Slide Layer)



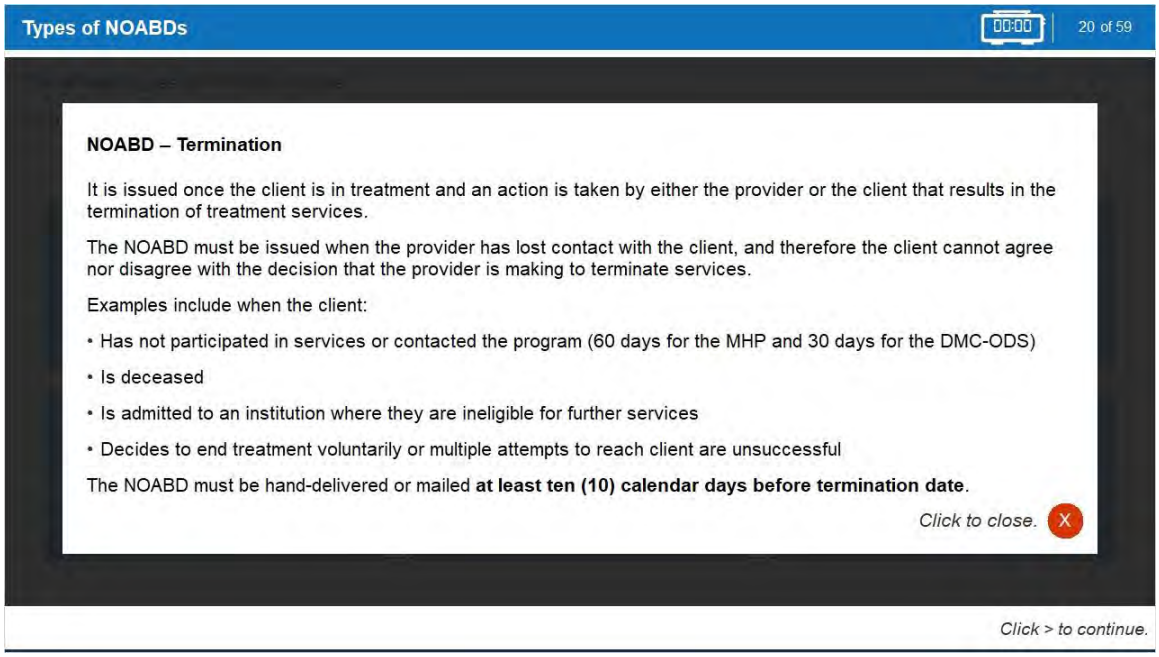
T2 (Slide Layer)



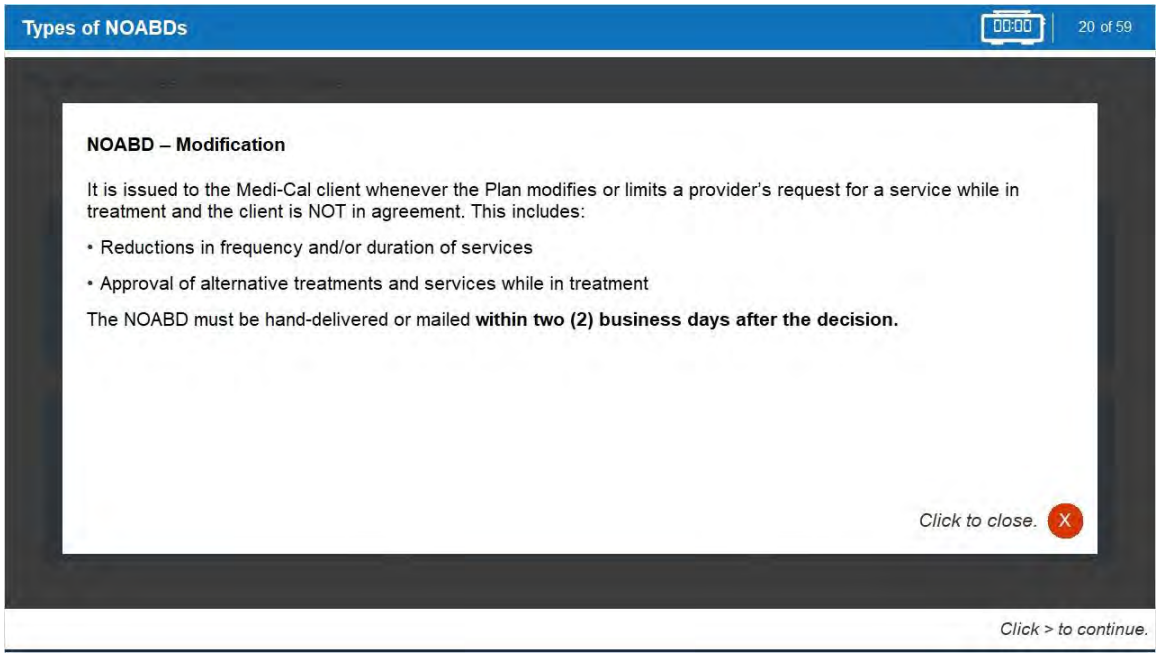
T3 (Slide Layer)



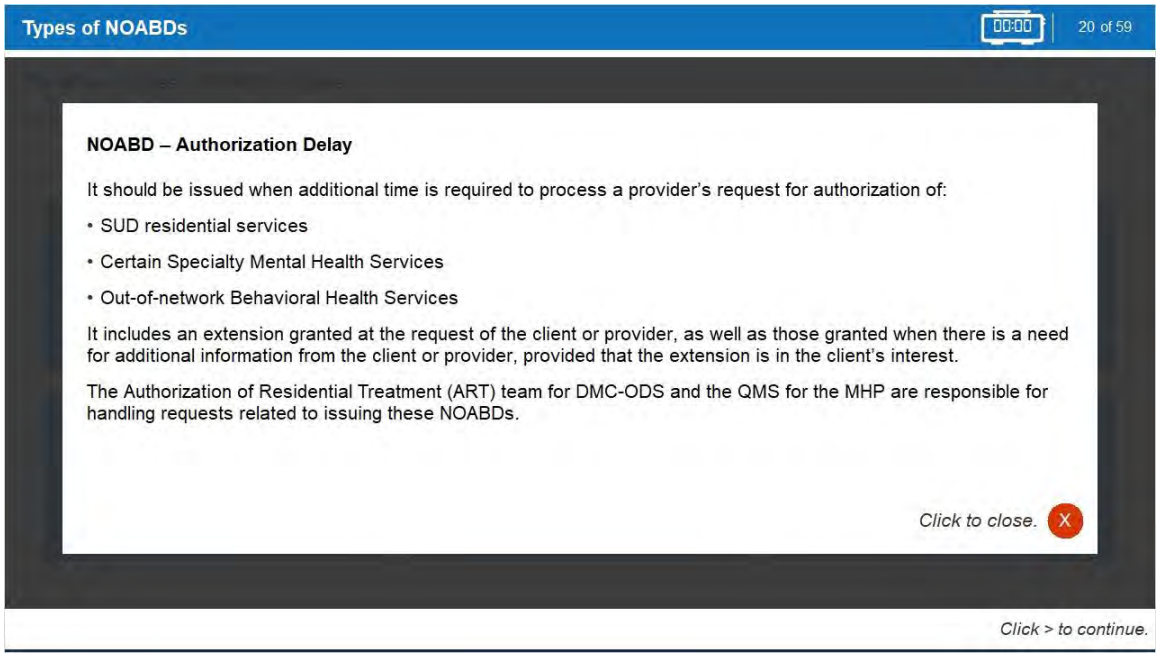
T4 (Slide Layer)



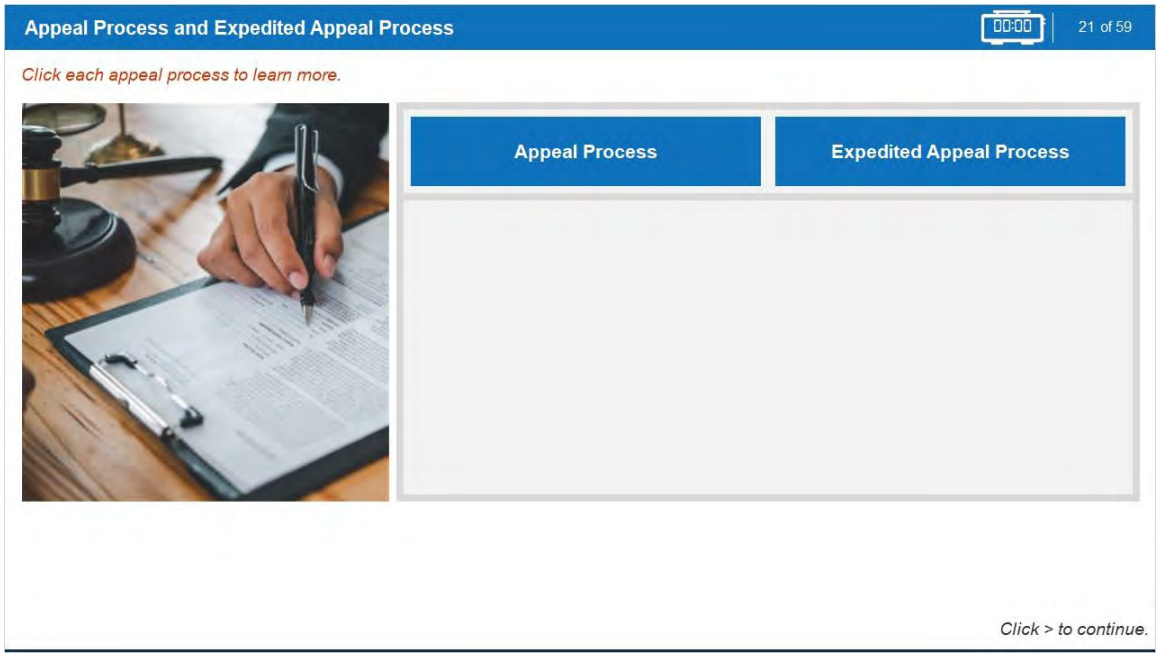
T5 (Slide Layer)



T6 (Slide Layer)



4.8 Appeal Process and Expedited Appeal Process



Notes:

Now that you're aware of the types of NOABD, let's now learn about the appeal process and the expedited appeal process.

Federal regulations allow clients the opportunity to file an appeal within 60 calendar days from the date on the NOABD. The Plan is required to provide the client with a written acknowledgment of receipt of the appeal, open an investigation, and resolve it within 30 calendar days.

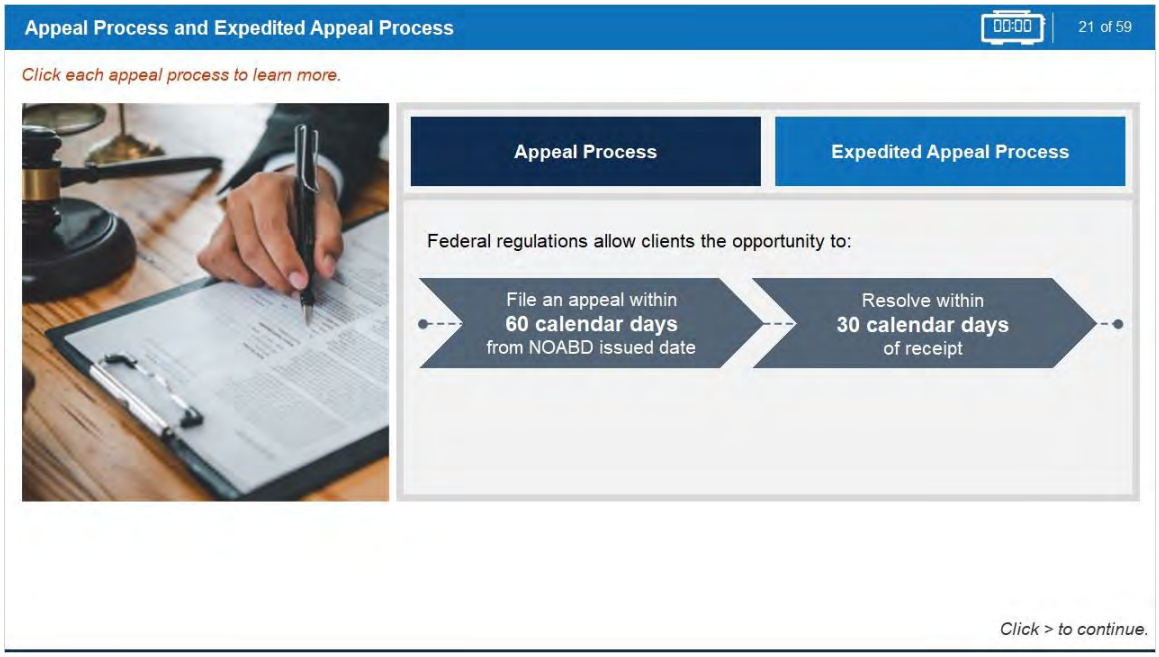
A client has the right to request an expedited appeal for a resolution within 72 hours. However, the Plan must review the expedited appeal and determine whether taking time for a standard resolution could seriously jeopardize the client's mental health, substance use disorder condition, and/or the client's ability to attain, maintain, or regain maximum function. The Plan may deny the request for expedited resolution of an appeal. When this occurs, the Plan changes it to a standard appeal of 30 calendar days instead of 72 hours.

At any point during the appeal process, the program is required to assist the client with the continuation of benefits during an appeal of the adverse benefit determination. This means the program must keep the case open and continue to provide services until the investigation has been upheld or overturned. If the appeal is overturned, the client will continue treatment services with the program.

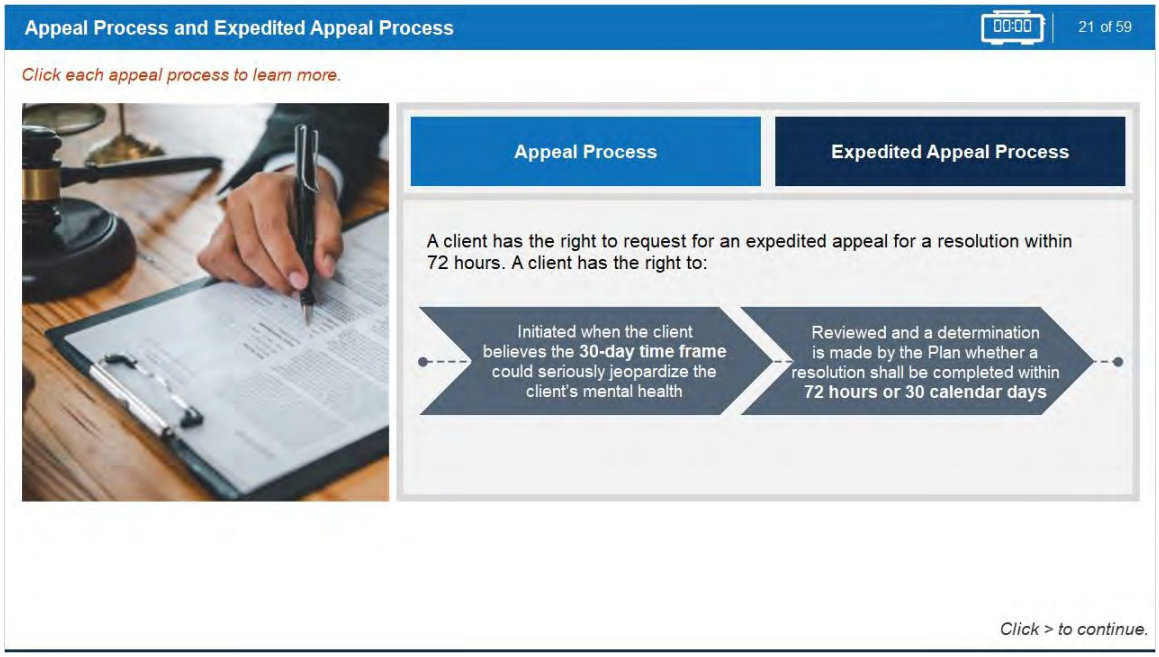
The Managed Care Support Team oversees, tracks, and monitors all appeals.

For more details or questions regarding the appeal process, please refer to the training materials or contact the Managed Care Support Team.

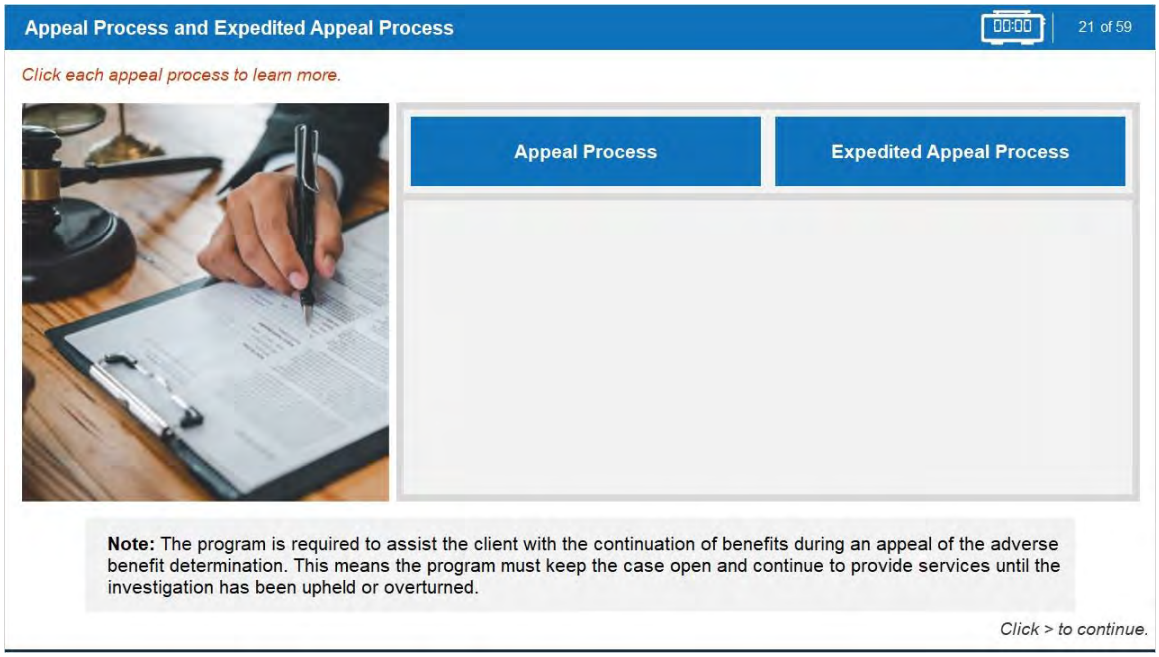
Tab_1 (Slide Layer)



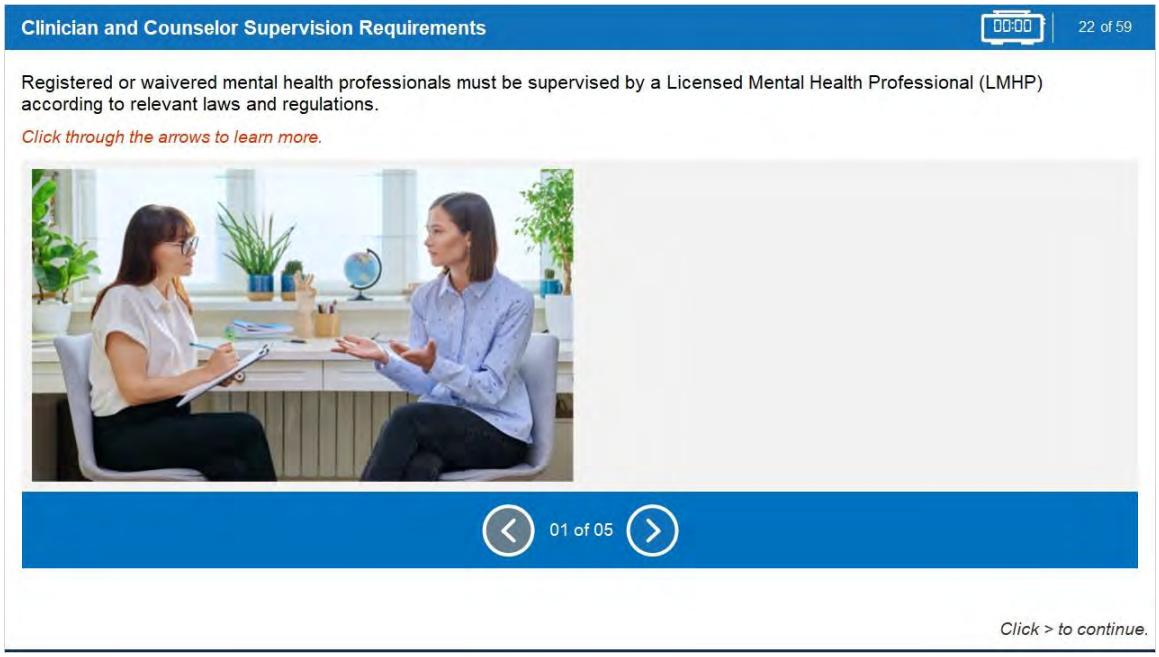
Tab_2 (Slide Layer)



More_info (Slide Layer)



4.9 Clinician and Counselor Supervision Requirements



Notes:

Registered or waivered mental health professionals must be supervised by a Licensed Mental Health Professional

(LMHP) according to relevant laws and regulations. The LMHP assumes ultimate responsibility for the services provided.

All registered or waivered employees, interns, and volunteers must receive mandated supervision, which must be documented to ensure compliance with regulations. Additionally, they must be assigned to a Clinical/Counselor Supervisor.

The Managed Care Support Team is responsible for receiving, storing, tracking, monitoring, and conducting periodic clinical billing and documentation reviews to ensure compliance with supervision requirements.

The Clinical or Counselor Supervision Reporting Form may require additional documents (e.g., BBS/BOP Supervision Agreement, Clinical Supervision Agreement, Supervisor Self-Assessment Report) to be submitted to the MCST at the start (e.g., new hire). Any change in status requires an updated Clinical or Counselor Supervision Reporting Form to be submitted to the MCST (e.g., separation, name change, change in Clinical/Counselor Supervisor).

Continuous Clinical or Counselor Supervision is mandatory to ensure there are no gaps.

A Clinical or Counselor Supervisor must always be assigned to the supervisee.

Supervision must occur weekly until the supervisee is licensed or certified.

Failure to submit the Clinical or Counselor Supervision Reporting Form (CSRF) and be assigned to a Clinical or Counselor Supervisor will result in registered and waivered providers being prohibited from delivering Medi-Cal covered services.

Non-independently licensed or certified staff must always be supervised as per their licensing board or certifying organization.

Failure to comply will result in disallowed services.

Clinician and Counselor Supervisors must adhere to supervision requirements outlined by their professional boards.

Supervisors must attest to their qualifications, experience, training, and understanding of relevant laws and regulations, providing documentation as required by Title 16, California Code of Regulations.

Tab 01 (Slide Layer)

Clinician and Counselor Supervision Requirements 00:00 22 of 59

Registered or waivered mental health professionals must be supervised by a Licensed Mental Health Professional (LMHP) according to relevant laws and regulations.

Click through the arrows to learn more.

All registered or waivered employees, interns, and volunteers must receive mandated supervision, which must be documented to ensure compliance with regulations.

02 of 05

Click > to continue.

Tab 02 (Slide Layer)

Clinician and Counselor Supervision Requirements 00:00 22 of 59

Registered or waivered mental health professionals must be supervised by a Licensed Mental Health Professional (LMHP) according to relevant laws and regulations.

Click through the arrows to learn more.

The Managed Care Support Team is responsible for receiving, storing, tracking, monitoring, and conducting periodic clinical billing and documentation reviews to ensure compliance with supervision requirements.

03 of 05

Click > to continue.

Tab 03 (Slide Layer)

Clinician and Counselor Supervision Requirements 00:00 22 of 59

Registered or waivered mental health professionals must be supervised by a Licensed Mental Health Professional (LMHP) according to relevant laws and regulations.

Click through the arrows to learn more.

The Clinical or Counselor Supervision Reporting Form may require additional documents to be submitted to the MCST at the start.

Any change in status requires an updated Clinical or Counselor Supervision Reporting Form to be submitted to the MCST.

04 of 05

Click > to continue.

Tab 04 (Slide Layer)

Clinician and Counselor Supervision Requirements 00:00 22 of 59

Registered or waivered mental health professionals must be supervised by a Licensed Mental Health Professional (LMHP) according to relevant laws and regulations.

Click through the arrows to learn more.

Continuous Clinical/Counselor Supervision is mandatory to ensure there are no gaps.

A Clinical/Counselor Supervisor must always be assigned to the supervisee.

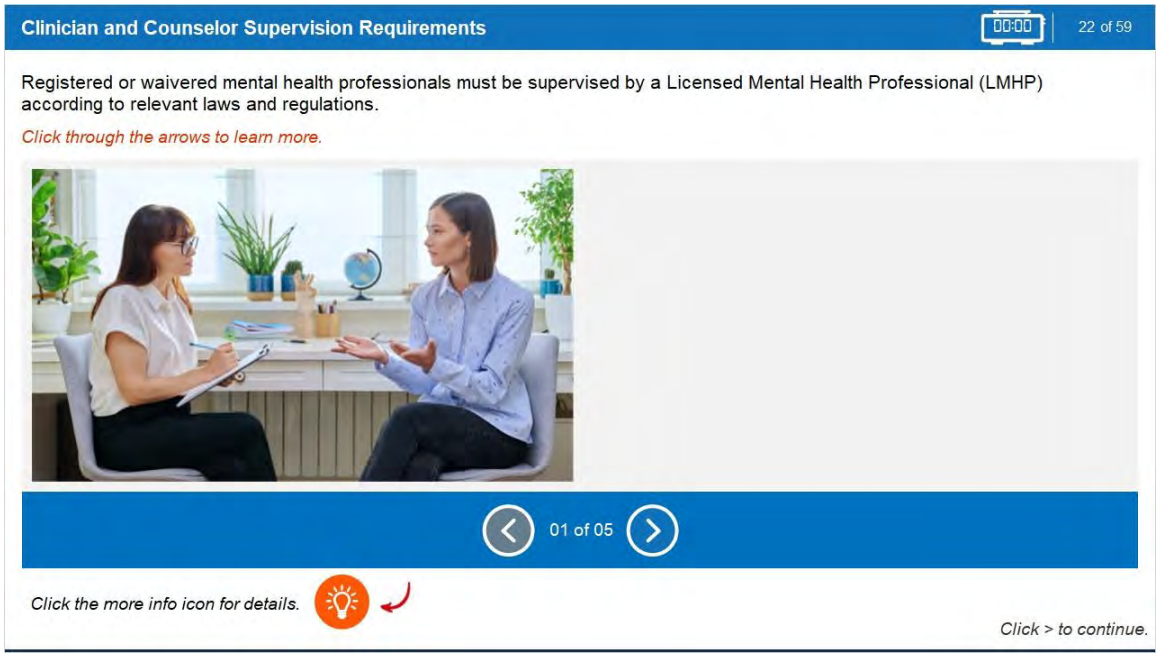
Supervision must occur weekly until the supervisee is licensed/certified.

Failure to submit the Clinical/Counselor Supervision Reporting Form (CSRF) and be assigned to a Clinical/Counselor Supervisor will result in registered and waivered providers being prohibited from delivering Medi-Cal covered services.

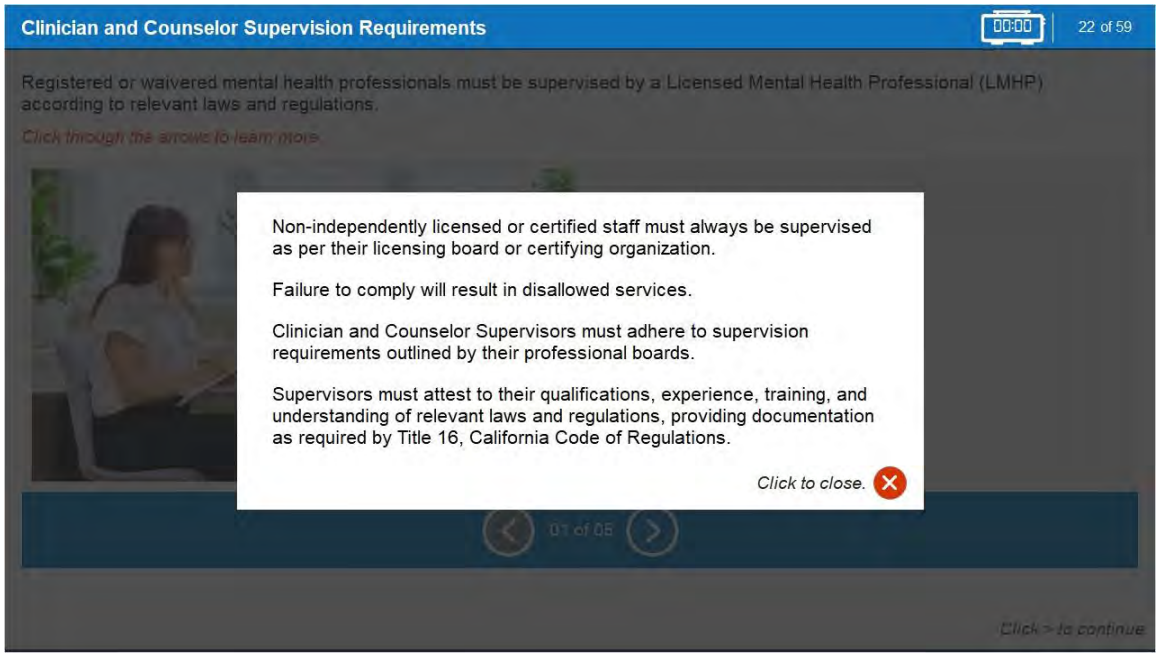
05 of 05

Click > to continue.

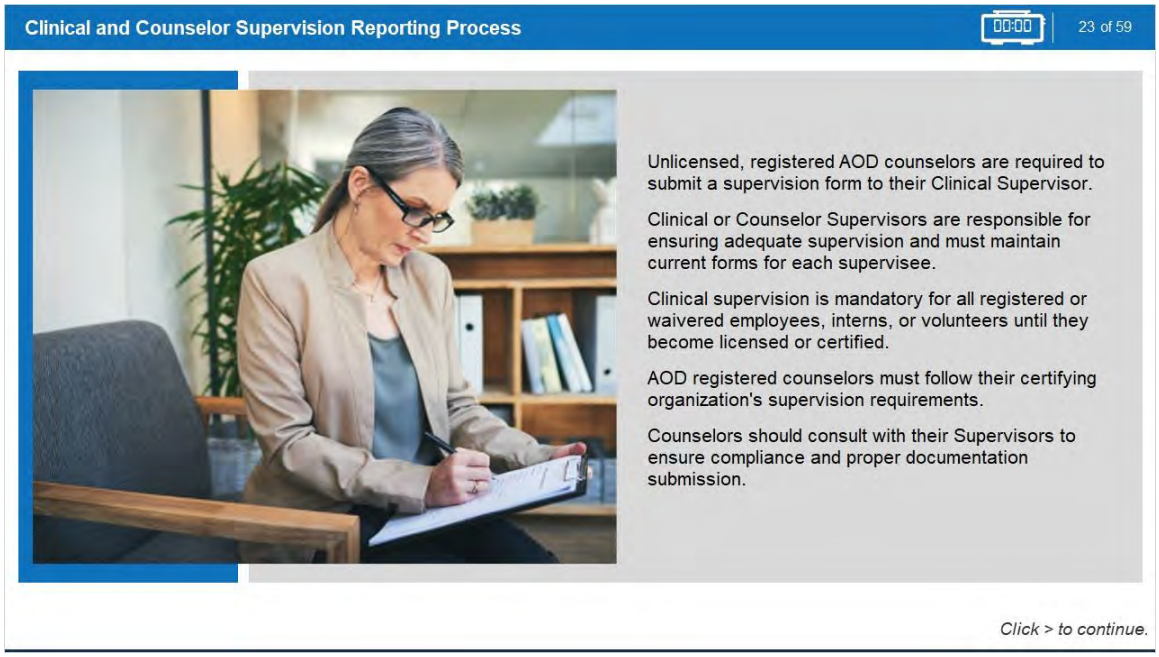
Clickable (Slide Layer)



More Info (Slide Layer)



4.10 Clinical and Counselor Supervision Reporting Process



Notes:

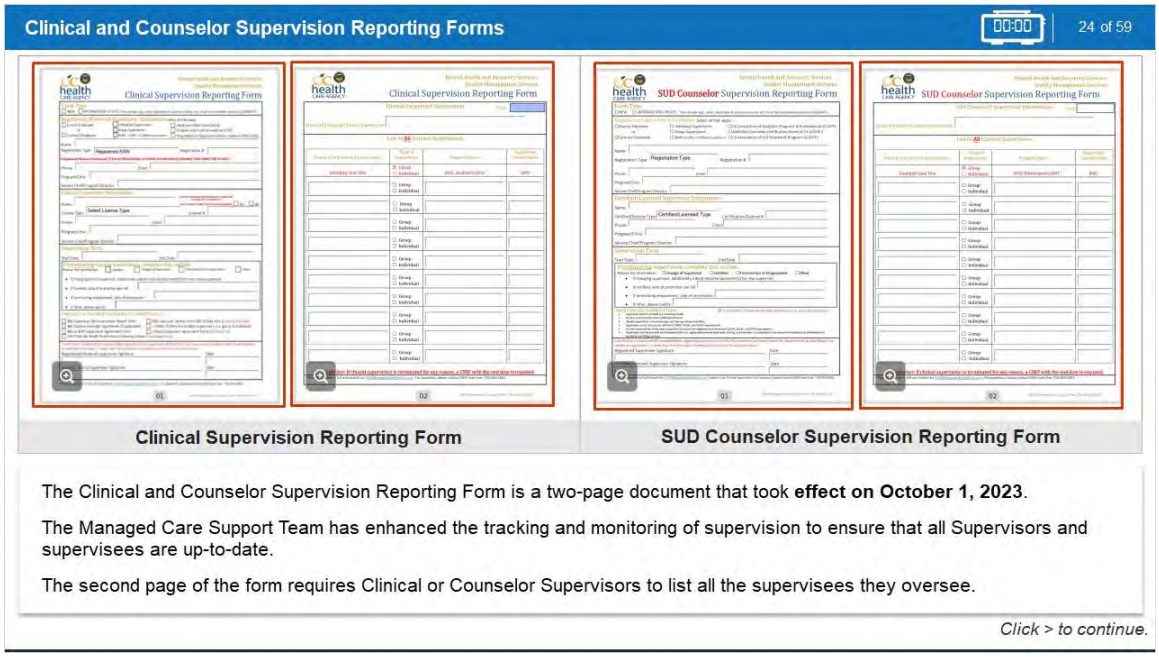
Unlicensed, registered AOD counselors are required to submit a supervision form to their Clinical Supervisor. Any updates to their supervision status require the submission of an updated form.

Clinical or Counselor Supervisors are responsible for ensuring adequate supervision and must maintain current forms for each Supervisee. It is recommended that Supervisors maintain their files for audit purposes.

Additionally, clinical supervision is mandatory for all registered or waivered employees, interns, or volunteers until they become licensed or certified. AOD registered counselors must follow their certifying organization's supervision requirements.

Counselors should consult with their Supervisors to ensure compliance and proper documentation submission. For general assistance, they can contact the Managed Care Support Team.

4.11 Clinical and Counselor Supervision Reporting Forms

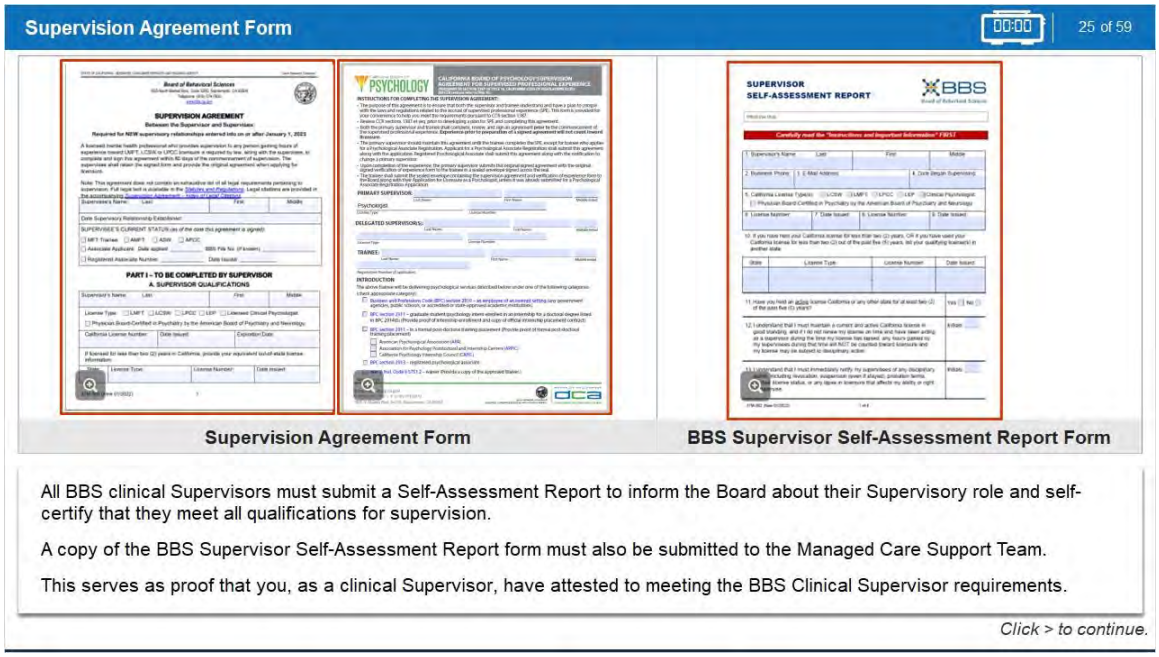


Notes:

The Clinical and Counselor Supervision Reporting Form is a two-page document that took effect on October 1, 2023. The Managed Care Support Team has enhanced the tracking and monitoring of supervision to ensure that all Supervisors and supervisees are up-to-date.

The second page of the form requires Clinical or Counselor Supervisors to list all the supervisees they oversee. This information allows the Managed Care Support Team to verify that both the supervisees and Supervisors have the most current forms on file, are properly accounted for, and meet compliance requirements.

4.12 Supervision Agreement Form



Notes:

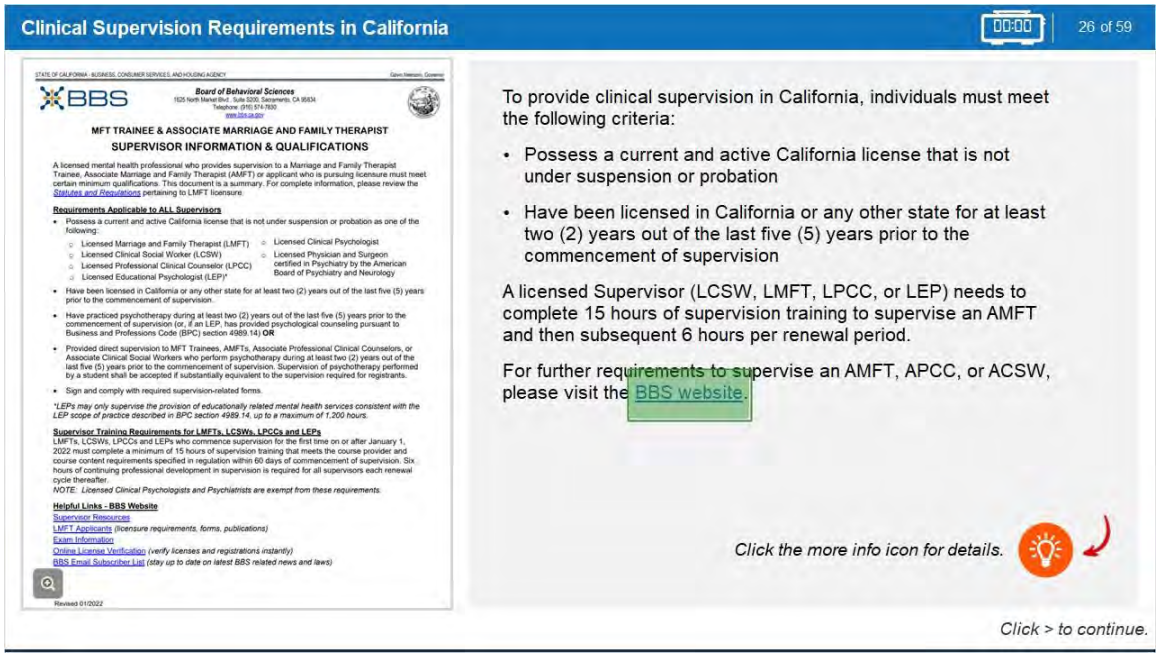
Displayed here is the Supervision Agreement form. For those registered through the BBS or BOP, Supervision Agreement form is also required when submitting your clinical supervision reporting form to the Managed Care Support Team.

You can download this form from the BBS or BOP websites. Both the Supervisor and the new supervisee must sign a Supervision Agreement within 60 days of commencing supervision. The supervisee should retain this agreement for submission to the board upon application for licensure.

Additionally, all BBS clinical Supervisors must submit a Self-Assessment Report to inform the Board about their supervisory role and self-certify that they meet all qualifications for supervision. These updated requirements came into effect on January 1, 2022.

A copy of the BBS Supervisor Self-Assessment Report form must also be submitted to the Managed Care Support Team. This serves as proof that you, as a clinical Supervisor, have attested to meeting the BBS Clinical Supervisor requirements.

4.13 Clinical Supervision Requirements in California



Notes:

Now that you're aware of the reporting forms, let's now learn about the qualification requirements. To provide clinical supervision in California, individuals must possess a current and active California license that is not under suspension or probation.

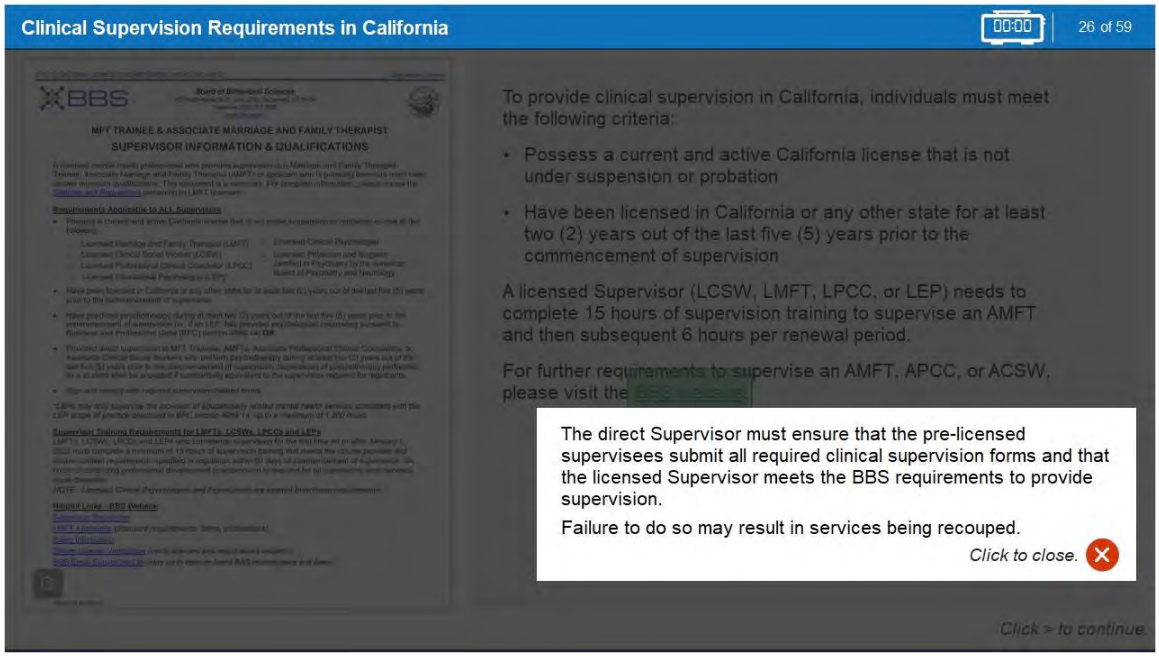
They should have been licensed in California or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision.

Additionally, a licensed supervisor needs to complete 15 hours of supervision training to supervise an AMFT and then subsequent 6 hours per renewal period. For further requirements to supervise an AMFT, APCC, or ACSW, please visit the BBS website.

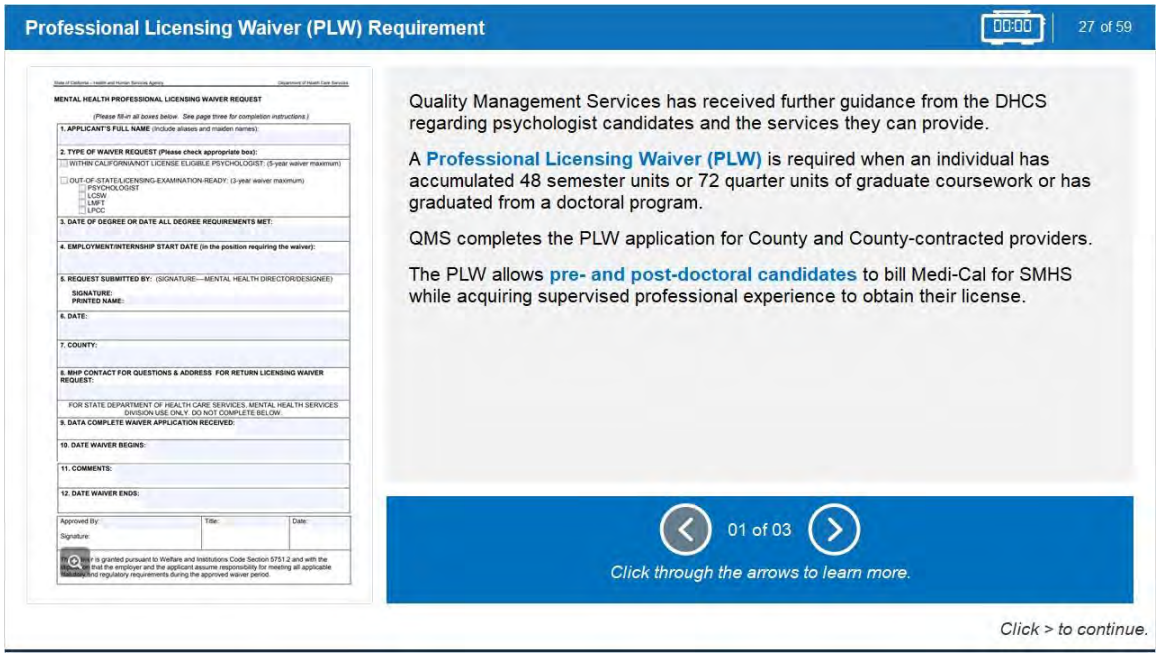
The direct Supervisor must ensure that the pre-licensed supervisees submit all required clinical supervision forms and that the licensed Supervisor meets the BBS requirements to provide supervision.

Failure to do so may result in services being recouped.

More Info (Slide Layer)



4.14 Professional Licensing Waiver (PLW) Requirement



Notes:

Quality Management Services has received further guidance from the DHCS regarding psychologist candidates and

the services they can provide.

A Professional Licensing Waiver (PLW) is required when an individual has accumulated 48 semester units or 72 quarter units of graduate coursework or has graduated from a doctoral program.

QMS completes the PLW application for County and County-contracted providers.

The PLW allows pre- and post-doctoral candidates to bill Medi-Cal for SMHS while acquiring supervised professional experience to obtain their license.

Before obtaining a PLW, a psychologist candidate is considered an Other Qualified Provider. As such, they can offer the following services:

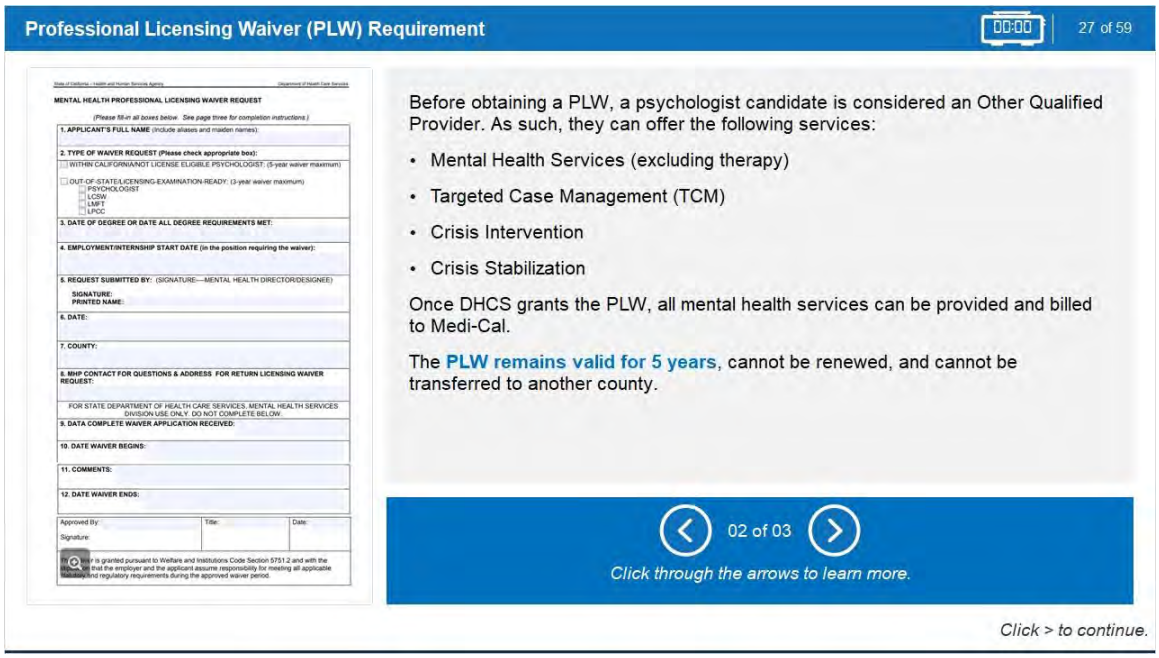
- Mental Health Services excluding therapy,
- Targeted Case Management (TCM),
- Crisis Intervention, and
- Crisis Stabilization.

These services must be conducted under the direction of a Licensed Mental Health Professional (LMHP) within their respective scope of practice, and all documentation must be co-signed.

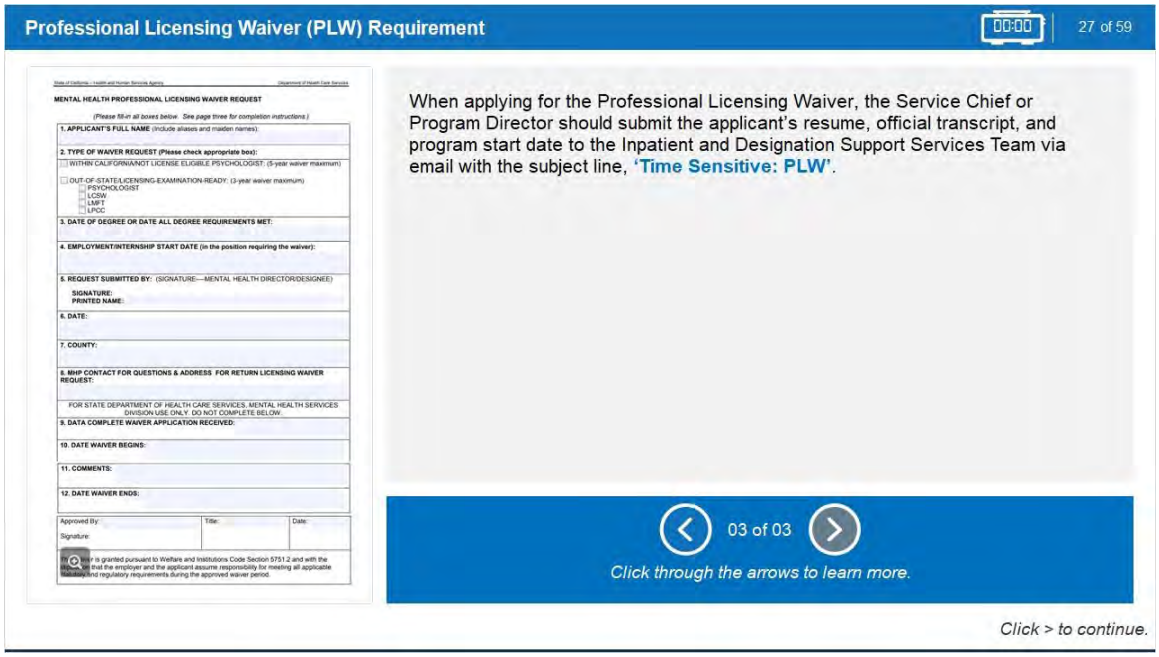
Once DHCS grants the PLW, all mental health services can be provided and billed to Medi-Cal. The PLW remains valid for 5 years, cannot be renewed, and cannot be transferred to another County.

When applying for the Professional Licensing Waiver, the Service Chief or Program Director should submit the applicant's resume, official transcript, and program start date to the Inpatient and Designation Support Services Team via email with the subject line, 'Time Sensitive: PLW'.

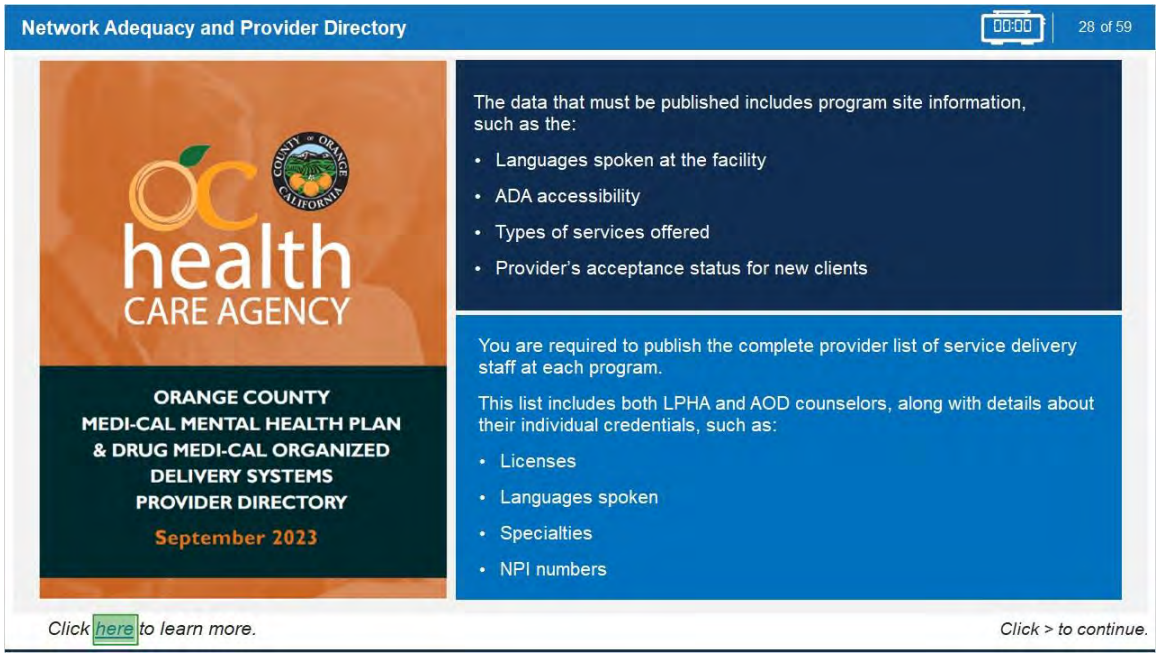
Tab 01 (Slide Layer)



Tab 02 (Slide Layer)



4.15 Network Adequacy and Provider Directory



Notes:

Network adequacy and the publication of our Provider Directory are also related to the managed care requirements

outlined in 42 CFR, Part 438.

The regulations state that you must provide clients with specified information about our network of providers in both paper and electronic form.

This includes County-operated programs, contracted organizational providers, provider groups, and individual practitioners.

The data that must be published includes program site information, such as the languages spoken at the facility, ADA accessibility, types of services offered, and the provider's acceptance status for new clients.

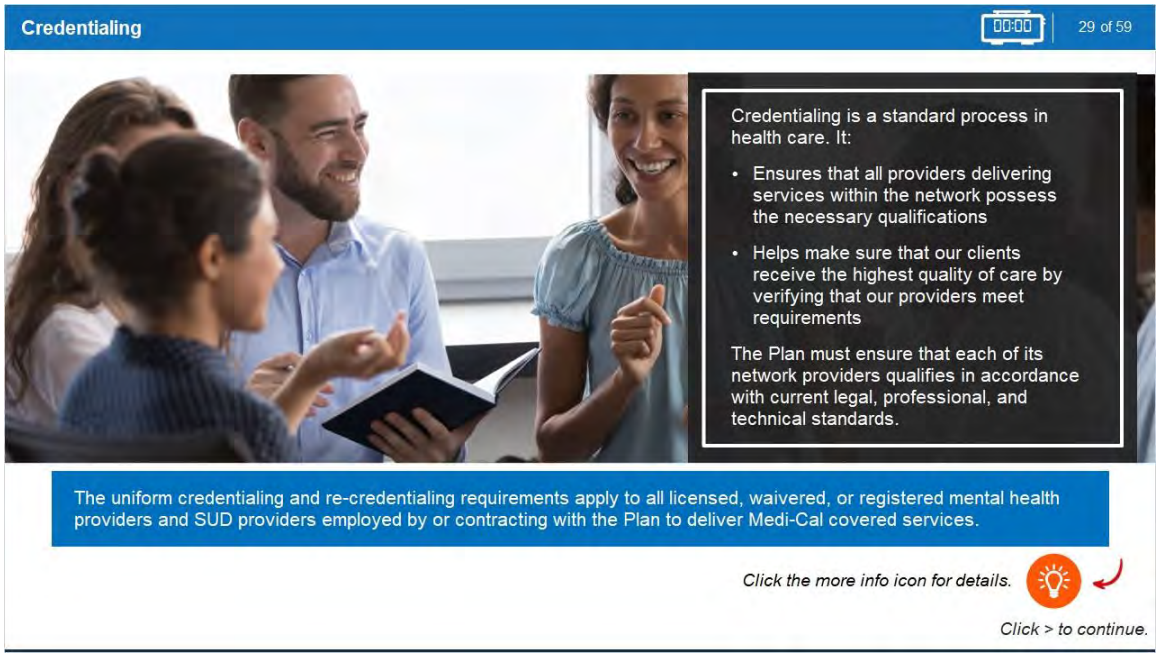
Additionally, you are required to publish the complete provider list of service delivery staff at each program.

This list includes both LPHA and AOD counselors, along with details about their individual credentials, such as licenses, languages spoken, specialties, NPI numbers, and other relevant information.

The data must remain current at all times, and the directory must be updated no later than every 30 days.

The directory must be updated sooner if the Plan learns of changes that affect services in the system.

4.16 Credentialing



Notes:

Now that you've gone through the clinical and counselor supervision requirements and reporting forms, let's now learn about credentialing.

Credentialing is a standard process in health care. It ensures that all providers delivering services within the network possess the necessary qualifications. Credentialing helps make sure that our clients receive the highest quality of care by verifying that our providers meet requirements.

The Plan must ensure that each of its network providers qualifies in accordance with current legal, professional, and

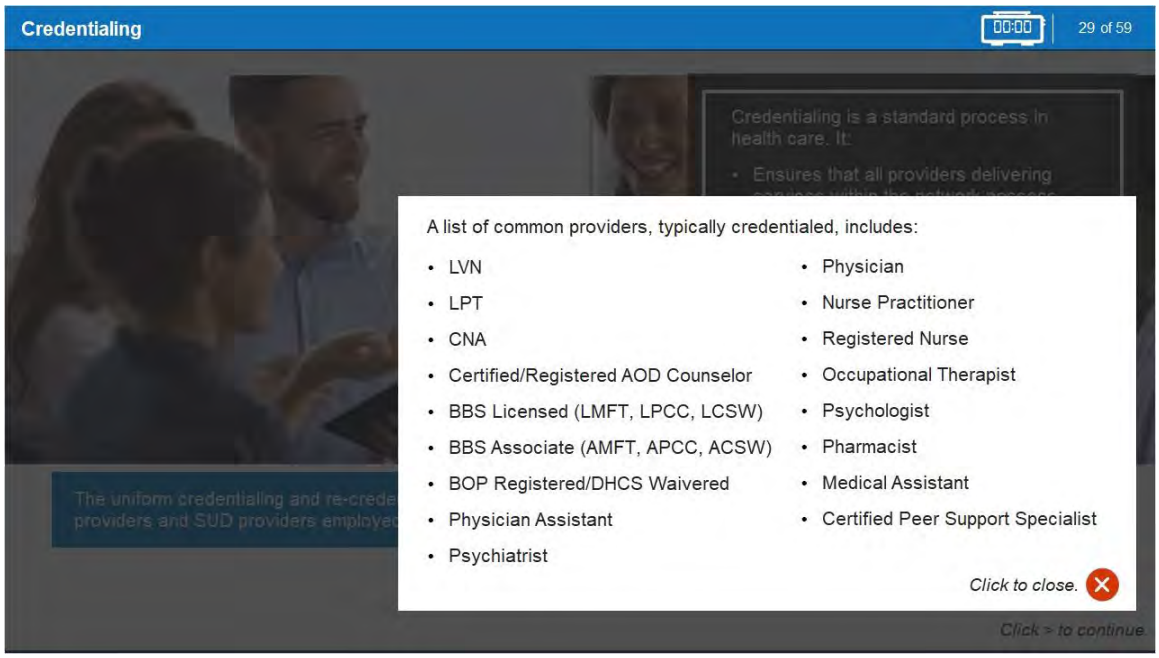
technical standards. These providers should be appropriately licensed, registered, waivered, and/or certified.

The uniform credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and SUD providers employed by or contracting with the Plan to deliver Medi-Cal covered services.

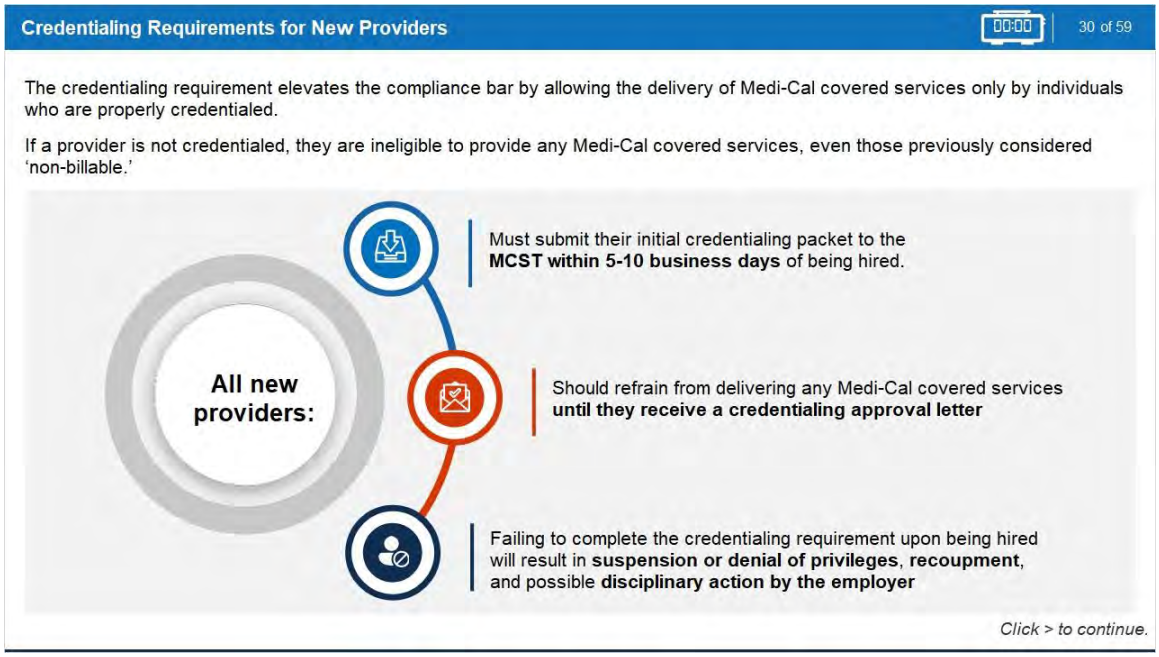
This is a Federal regulation, and it does not permit any Medi-Cal covered services to be delivered until a provider has been fully credentialed.

Displayed here is a list of common providers, typically credentialed. While it is not an exhaustive list, we encourage you to reach out to the Managed Care Support Team to speak with a credentialing representative if you have any uncertainties about a specific provider type.

More Info (Slide Layer)



4.17 Credentialing Requirements for New Providers



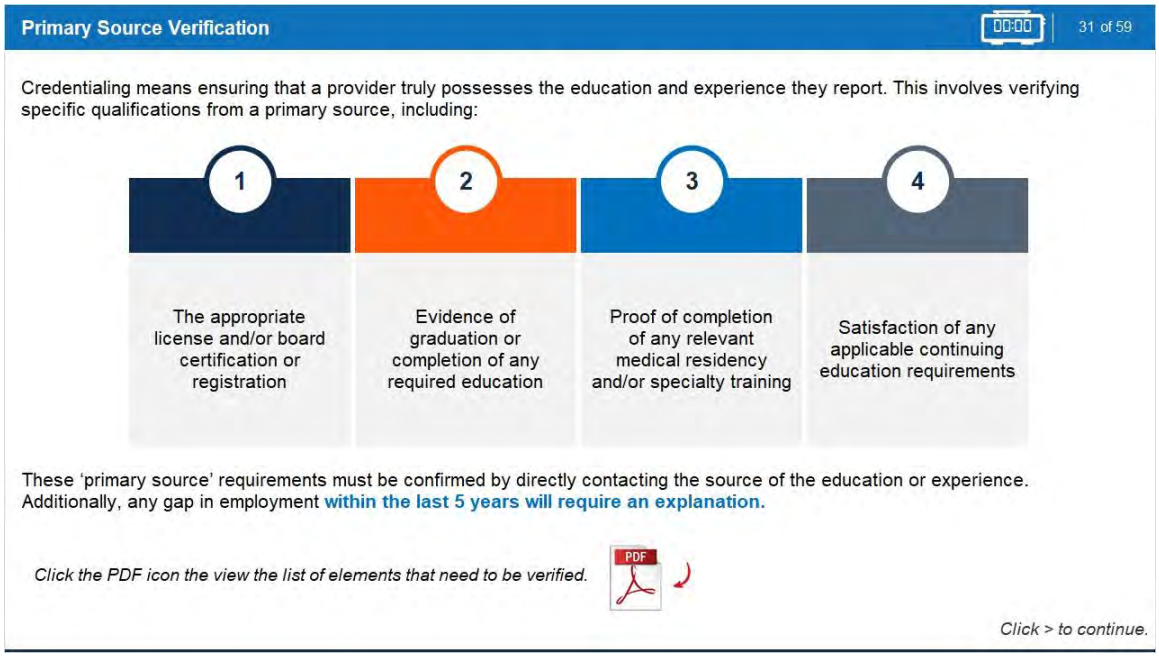
Notes:

The credentialing requirement elevates the compliance bar by allowing the delivery of Medi-Cal covered services only by individuals who are properly credentialed. If a provider is not credentialed, they are ineligible to provide any Medi-Cal covered services, even those previously considered 'non-billable.'

As a result, all new providers:

- Must submit their initial credentialing packet to the MCST within 5-10 business days of being hired,
- Should refrain from delivering any Medi-Cal covered services if they are not credentialed until they receive a credentialing approval letter, and
- Failing to complete the credentialing requirement upon being hired is a compliance issue that will result in suspension or denial of privileges, recoupment, and possible disciplinary action by the employer.

4.18 Primary Source Verification



Notes:

Credentialing means ensuring that a provider truly possesses the education and experience they report.

This involves verifying specific qualifications from a primary source, including:

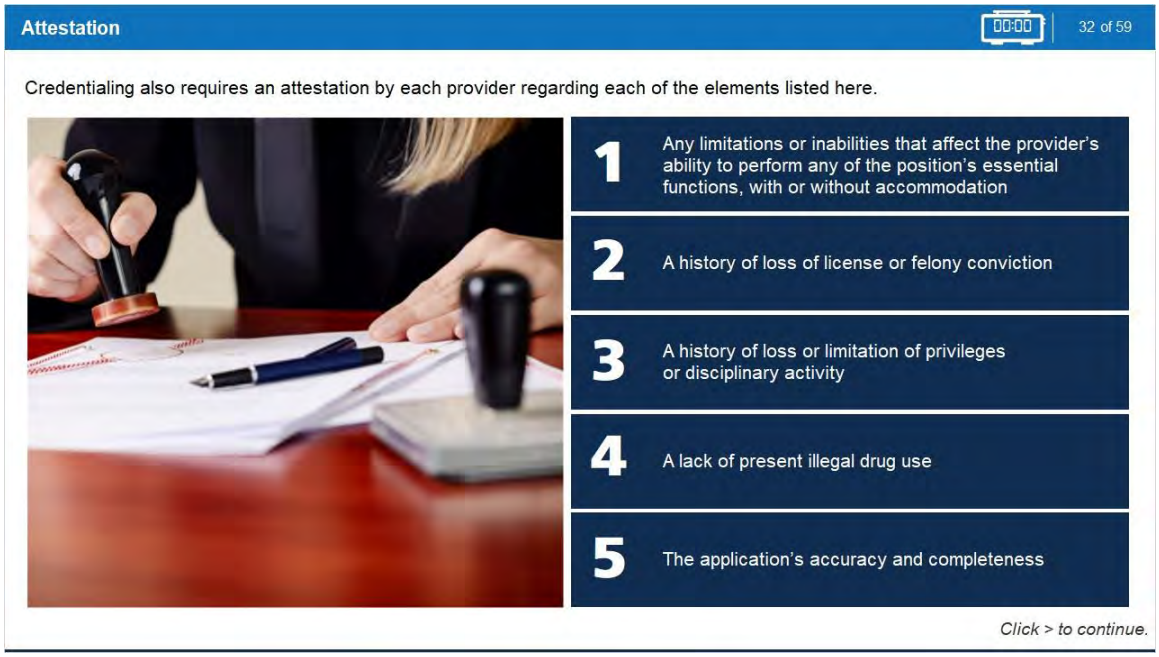
- The appropriate license and/or board certification or registration, as required for the particular provider type.
- Evidence of graduation or completion of any required education, as required for the particular provider type.
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type.
- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

For example, obtaining confirmation from the school the person attended to verify that the provider indeed attended the school and that it occurred when the provider claimed.

These 'primary source' requirements must be confirmed by directly contacting the source of the education or experience.

Additionally, any gap in employment within the last 5 years will require an explanation.

4.19 Attestation



Notes:

Credentialing also requires an attestation by each provider regarding each of the elements listed on the slide.

As providers progress through the credentialing process, they will be asked to either verify or input information about their professional history into the HCA's credentialing system, as required.

When finalizing their credentialing application, providers will be required to attest to the five items listed on the slide.

It's important to note that the answers to these items do not automatically disqualify a provider from becoming credentialed. If necessary, applicants will be referred to their organization's appropriate body for assistance.

4.20 Re-Credentialing

Notes:

Re-credentialing must occur every three years to verify that the provider continues to possess valid credentials. During this process, providers are required to submit a new signed attestation.

In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process.

These sources may include quality improvement activities, client grievances, and medical record reviews.

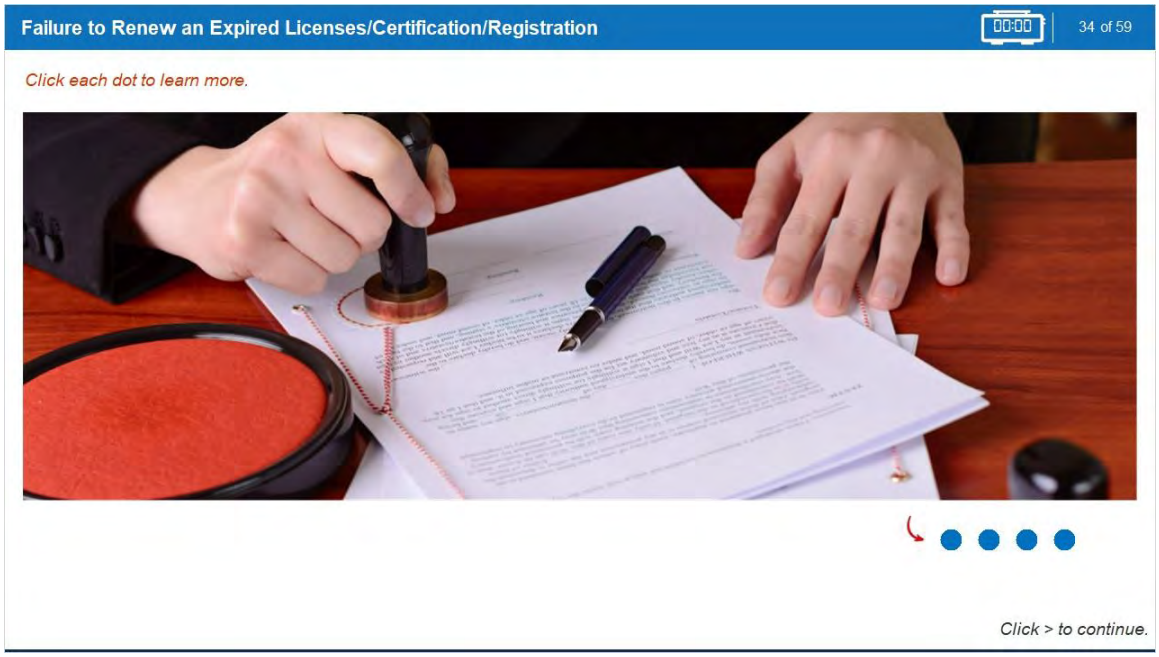
HCA has contracted a Credentialing Verification Organization (CVO) to perform the verification steps of credentialing, except for making the final credentialing decision. Ultimately, BHS retains responsibility for the final decision.

By leveraging the partnership with the CVO, the Plan maintains an ongoing database for each provider.

This database can be updated as new events occur, including license renewals, continuing education certificates, certifications, education, and other relevant information.

By keeping their profile current at all times, a provider makes their re-credentialing process very fast and simple.

4.21 Failure to Renew an Expired Licenses/Certification/Registration



Notes:

Failure to meet and maintain all credentialing requirements will result in an email notification from the MCST. This notification will inform you of the suspension and denial of privileges for delivering services that require licensure within the Orange County Health Care Agency.

Providing Medi-Cal covered services without proper credentials not only results in the loss of revenue due to disallowed or recouped services but could lead to possible disciplinary action by the provider's Human Resources department.

Additionally, QMS will initiate a Compliance Investigation, necessitating immediate action. Disciplinary measures may also be taken by Human Resources.

It is important to remember that the provider's reinstatement is not automatic.

The provider must contact MCST and IRIS immediately to reactivate their IRIS access and must provide proof of the license, certification, or registration renewal.

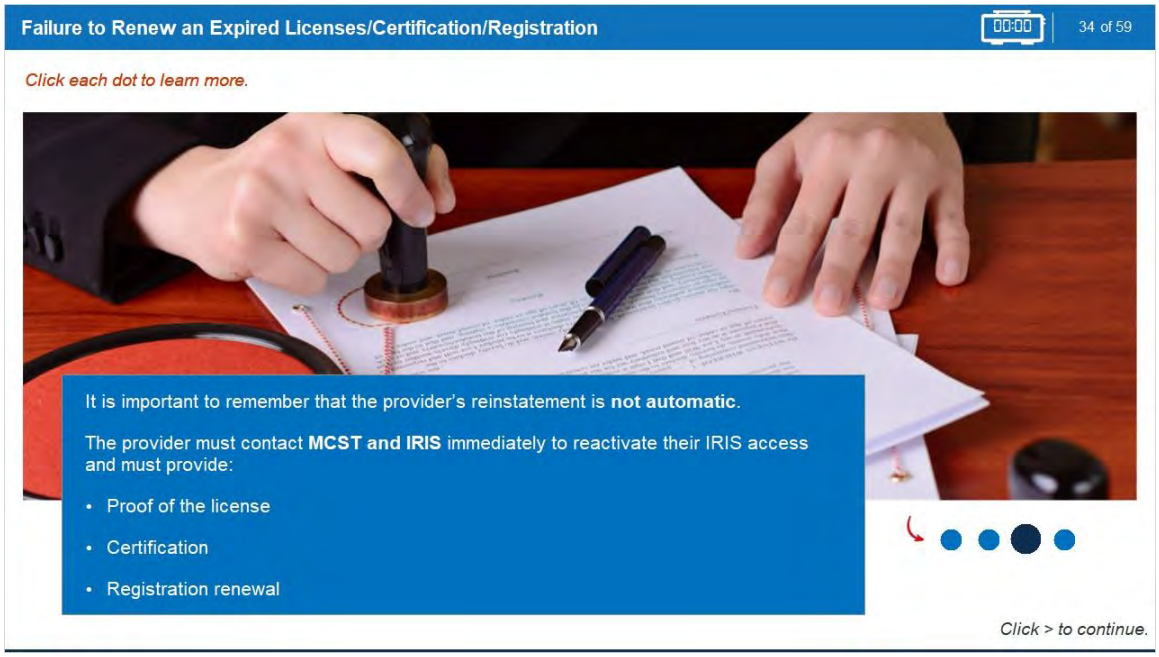
Continuing to offer services with an expired license is a compliance issue that requires close monitoring by the provider, program, and Contract Monitors.

Lastly, it's essential to remember that reactivation is not retroactive. Providers should refrain from delivering any Medi-Cal covered services if their credentialing is suspended.

Tab 1 (Slide Layer)

Tab 2 (Slide Layer)

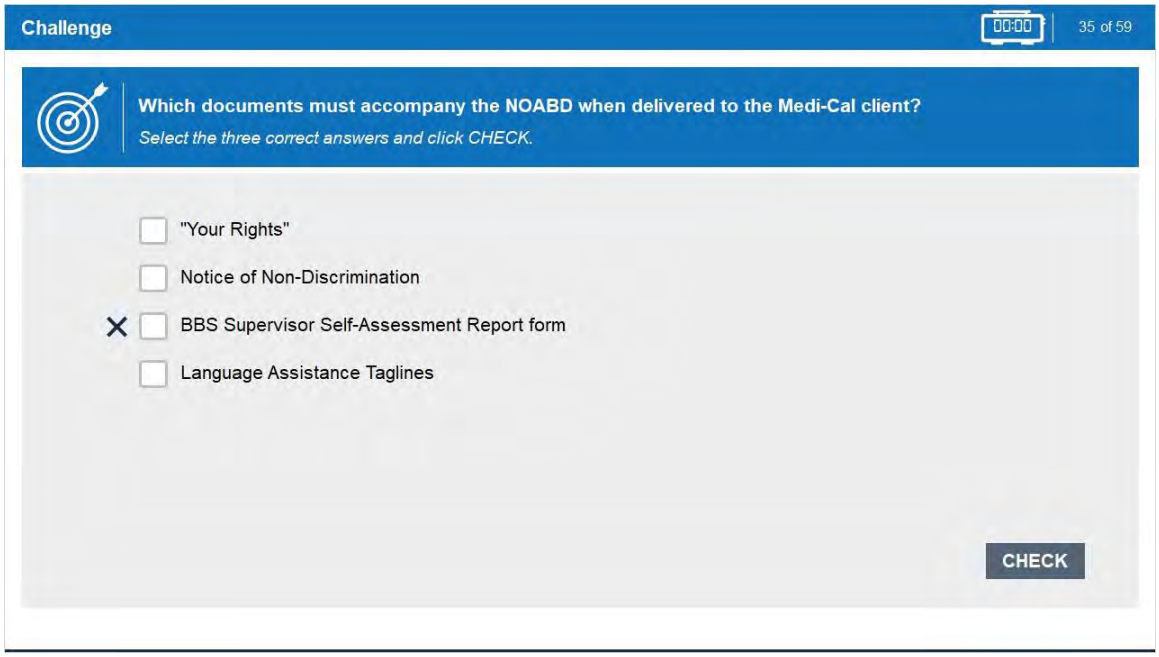
Tab 3 (Slide Layer)



Tab 4 (Slide Layer)

4.22 Challenge

(Pick Many, 10 points, 1 attempt permitted)



Correct	Choice
X	"Your Rights"
X	Notice of Non-Discrimination
	BBS Supervisor Self-Assessment Report form
X	Language Assistance Taglines

Notes:

It's time for an activity.

Which documents must accompany the NOABD when delivered to the Medi-Cal client?

Correct (Slide Layer)

Challenge 00:00 35 of 59

Which documents must accompany the NOABD when delivered to the Medi-Cal client?

Select the three correct answers and click CHECK.

- ✓ ☐ "Your Rights"
- ✓ ☐ Notice of Non-Discrimination
- ✗ ☐ BBS Supervisor Self-Assessment Report form
- ✓ ☐ Language Assistance Taglines

Excellent! This notice must be accompanied by three enclosure documents: "Your Rights," Language Assistance Taglines, and the Notice of Non-Discrimination.

CHECK

Click > to continue.

Incorrect (Slide Layer)

Challenge 00:00 35 of 59

Which documents must accompany the NOABD when delivered to the Medi-Cal client?

Select the three correct answers and click CHECK.

- ✓ ☐ "Your Rights"
- ✓ ☐ Notice of Non-Discrimination
- ✗ ☐ BBS Supervisor Self-Assessment Report form
- ✓ ☐ Language Assistance Taglines

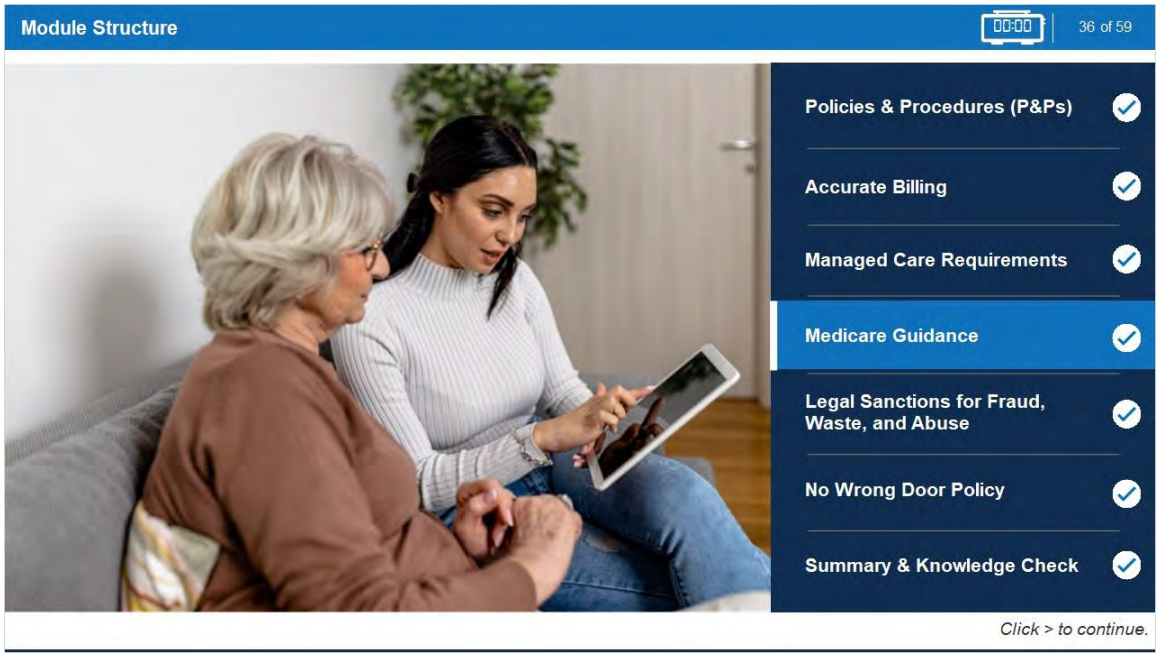
Not quite. This notice must be accompanied by three enclosure documents: "Your Rights," Language Assistance Taglines, and the Notice of Non-Discrimination.

CHECK

Click > to continue.

5. Medicare Guidance

5.1 Module Structure



Notes:

Now that we've gone through Managed Care Requirements, let's move on to Medicare Guidance.

5.2 Medicare Guidance

Medicare Guidance 00:00 37 of 59

BHS documentation and billing for Medi-Cal clients significantly changed following the implementation of CalAIM.

The QMS shifted its focus to training HCA providers on the new CalAIM standards.

The **Office of Inspector General (OIG)** regularly publishes a semiannual report to Congress, detailing both spending and instances of misspending of Medicare funds.

In their most recent report, the OIG:

- Highlighted multiple investigations into services billed to Medicare that did not meet Medicare requirements
- Recommended recoupment of Medicare funds for these investigated services

Click > to continue.

Notes:

BHS documentation and billing for Medi-Cal clients significantly changed following the implementation of CalAIM.

The Quality Management Services (QMS) shifted its focus to training HCA providers on documenting and billing according to the new CalAIM standards.

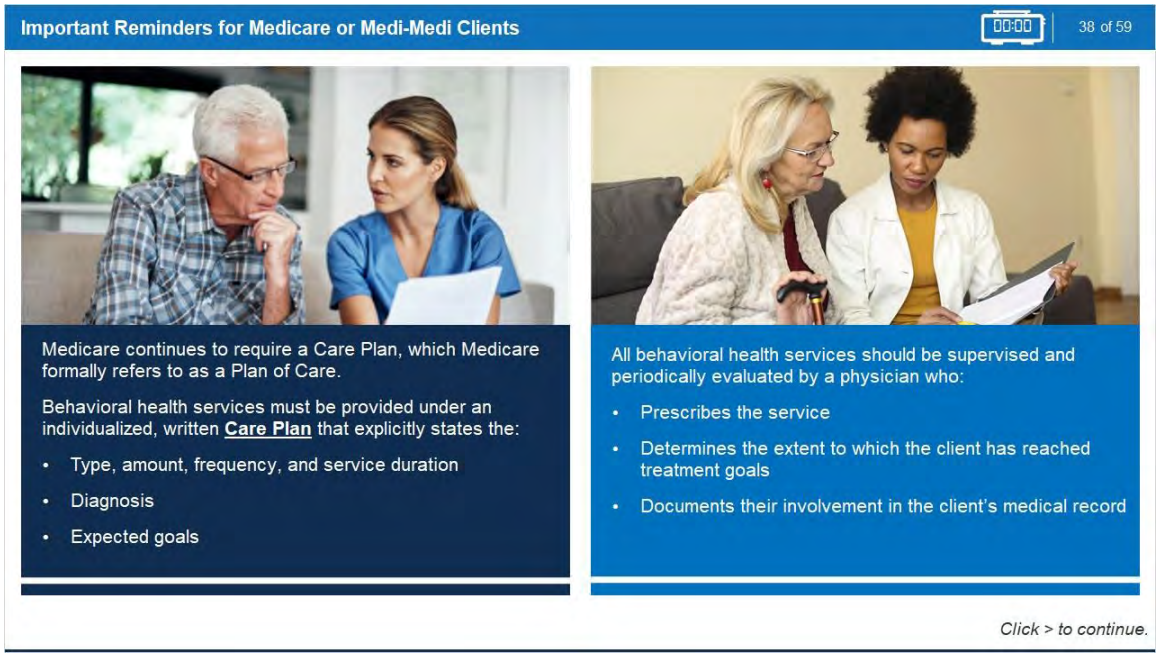
Notably, while the Medi-Cal requirements were changed, the Medicare documentation and billing requirements remained unchanged.

Consequently, we now aim to redirect some of our attention to Medicare.

The Office of Inspector General (OIG) regularly publishes a semiannual report to Congress, detailing both spending and instances of misspending of Medicare funds.

In their most recent report, the OIG highlighted multiple investigations related to services billed to Medicare that did not adhere to Medicare requirements. As a result, the OIG recommended recouping Medicare funds for these investigated services.

5.3 Important Reminders for Medicare or Medi-Medi Clients



Notes:

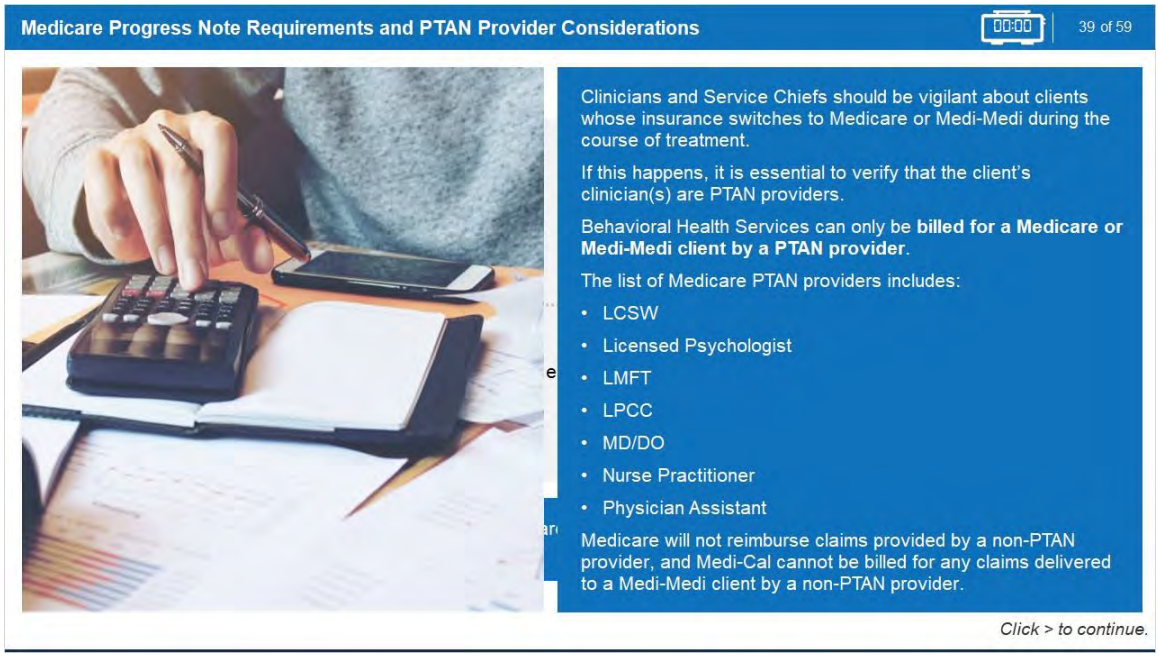
Let's now look at the essential reminders about Medicare requirements that all providers delivering behavioral health services to Medicare/Medi-Medi clients must follow.

Unlike most services under CalAIM, Medicare continues to require a Care Plan, which Medicare formally refers to as a Plan of Care.

For Medicare or Medi-Medi clients, behavioral health services must be provided under an individualized, written Care Plan that explicitly states the type, amount, frequency, and service duration, diagnosis, and expected goals.

Specifically, all behavioral health services should be supervised and periodically evaluated by a physician who prescribes the service, determines the extent to which the client has reached treatment goals, and documents their involvement in the client's medical record.

5.4 Medicare Progress Note Requirements and PTAN Provider Considerations



Notes:

The Medicare progress note requirements include:

- Name of the client and date of service,
- Type of service,
- Time element,
- Modalities and frequency of treatment,
- A clinical summary of the encounter, including but not limited to symptoms, functional status, and progress to date, and
- Professional credentials of the person performing the service.

Please ensure that you capture all the listed requirements in your progress notes for all Medicare and/or Medi-Medi clients.

It is important to note that all services ordered or rendered to Medicare clients must be legibly signed by the provider, along with their professional credentials.

Clinicians and Service Chiefs should be vigilant about clients whose insurance switches to Medicare or Medi-Medi during the course of treatment. If this happens, it is essential to verify that the client's clinician(s) are PTAN providers.

Behavioral Health Services can only be billed for a Medicare or Medi-Medi client by a PTAN provider.

The list of Medicare PTAN providers includes:

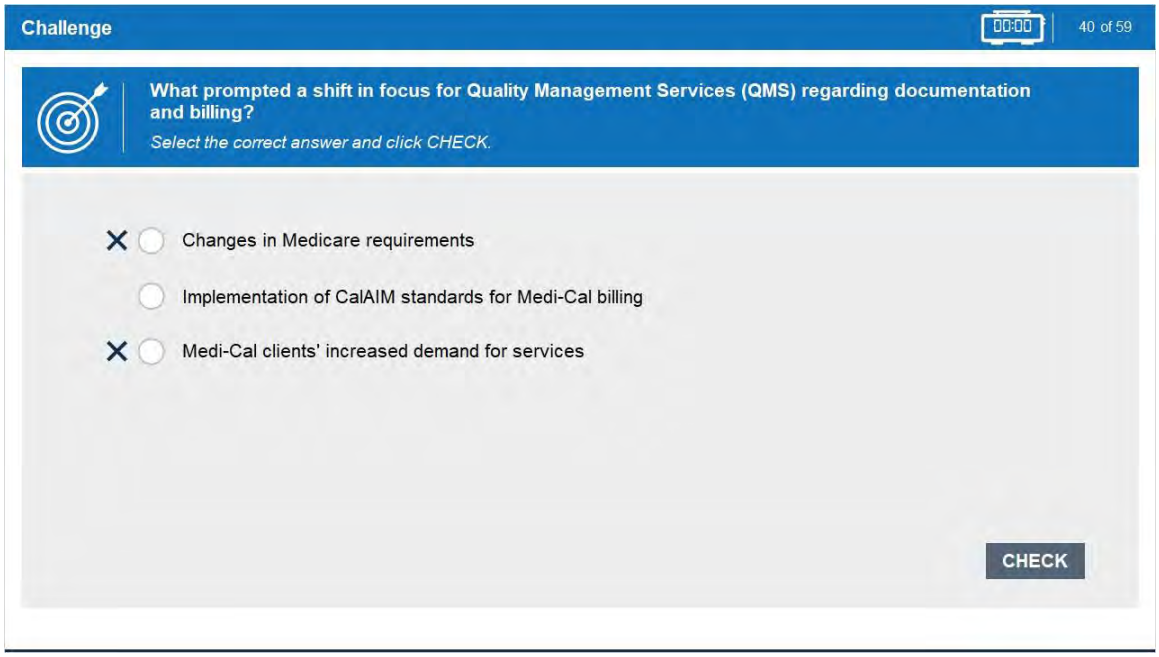
- LCSW,
- Licensed Psychologist,

- LMFT,
- LPCC,
- MD/DO,
- Nurse Practitioner, and
- Physician Assistant.

Medicare will not reimburse claims provided by a non-PTAN provider, and Medi-Cal cannot be billed for any claims delivered to a Medi-Medi client by a non-PTAN provider.

5.5 Challenge

(Pick One, 10 points, 1 attempt permitted)



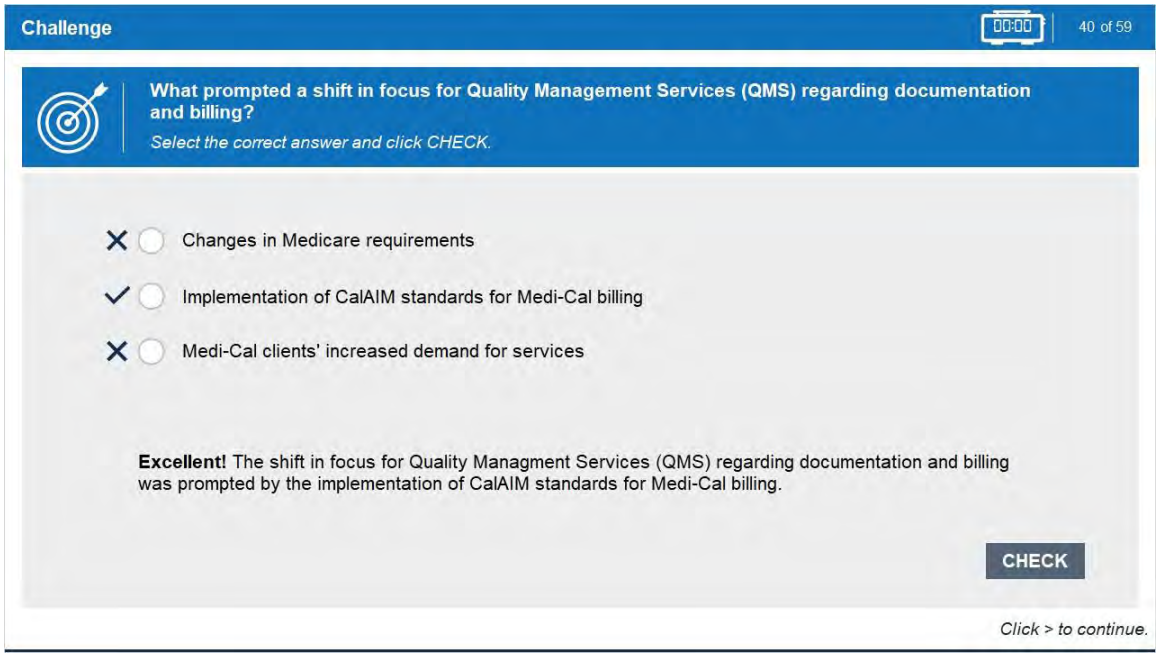
Correct	Choice
	Changes in Medicare requirements
X	Implementation of CalAIM standards for Medi-Cal billing
	Medi-Cal clients' increased demand for services

Notes:

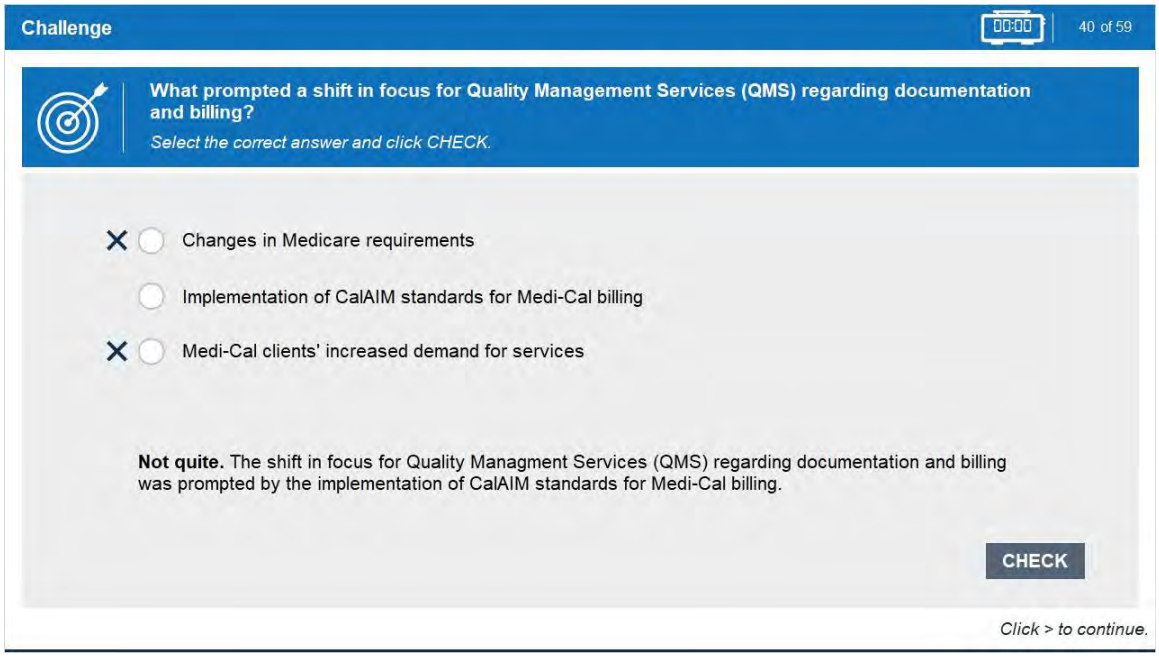
It's time for an activity.

What prompted a shift in focus for Quality Management Services (QMS) regarding documentation and billing?

Correct (Slide Layer)

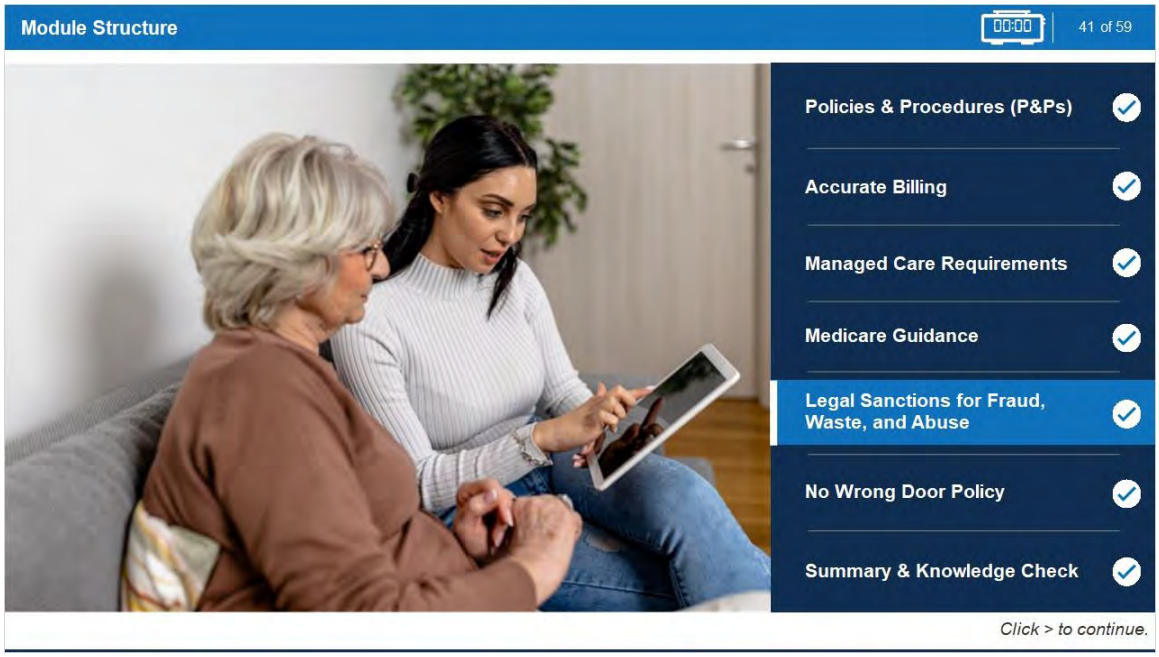


Incorrect (Slide Layer)



6. Legal Sanctions for Fraud, Waste, and Abuse

6.1 Module Structure



Notes:

That was about Medicare Guidance. Let's now move on to Legal Sanctions for Fraud, Waste, and Abuse.

6.2 Responsibilities of the HCA Compliance Program

Notes:

The Health Care Agency Compliance Program is responsible for ensuring organizational compliance with Federal and State regulatory requirements.

The compliance program establishes standards of compliance and ethical conduct for HCA staff, provides ongoing support and education, and offers a mechanism by which to report suspected violations.

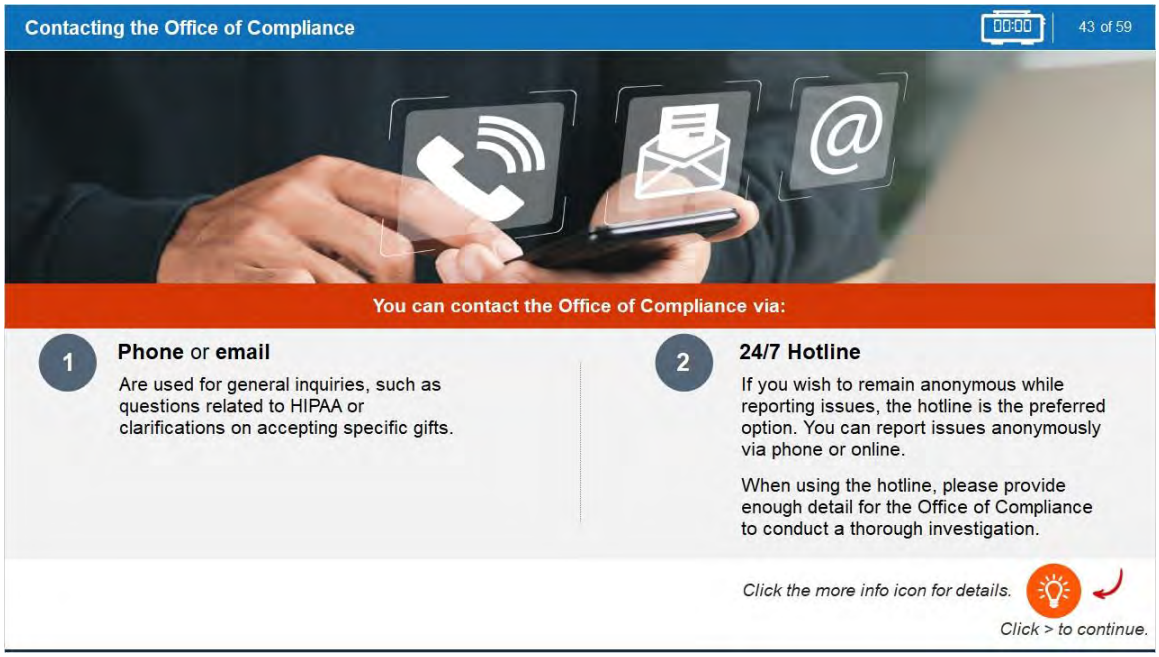
The Office of Compliance also works to prevent, detect, and correct potential violations of law and policy.

Additionally, the Office of Compliance is responsible for the daily management of HIPAA privacy incidents, risk assessments, breach analysis of unsecured Protected Health Information (PHI), and government reporting.

The implementation and effective operation of the HCA Compliance Program ensures that the program adheres to the elements of an effective compliance program established by the Office of Inspector General's (OIG) Federal Sentencing Guidelines.

For providers who have not opted into the County's Compliance Program, please consult with your agency's compliance officer.

6.3 Contacting the Office of Compliance



Notes:

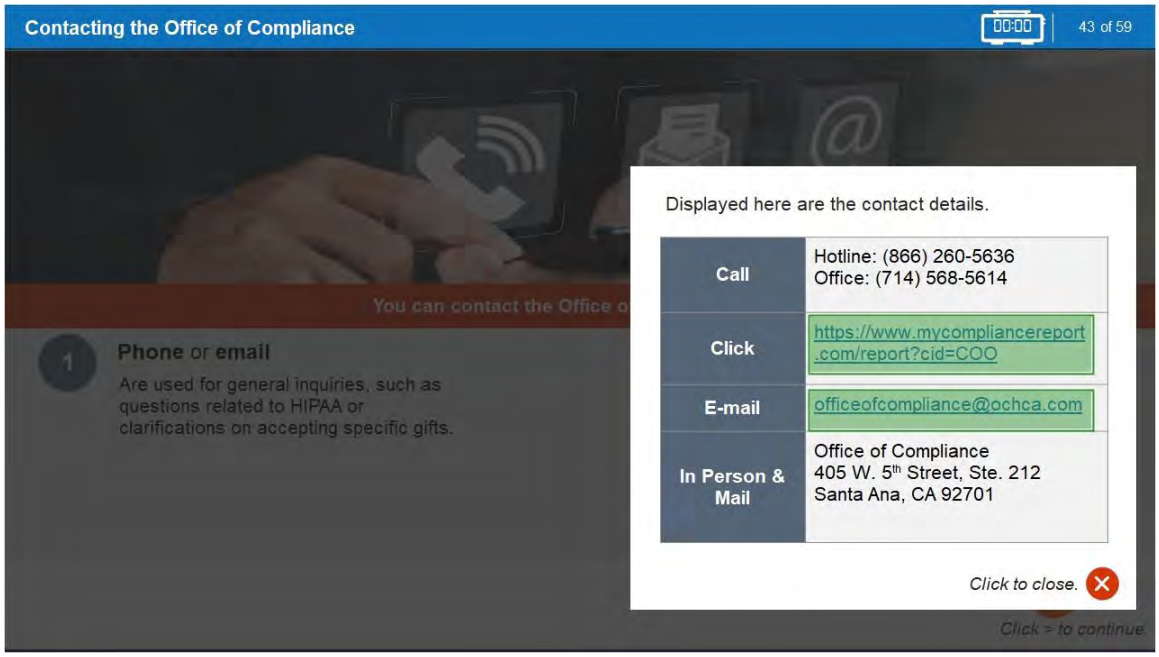
The Office of Compliance offers a variety of methods for you to contact them. You can reach out via the phone or email for general inquiries, such as questions related to HIPAA or clarifications on accepting specific gifts.

Alternatively, if you prefer to remain anonymous while reporting issues, the hotline (provided by a third-party vendor) is the preferred option. You can report issues anonymously via phone or online. When using the hotline, please provide enough detail for the Office of Compliance to conduct a thorough investigation.

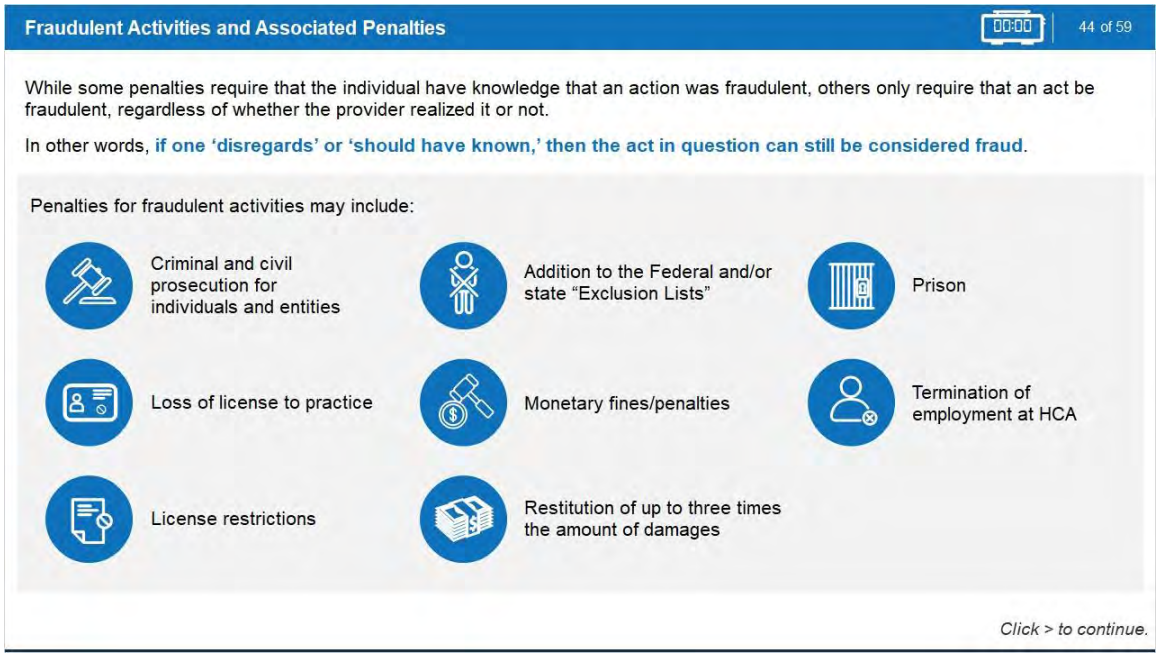
If you prefer not to remain anonymous, you can always reach out via the phone or email.

Displayed here is the Office of Compliance's email address, office phone number, hotline phone number, and link for anonymous reporting. These issues can be reported 24 hours a day, 7 days a week.

More Info (Slide Layer)



6.4 Fraudulent Activities and Associated Penalties



Notes:

While some penalties require that the individual have knowledge that an action was fraudulent, others only require

that an act be fraudulent, regardless of whether the provider realized it or not.

This includes making false statements and omitting and/or misrepresenting information.

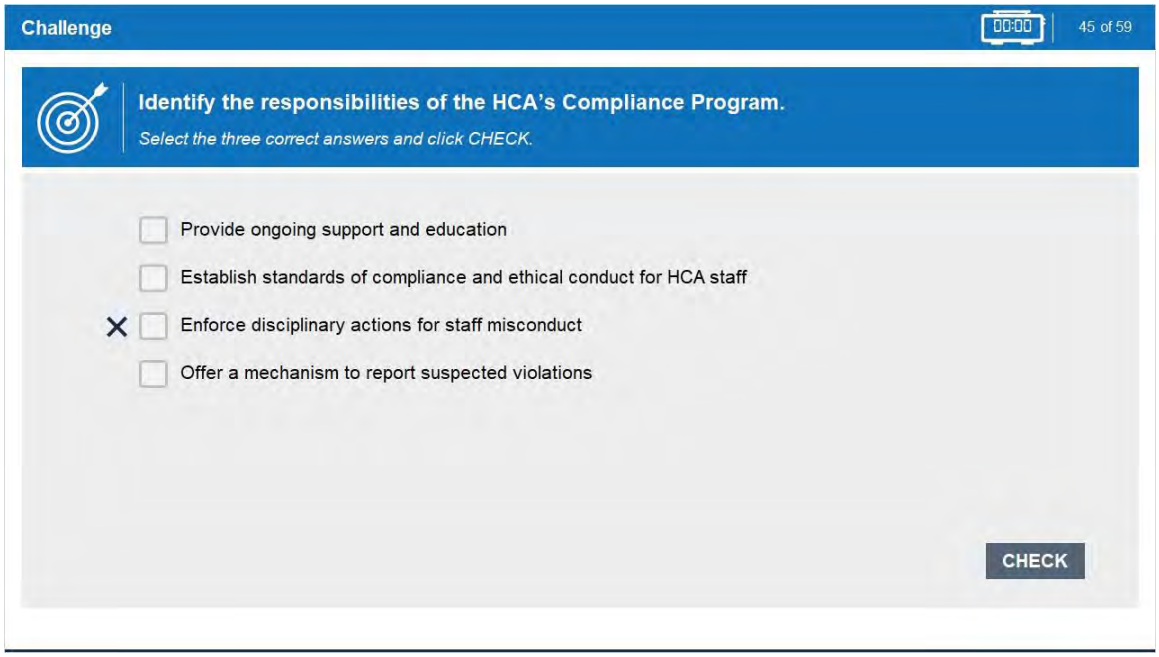
In other words, if one 'disregards' or 'should have known,' then the act in question can still be considered fraud.

Penalties for fraudulent activities may include criminal and civil prosecution for individuals and entities, loss of license to practice, license restrictions, addition to the Federal and/or state "Exclusion Lists," monetary fines/penalties, restitution of up to three times the amount of damages, or prison.

Finally, fraudulent activity may result in the termination of employment at HCA.

6.5 Challenge

(Pick Many, 10 points, 1 attempt permitted)



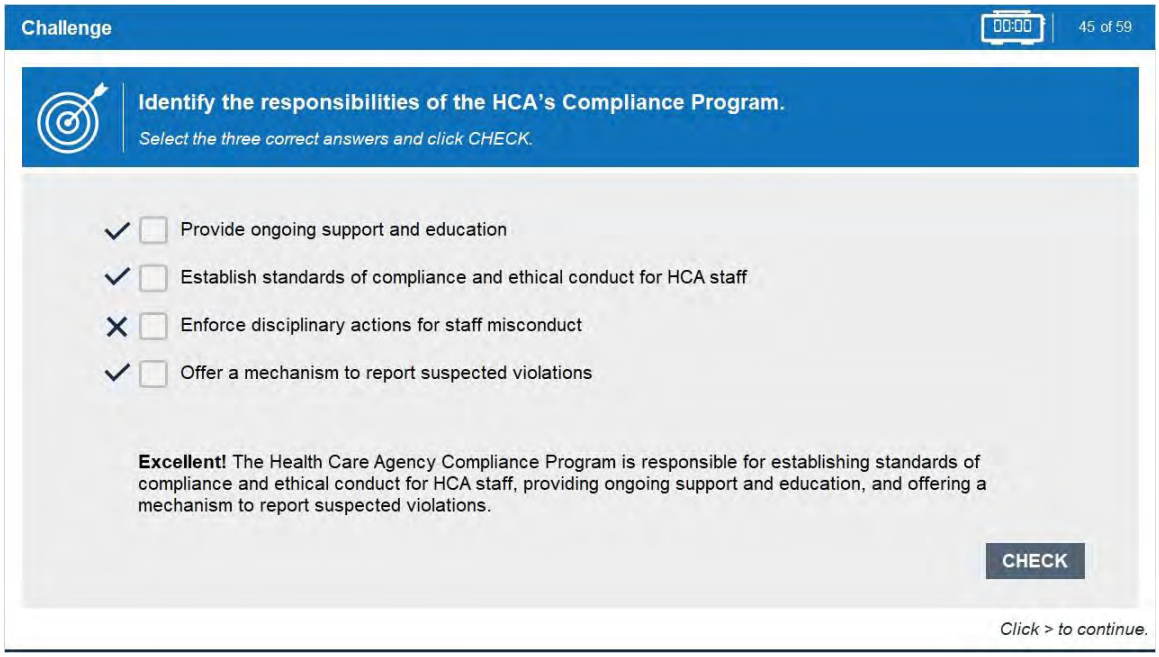
Correct	Choice
X	Rectangle 1
X	Rectangle 2
	Rectangle 3
X	Rectangle 4

Notes:

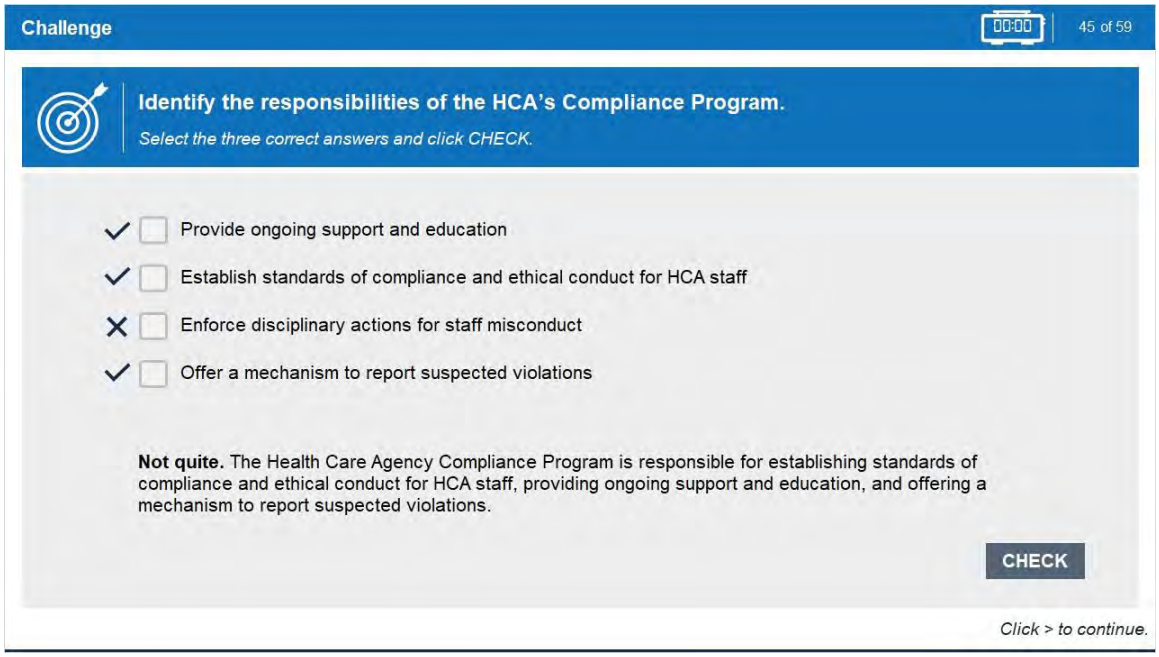
It's time for an activity.

Identify the responsibilities of the HCA's Compliance Program.

Correct (Slide Layer)

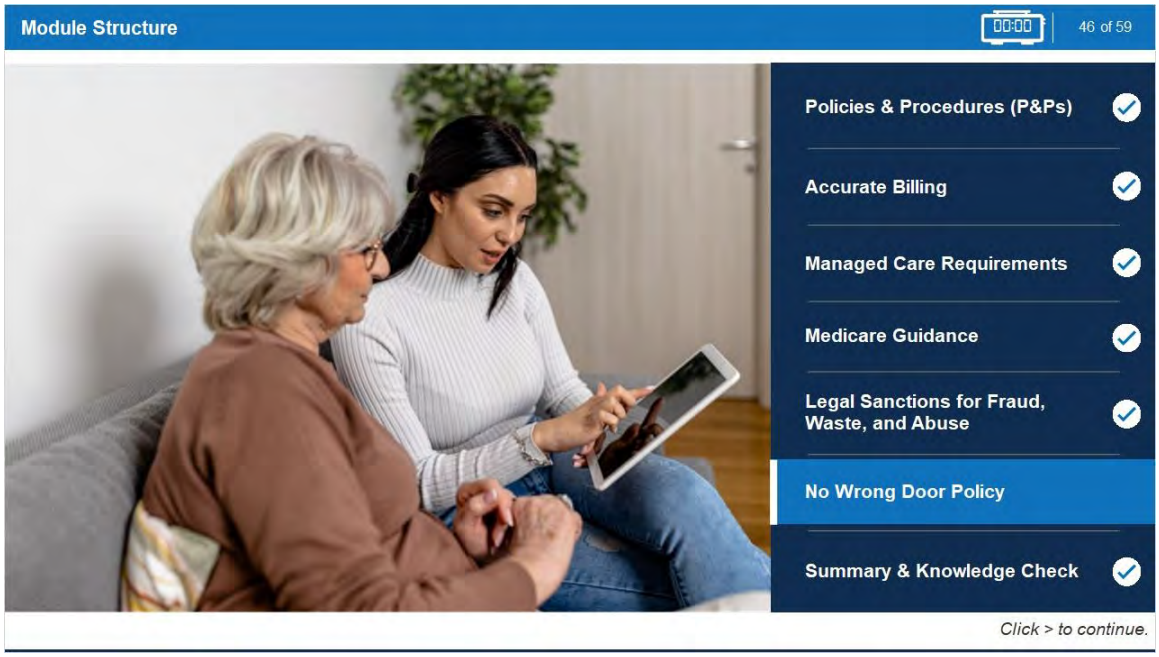


Incorrect (Slide Layer)



7. No Wrong Door Policy

7.1 Module Structure



Notes:

Now that we've learned about the Legal Sanctions for Fraud, Waste, and Abuse, let's move on to the No Wrong Door Policy.

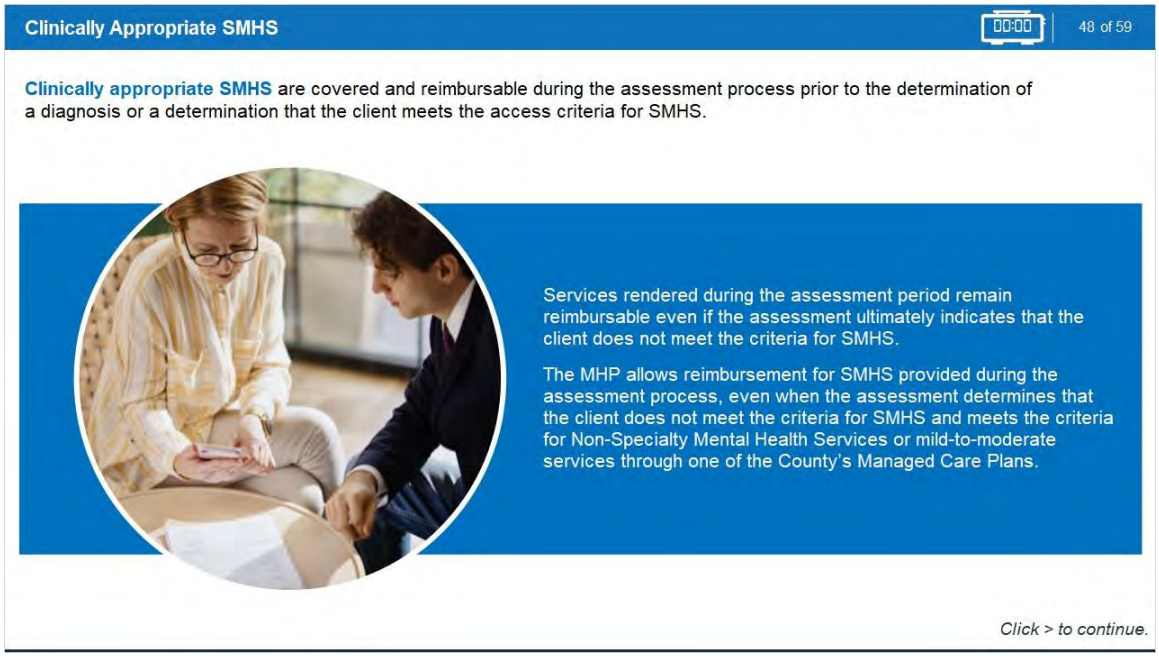
7.2 Introduction to the No Wrong Door Policy

Notes:

The California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to address clients' needs across the continuum of care. It seeks to ensure that all clients receive coordinated services and improve their health outcomes.

The No Wrong Door policy for Behavioral Health Services, which became effective on July 1, 2022, ensures that Medi-Cal clients receive timely mental health and substance abuse services without delay, regardless of the delivery system where they seek care, and that clients are able to maintain treatment relationships with trusted providers without interruption.

7.3 Clinically Appropriate SMHS



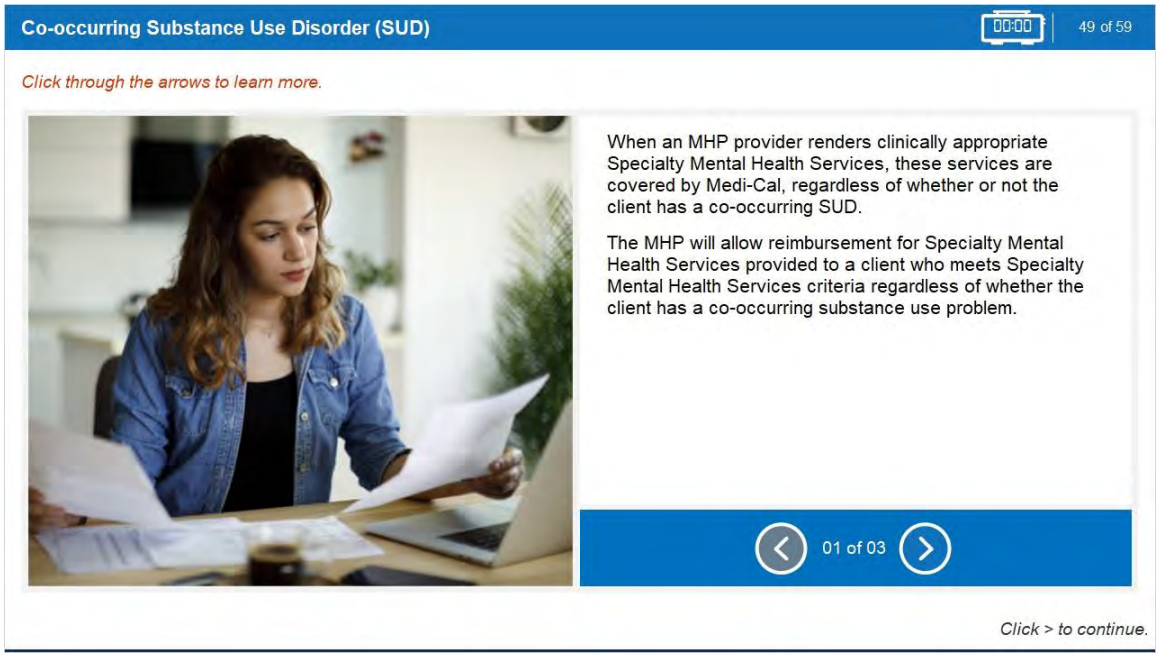
Notes:

Now that you're aware of the No Wrong Door policy, let's have a closer look at the policy.

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to the determination of a diagnosis or a determination that the client meets the access criteria for SMHS. Importantly, services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates that the client does not meet the criteria for SMHS.

Furthermore, the MHP allows reimbursement for SMHS provided during the assessment process, even when the assessment determines that the client does not meet the criteria for SMHS and meets the criteria for Non-Specialty Mental Health Services or mild-to-moderate services through one of the County's Managed Care Plans.

7.4 Co-occurring Substance Use Disorder (SUD)



Notes:

When an MHP provider renders clinically appropriate Specialty Mental Health Services, these services are covered by Medi-Cal, regardless of whether or not the client has a co-occurring SUD.

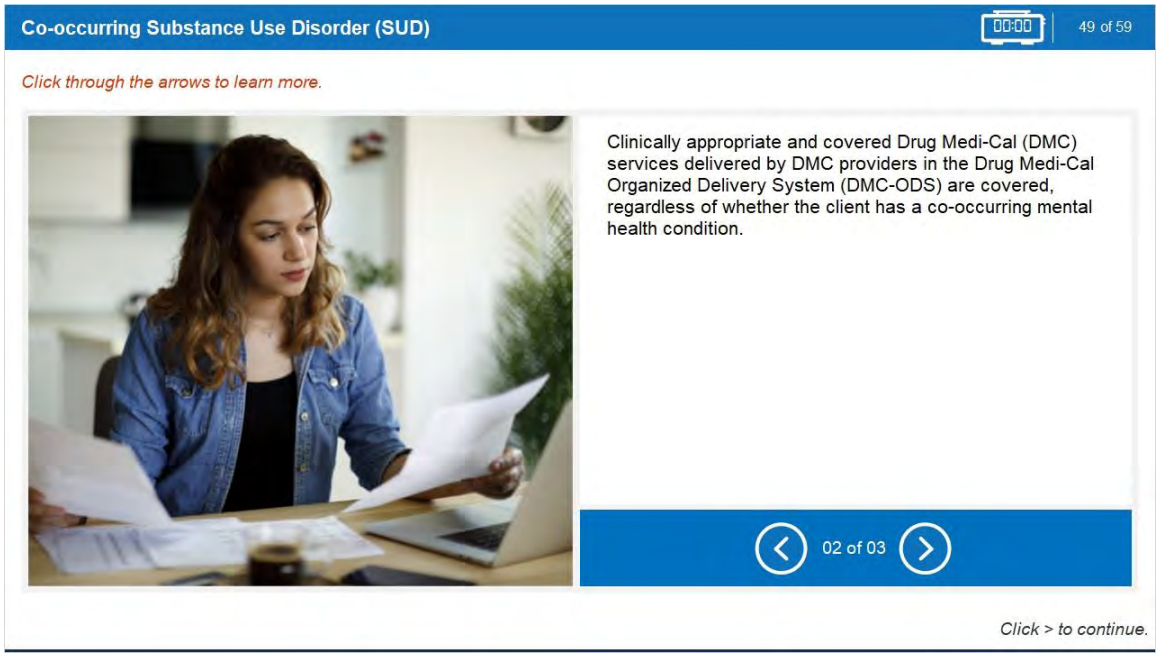
The MHP will allow reimbursement for Specialty Mental Health Services provided to a client who meets Specialty Mental Health Services criteria regardless of whether the client has a co-occurring substance use problem.

Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers in the Drug Medi-Cal Organized Delivery System (DMC-ODS) are covered, regardless of whether the client has a co-occurring mental health condition.

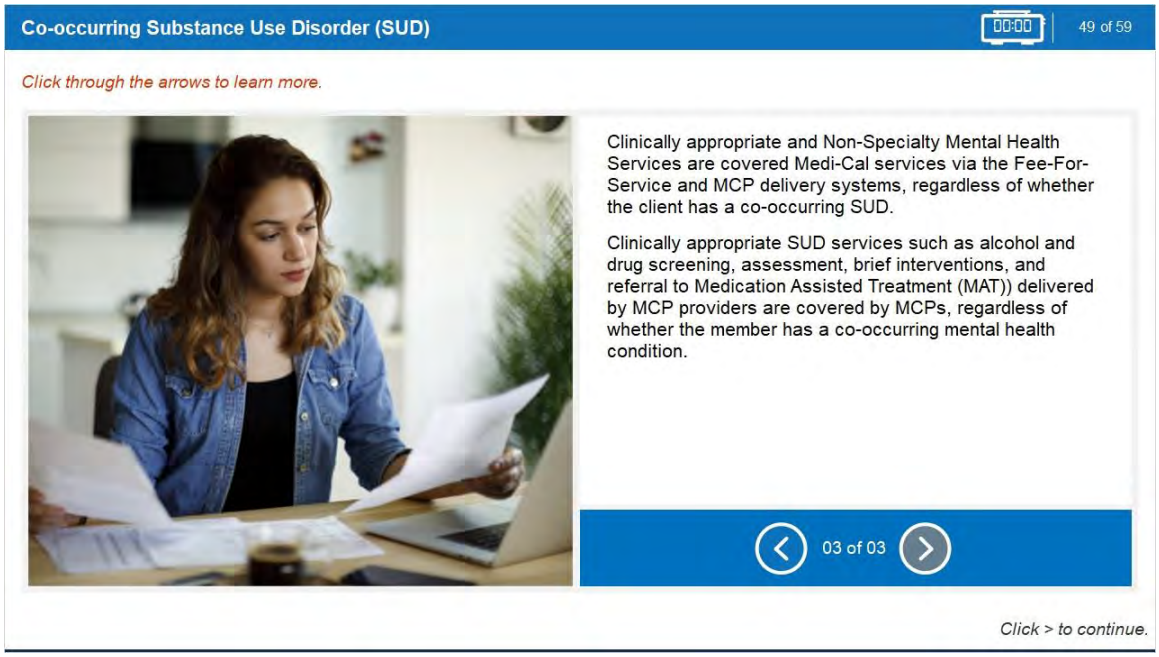
Clinically appropriate and Non-Specialty Mental Health Services are covered Medi-Cal services via the Fee-For-Service and MCP delivery systems, regardless of whether the client has a co-occurring SUD.

Additionally, clinically appropriate SUD services such as alcohol and drug screening, assessment, brief interventions, and referral to Medication Assisted Treatment (MAT)) delivered by MCP providers are covered by MCPs, regardless of whether the member has a co-occurring mental health condition.

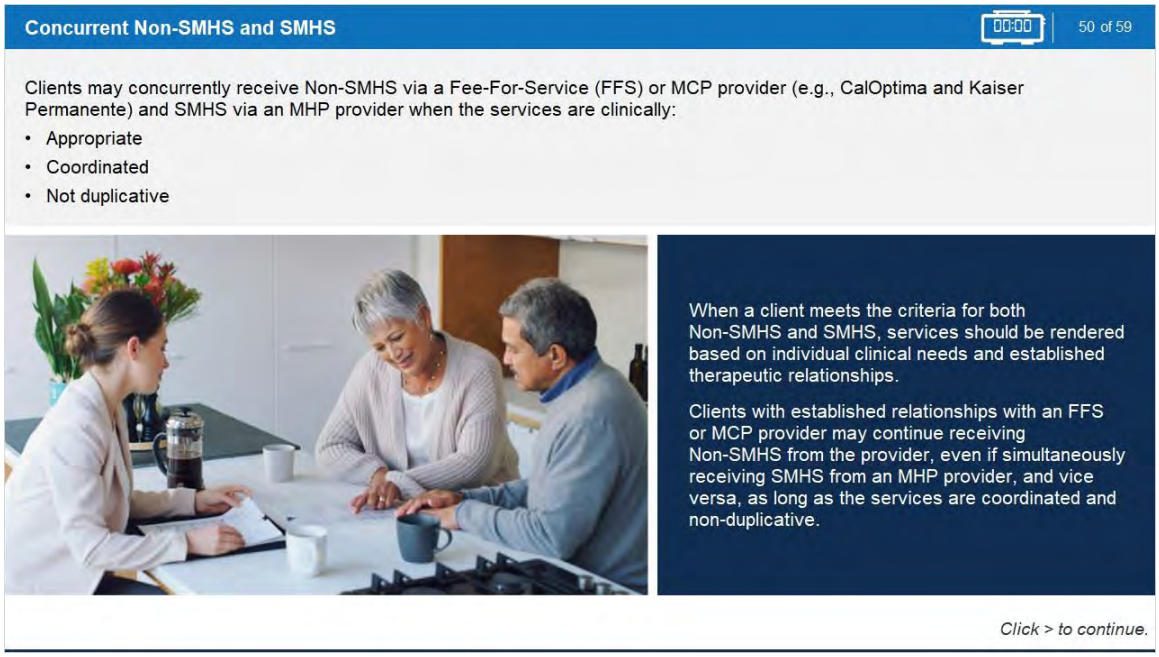
Tab 01 (Slide Layer)



Tab 02 (Slide Layer)



7.5 Concurrent Non-SMHS and SMHS



Notes:

Under certain circumstances, clients may concurrently receive Non-SMHS via a Fee-For-Service (FFS) or MCP provider and SMHS via an MHP provider when the services are clinically appropriate, coordinated, and not duplicative.

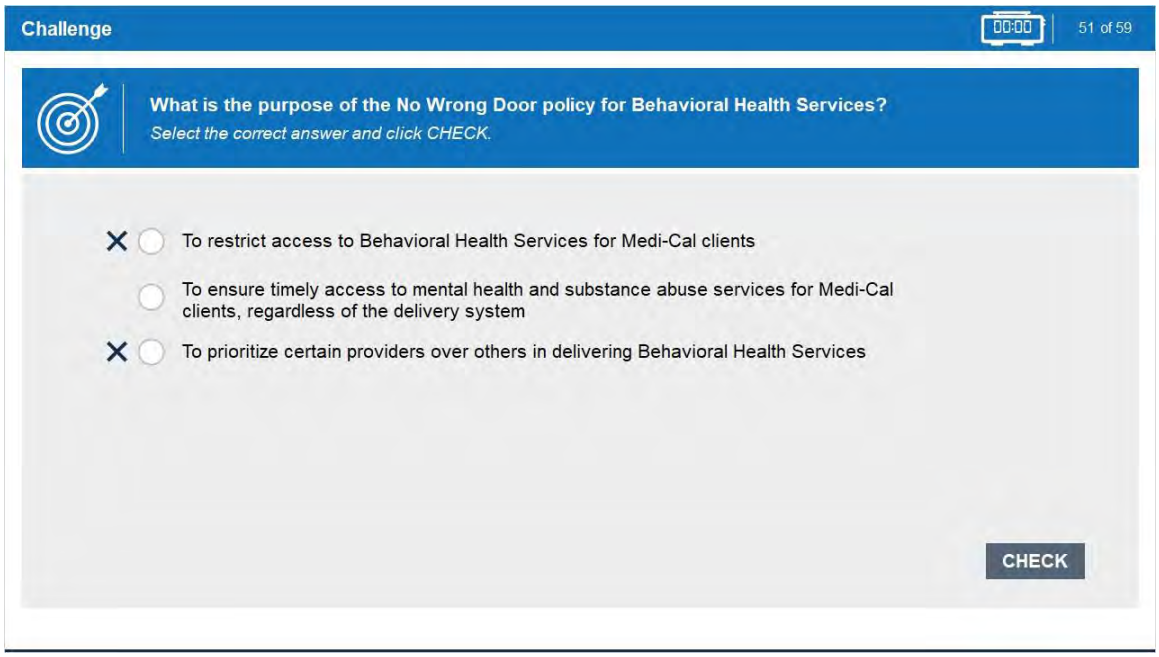
When a client meets the criteria for both Non-SMHS and SMHS, services should be rendered based on individual clinical needs and established therapeutic relationships.

Clients with established relationships with an FFS or MCP provider may continue receiving Non-SMHS from the provider, even if simultaneously receiving SMHS from an MHP provider, and vice versa, as long as the services are coordinated and non-duplicative.

Please ensure that you discuss these circumstances with your Supervisor to ensure close coordination takes place to avoid duplication of services and billing.

7.6 Challenge

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	To restrict access to Behavioral Health Services for Medi-Cal clients
X	To ensure timely access to mental health and substance abuse services for Medi-Cal clients, regardless of the delivery system
	To prioritize certain providers over others in delivering Behavioral Health Services

Notes:

It's time for an activity.

What is the purpose of the No Wrong Door policy for Behavioral Health Services?

Correct (Slide Layer)

Challenge 00:00 51 of 59

What is the purpose of the No Wrong Door policy for Behavioral Health Services?

Select the correct answer and click CHECK.

- ✗ To restrict access to Behavioral Health Services for Medi-Cal clients
- ✓ To ensure timely access to mental health and substance abuse services for Medi-Cal clients, regardless of the delivery system
- ✗ To prioritize certain providers over others in delivering Behavioral Health Services

Excellent! The purpose of the No Wrong Door Policy is to ensure that Medi-Cal clients receive timely mental health and substance abuse services without delay, regardless of the delivery system where they seek care.

CHECK

Click > to continue.

Incorrect (Slide Layer)

Challenge 00:00 51 of 59

What is the purpose of the No Wrong Door policy for Behavioral Health Services?

Select the correct answer and click CHECK.

- ✗ To restrict access to Behavioral Health Services for Medi-Cal clients
- ✓ To ensure timely access to mental health and substance abuse services for Medi-Cal clients, regardless of the delivery system
- ✗ To prioritize certain providers over others in delivering Behavioral Health Services

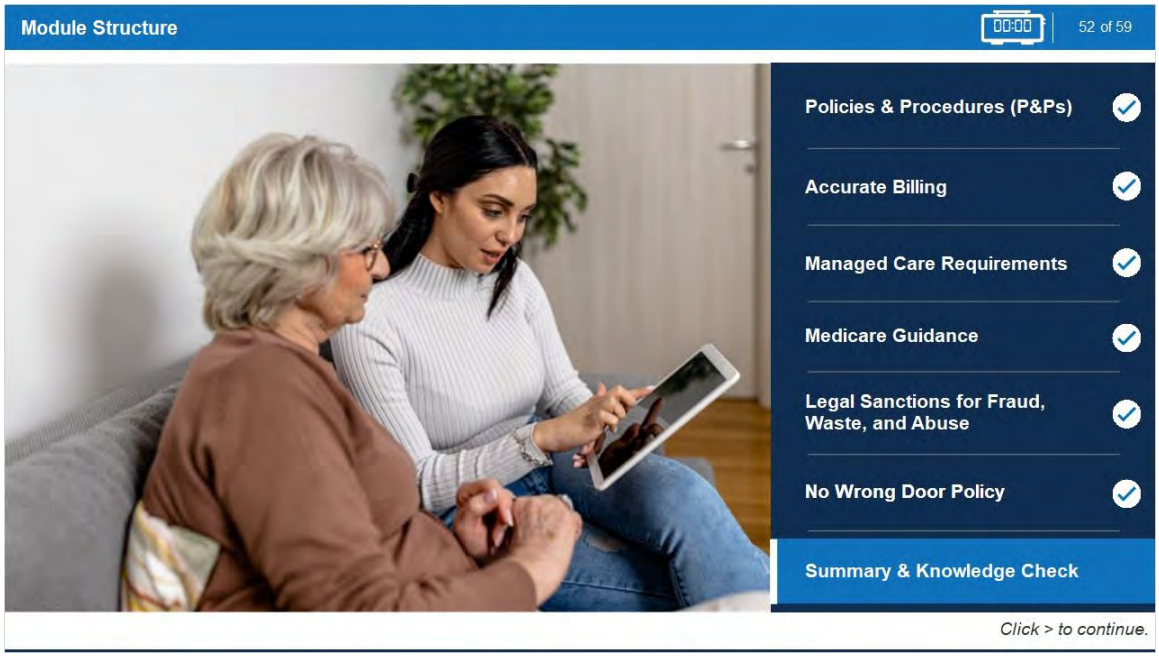
Not quite. The purpose of the No Wrong Door Policy is to ensure that Medi-Cal clients receive timely mental health and substance abuse services without delay, regardless of the delivery system where they seek care.

CHECK

Click > to continue.

8. Summary & Knowledge Check

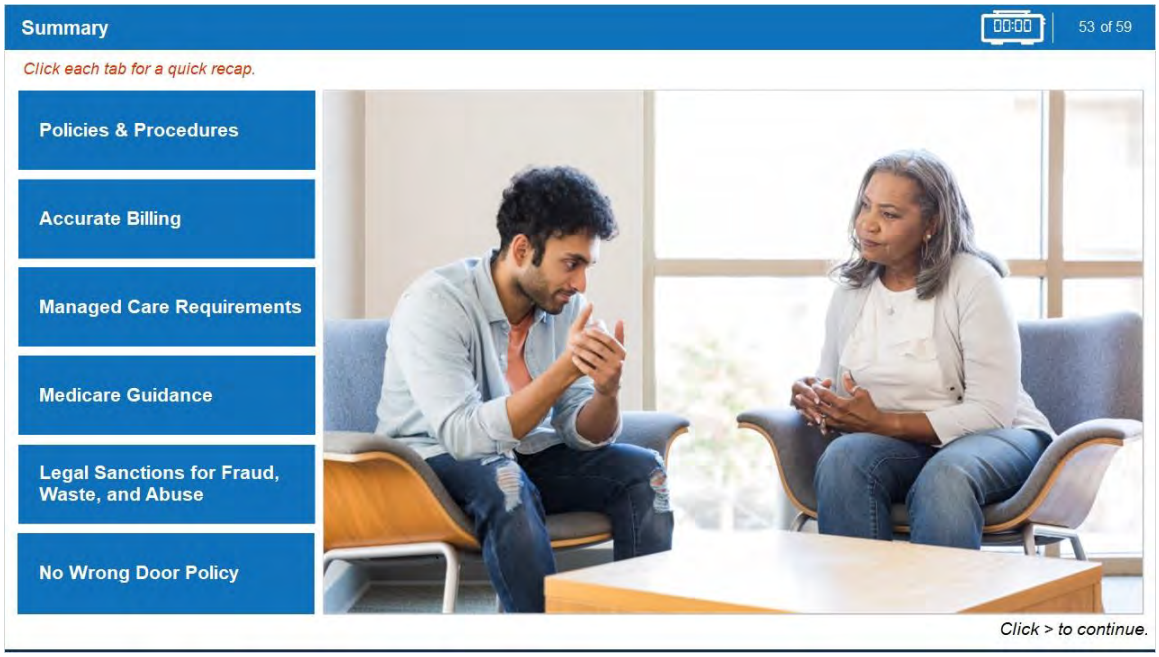
8.1 Module Structure



Notes:

We have come to the end of the general slides portion of the Annual Provider Training, let's summarize.

8.2 Summary



Notes:

Policies & Procedures

BHS P&Ps are available to all providers via the County website or from Contract Monitors.

P&Ps explain the requirements for conducting business within the MHP and DMC-ODS behavioral health plans.

Providers are expected to review P&Ps and be familiar with those that directly impact operations specific to one's role within the agency.

Accurate Billing

The clients, State, and Federal government expect documentation and billing to accurately reflect the treatment that was provided.

Inaccurate documentation and billing can lead to fraud, waste, and abuse concerns.

A few examples of documentation and billing errors include:

- No progress note found to substantiate the service that was provided
- Claiming a service for a no-show or canceled appointment
- Documenting a billable service as a 'Note to Chart'
- Discrepancies between claimed and documented services

Managed Care Requirements

Every clinic that serves as an access point should complete an Access Log entry for all new requests to start services with the MHP or DMC-ODS.

If a client can access services through a specific place or program, then that "place" qualifies as an access point.

Clients have the right to file grievances whenever they are dissatisfied with any aspect of the services they receive.

Federal regulations allow clients the opportunity to file an appeal within 60 calendar days from the date on the NOABD and resolve it within 30 calendar days.

Credentialing ensures that all providers delivering services within the network possess the necessary qualifications. It helps make sure that our clients receive the highest quality of care by verifying that our providers meet requirements.

Medicare Guidance

For Medicare or Medi-Medi clients, Behavioral Health Services must be provided under an individualized, written Care Plan that explicitly states the type, amount, frequency, and service duration, diagnosis, and expected goals.

Specifically, all Behavioral Health Services should be supervised and periodically evaluated by a physician who prescribes the service, determines the extent to which the patient has reached treatment goals, and documents their involvement in the patient's medical record.

Behavioral Health Services can only be billed for a Medicare or Medi-Medi client by a PTAN provider.

Medicare will not reimburse claims provided by a non-PTAN provider, and Medi-Cal cannot be billed for any claims delivered to a Medi-Medi client by a non-PTAN provider.

Legal Sanctions for Fraud, Waste, and Abuse

While some penalties require that the individual have knowledge that an action was fraudulent, others only require that an act be fraudulent, regardless of whether the provider realized it or not.

This includes making false statements and omitting and/or misrepresenting information.

Penalties for fraudulent activities may include criminal and civil prosecution for individuals and entities, loss of license to practice, license restrictions, addition to the Federal and/or state "Exclusion Lists," monetary fines/penalties, restitution of up to three times the amount of damages, or prison.

Fraudulent activity may result in the termination of employment at HCA.

The fraud, waste, and abuse issues can be reported to the Office of Compliance via the main line, email, or 24/7 hotline.

No Wrong Door Policy

The No Wrong Door Policy ensures that Medi-Cal clients:

- Receive timely mental health and substance abuse services without delay
- Are able to maintain treatment relationships with trusted providers without interruption

Clinically appropriate SMHS are covered and reimbursable:

- Prior to the determination of a diagnosis
- During the assessment process

Medi-Cal clients may concurrently receive Non-Specialty Mental Health Services through either of the County's Managed Care Plans or SMHS through the MHP when the services are clinically appropriate, coordinated, and not duplicative.

01 (Slide Layer)

Summary 00:00 53 of 59

Click each tab for a quick recap.

- Policies & Procedures
- Accurate Billing
- Managed Care Requirements
- Medicare Guidance
- Legal Sanctions for Fraud, Waste, and Abuse
- No Wrong Door Policy

Policies & Procedures

BHS P&Ps are available to all providers via the County website or from Contract Monitors.

P&Ps explain the requirements for conducting business within the MHP and DMC-ODS behavioral health plans.

Providers are expected to review P&Ps and be familiar with those that directly impact operations specific to one's role within the agency.

Click > to continue.

02 (Slide Layer)

Summary 00:00 53 of 59

Click each tab for a quick recap.

- Policies & Procedures
- Accurate Billing
- Managed Care Requirements
- Medicare Guidance
- Legal Sanctions for Fraud, Waste, and Abuse
- No Wrong Door Policy

Accurate Billing

The clients, State, and Federal government expect documentation and billing to accurately reflect the treatment that was provided.

Inaccurate documentation and billing can lead to fraud, waste, and abuse concerns.

A few examples of documentation and billing errors include:

- No progress note found to substantiate the service that was provided
- Claiming a service for a no-show or canceled appointment
- Documenting a billable service as a 'Note to Chart'
- Discrepancies between claimed and documented services

Click > to continue.

03 (Slide Layer)

Summary 00:00 53 of 59

Click each tab for a quick recap.

- Policies & Procedures
- Accurate Billing
- Managed Care Requirements
- Medicare Guidance
- Legal Sanctions for Fraud, Waste, and Abuse
- No Wrong Door Policy

Managed Care Requirements

Every clinic that serves as an access point should complete an Access Log entry for all new requests to start services with the MHP or DMC-ODS.

If a client can access services through a specific place or program, then that "place" qualifies as an access point.

Client have the right to file grievances whenever they are dissatisfied with any aspect of the services they receive.

Federal regulations allow clients the opportunity to file an appeal within 60 calendar days from the date on the NOABD and resolve it within 30 calendar days.

Credentialing ensures that all providers delivering services within the network possess the necessary qualifications. It helps make sure that our clients receive the highest quality of care by verifying that our providers meet requirements.

Click > to continue.

04 (Slide Layer)

Summary 00:00 53 of 59

Click each tab for a quick recap.

- Policies & Procedures
- Accurate Billing
- Managed Care Requirements
- Medicare Guidance
- Legal Sanctions for Fraud, Waste, and Abuse
- No Wrong Door Policy

Medicare Guidance

For Medicare or Medi-Medi clients, Behavioral Health Services must be provided under an individualized, written Care Plan that explicitly states the type, amount, frequency, and service duration, diagnosis, and expected goals.

Specifically, all Behavioral Health Services should be supervised and periodically evaluated by a physician who prescribes the service, determines the extent to which the patient has reached treatment goals, and documents their involvement in the patient's medical record.

Behavioral Health Services can only be billed for a Medicare or Medi-Medi client by a PTAN provider.

Medicare will not reimburse claims provided by a non-PTAN provider, and Medi-Cal cannot be billed for any claims delivered to a Medi-Medi client by a non-PTAN provider.

Click > to continue.

05 (Slide Layer)

Summary 00:00 53 of 59

Click each tab for a quick recap.

- Policies & Procedures
- Accurate Billing
- Managed Care Requirements
- Medicare Guidance
- Legal Sanctions for Fraud, Waste, and Abuse
- No Wrong Door Policy

Legal Sanctions for Fraud, Waste, and Abuse

While some penalties require that the individual have knowledge that an action was fraudulent, others only require that an act be fraudulent, regardless of whether the provider realized it or not.

This includes making false statements and omitting and/or misrepresenting information.

Penalties for fraudulent activities may include criminal and civil prosecution for individuals and entities, loss of license to practice, license restrictions, addition to the Federal and/or State "Exclusion Lists," monetary fines/penalties, restitution of up to three times the amount of damages, or prison.

Fraudulent activity may result in the termination of employment at HCA.

The fraud, waste, and abuse issues can be reported to the Office of Compliance via the main line, email, or 24/7 hotline.

Click > to continue.

06 (Slide Layer)

Summary 00:00 53 of 59

Click each tab for a quick recap.

- Policies & Procedures
- Accurate Billing
- Managed Care Requirements
- Medicare Guidance
- Legal Sanctions for Fraud, Waste, and Abuse
- No Wrong Door Policy

No Wrong Door Policy

The No Wrong Door Policy ensures that Medi-Cal clients:

- Receive timely mental health and substance abuse services without delay
- Are able to maintain treatment relationships with trusted providers without interruption

Clinically appropriate SMHS are covered and reimbursable:

- Prior to the determination of a diagnosis
- During the assessment process

Medi-Cal clients may concurrently receive Non-Specialty Mental Health Services through either of the County's Managed Care Plans or SMHS through the MHP when the services are clinically appropriate, coordinated, and not duplicative.

Click > to continue.

8.3 Knowledge Check

(Pick One, 10 points, 1 attempt permitted)

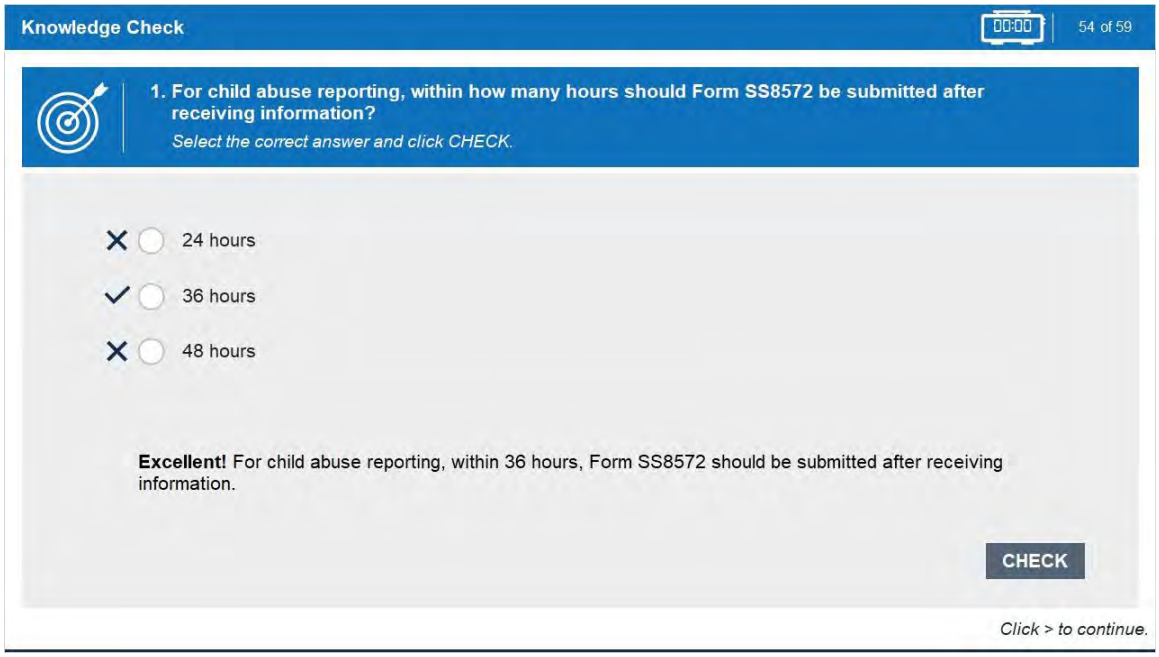
Correct	Choice
	24 hours
X	36 hours
	48 hours

Notes:

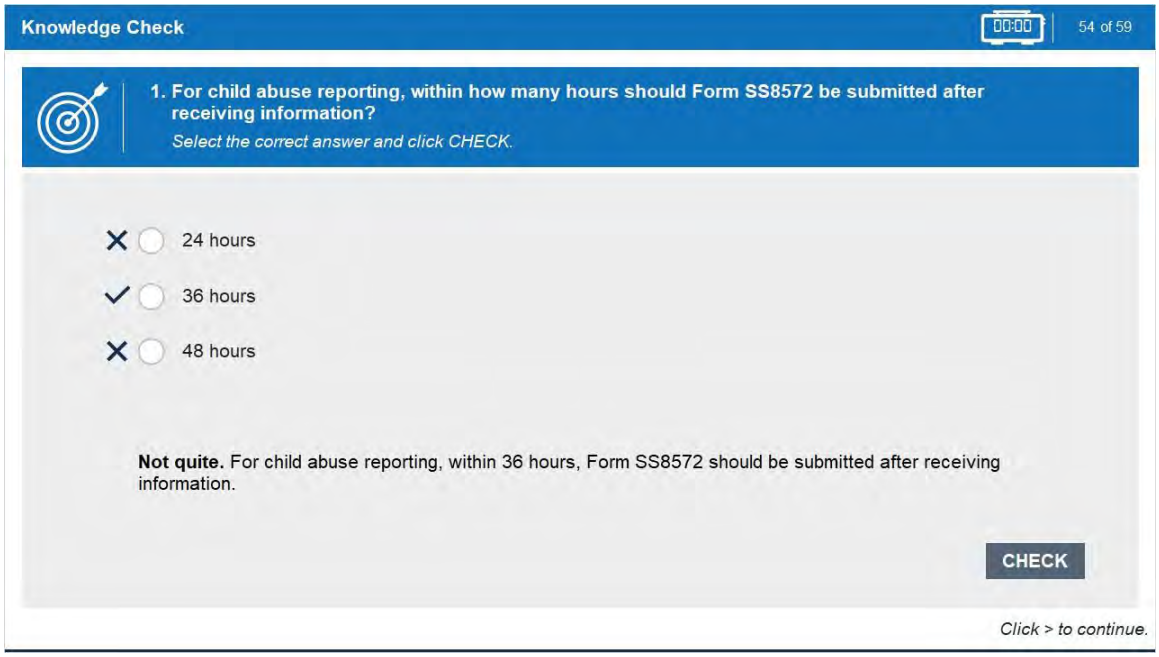
It's time for an activity.

For child abuse reporting, within how many hours should Form SS8572 be submitted after receiving information?

Correct (Slide Layer)

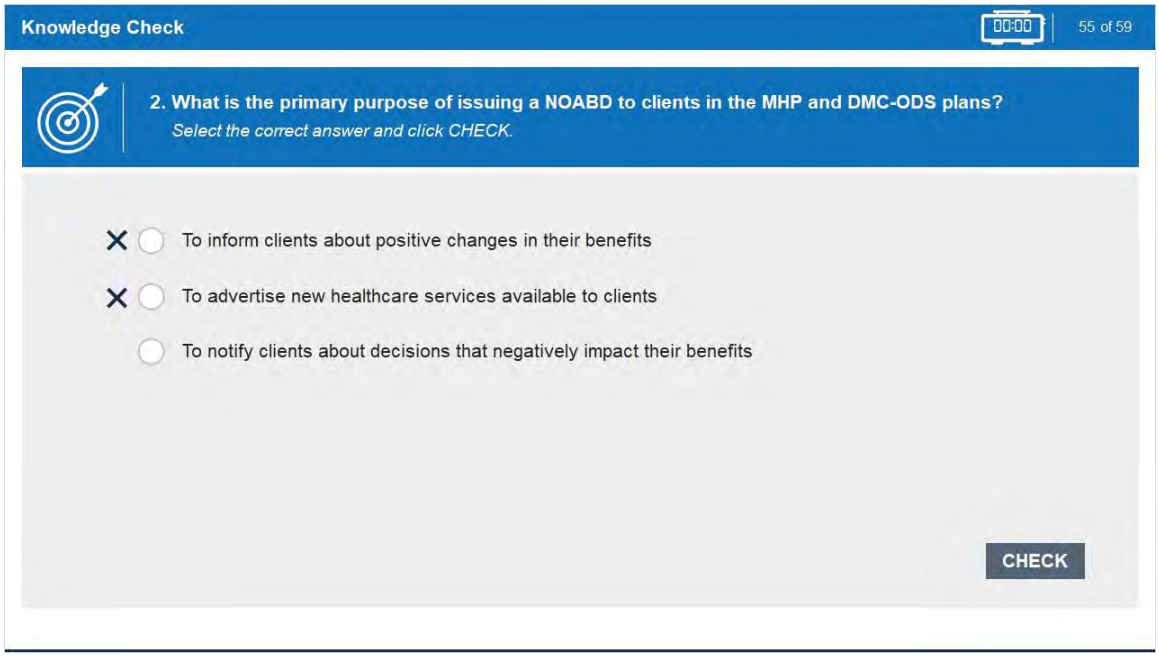


Incorrect (Slide Layer)



8.4 Knowledge Check

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	To inform clients about positive changes in their benefits
	To advertise new healthcare services available to clients
X	To notify clients about decisions that negatively impact their benefits

Notes:

What is the primary purpose of issuing a NOABD to clients in the MHP and DMC-ODS plans?

Correct (Slide Layer)

Knowledge Check 55 of 59

2. What is the primary purpose of issuing a NOABD to clients in the MHP and DMC-ODS plans?

Select the correct answer and click CHECK.

- ✗ To inform clients about positive changes in their benefits
- ✗ To advertise new healthcare services available to clients
- ✓ To notify clients about decisions that negatively impact their benefits

Excellent! The primary purpose of issuing a NOABD to clients in the MHP and DMC-ODS plans is to notify clients about decisions that negatively impact their benefits.

CHECK

Click > to continue.

Incorrect (Slide Layer)

Knowledge Check 55 of 59

2. What is the primary purpose of issuing a NOABD to clients in the MHP and DMC-ODS plans?

Select the correct answer and click CHECK.

- ✗ To inform clients about positive changes in their benefits
- ✗ To advertise new healthcare services available to clients
- ✓ To notify clients about decisions that negatively impact their benefits

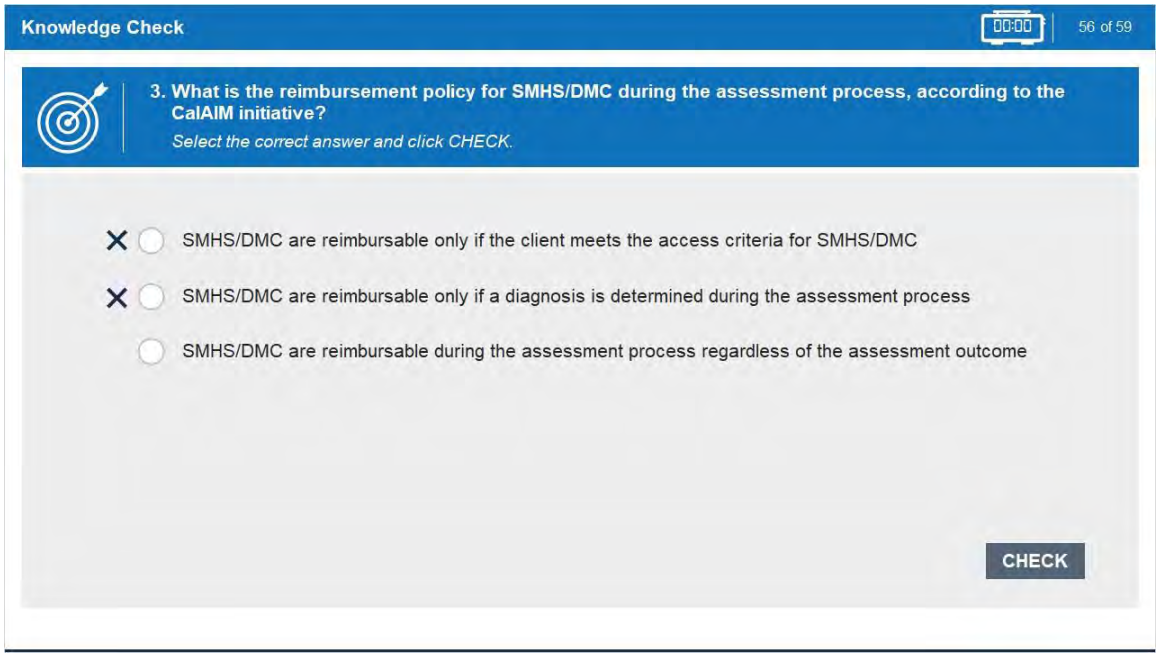
Not quite. The primary purpose of issuing a NOABD to clients in the MHP and DMC-ODS plans is to notify clients about decisions that negatively impact their benefits.

CHECK

Click > to continue.

8.5 Knowledge Check

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	SMHS/DMC are reimbursable only if the client meets the access criteria for SMHS/DMC
	SMHS/DMC are reimbursable only if a diagnosis is determined during the assessment process
X	SMHS/DMC are reimbursable during the assessment process regardless of the assessment outcome

Notes:

What is the reimbursement policy for SMHS/DMC during the assessment process, according to the CalAIM initiative?

Correct (Slide Layer)

Knowledge Check 56 of 59

3. What is the reimbursement policy for SMHS/DMC during the assessment process, according to the CalAIM initiative?

Select the correct answer and click CHECK.

- ✗ SMHS/DMC are reimbursable only if the client meets the access criteria for SMHS/DMC
- ✗ SMHS/DMC are reimbursable only if a diagnosis is determined during the assessment process
- ✓ SMHS/DMC are reimbursable during the assessment process regardless of the assessment outcome

Excellent! According to the CalAIM initiative, SMHS/DMC are reimbursable during the assessment process, regardless of the assessment outcome.

CHECK

Click > to continue.

Incorrect (Slide Layer)

Knowledge Check 56 of 59

3. What is the reimbursement policy for SMHS/DMC during the assessment process, according to the CalAIM initiative?

Select the correct answer and click CHECK.

- ✗ SMHS/DMC are reimbursable only if the client meets the access criteria for SMHS/DMC
- ✗ SMHS/DMC are reimbursable only if a diagnosis is determined during the assessment process
- ✓ SMHS/DMC are reimbursable during the assessment process regardless of the assessment outcome

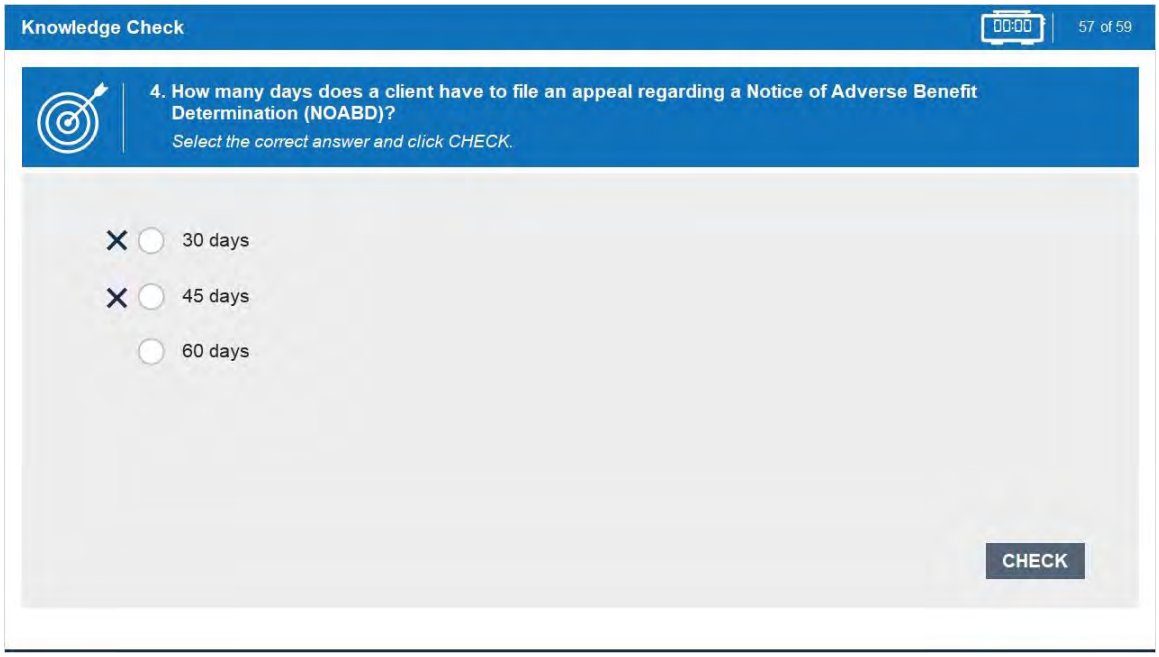
Not quite. According to the CalAIM initiative, SMHS/DMC are reimbursable during the assessment process, regardless of the assessment outcome.

CHECK

Click > to continue.

8.6 Knowledge Check

(Pick One, 10 points, 1 attempt permitted)

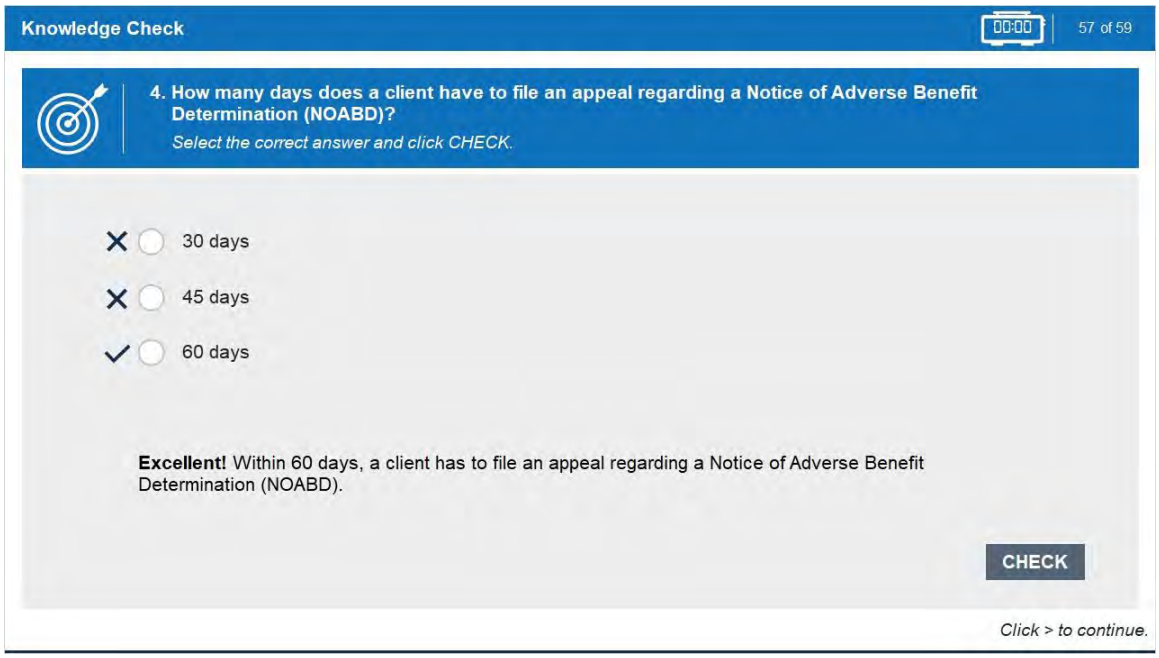


Correct	Choice
	30 days
	45 days
X	60 days

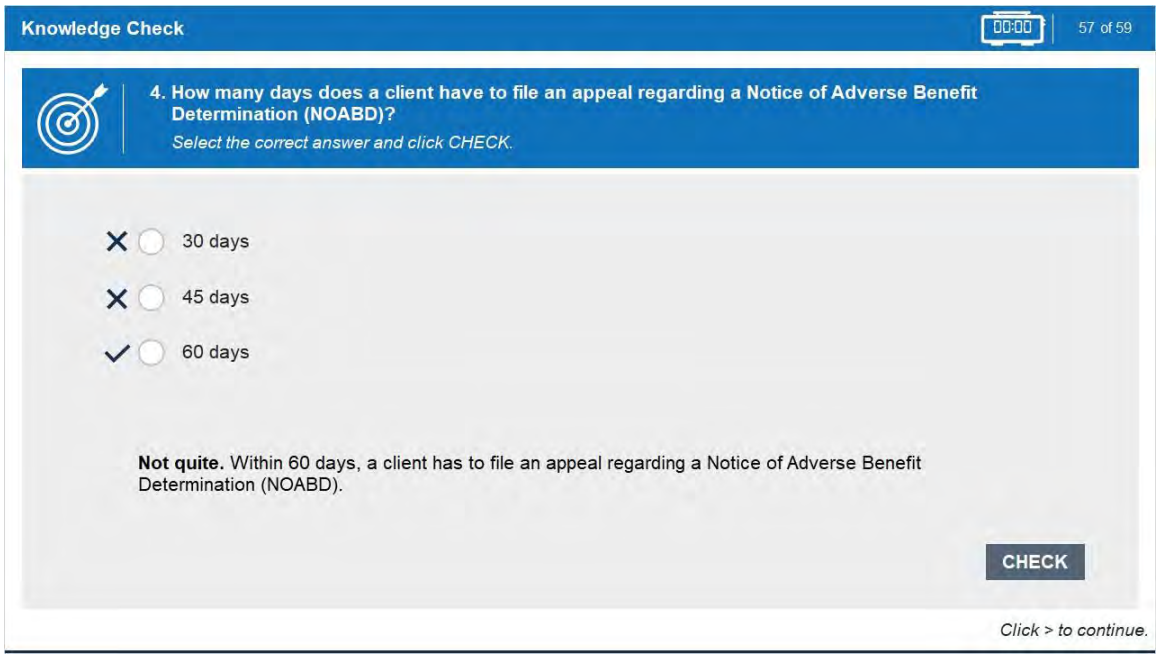
Notes:

How many days does a client have to file an appeal regarding a Notice of Adverse Benefit Determination (NOABD)?

Correct (Slide Layer)

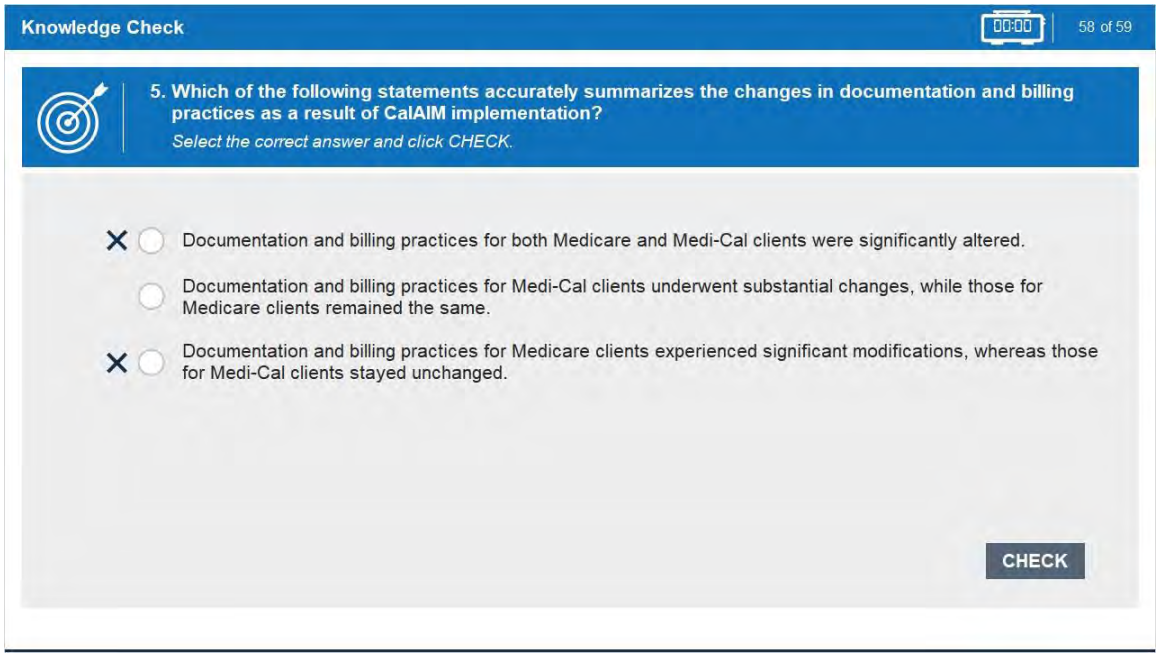


Incorrect (Slide Layer)



8.7 Knowledge Check

(Pick One, 10 points, 1 attempt permitted)



Correct	Choice
	Documentation and billing practices for both Medicare and Medi-Cal clients were significantly altered.
X	Documentation and billing practices for Medi-Cal clients underwent substantial changes, while those for Medicare clients remained the same.
	Documentation and billing practices for Medicare clients experienced significant modifications, whereas those for Medi-Cal clients stayed unchanged.

Notes:

Which of the following statements accurately summarizes the changes in documentation and billing practices as a result of CalAIM implementation?

Correct (Slide Layer)

Knowledge Check 58 of 59

5. Which of the following statements accurately summarizes the changes in documentation and billing practices as a result of CalAIM implementation?

Select the correct answer and click CHECK.

- ✗ Documentation and billing practices for both Medicare and Medi-Cal clients were significantly altered.
- ✓ Documentation and billing practices for Medi-Cal clients underwent substantial changes, while those for Medicare clients remained the same.
- ✗ Documentation and billing practices for Medicare clients experienced significant modifications, whereas those for Medi-Cal clients stayed unchanged.

Excellent! The correct statement is "Documentation and billing practices for Medi-Cal clients underwent substantial changes, while those for Medicare clients remained the same."

CHECK

Click > to continue.

Incorrect (Slide Layer)

Knowledge Check 58 of 59

5. Which of the following statements accurately summarizes the changes in documentation and billing practices as a result of CalAIM implementation?

Select the correct answer and click CHECK.

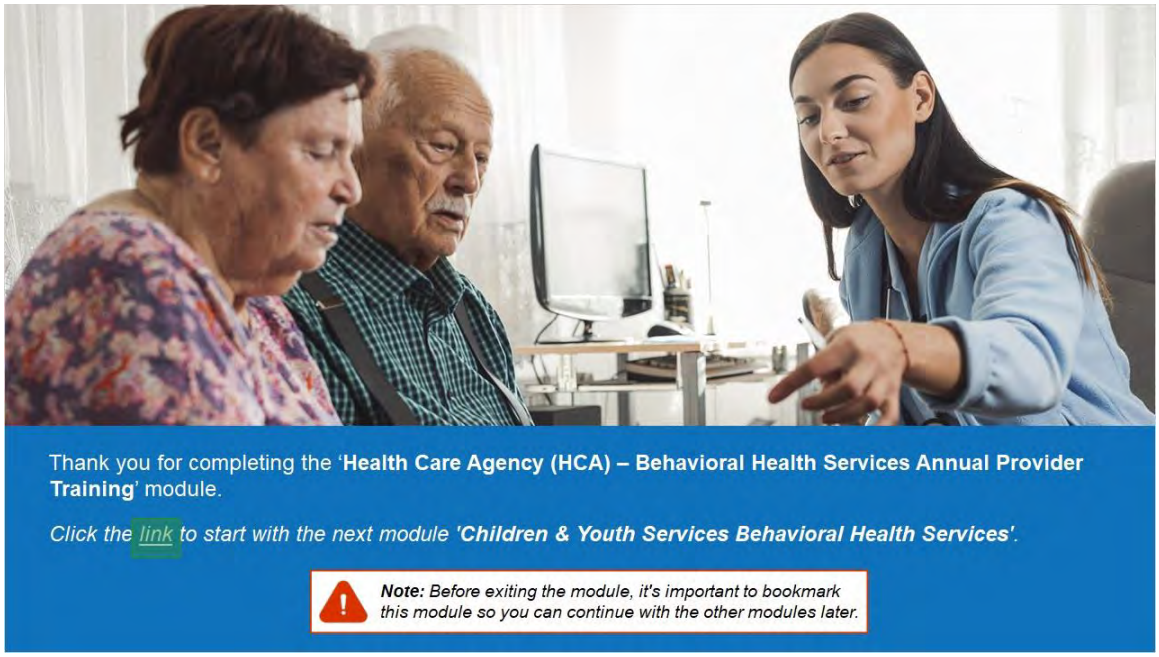
- ✗ Documentation and billing practices for both Medicare and Medi-Cal clients were significantly altered.
- ✓ Documentation and billing practices for Medi-Cal clients underwent substantial changes, while those for Medicare clients remained the same.
- ✗ Documentation and billing practices for Medicare clients experienced significant modifications, whereas those for Medi-Cal clients stayed unchanged.

Not quite. The correct statement is "Documentation and billing practices for Medi-Cal clients underwent substantial changes, while those for Medicare clients remained the same."

CHECK

Click > to continue.

8.8 Thank you



Notes:

Thank you for completing the 'Health Care Agency (HCA) – Behavioral Health Services Annual Provider Training' module.

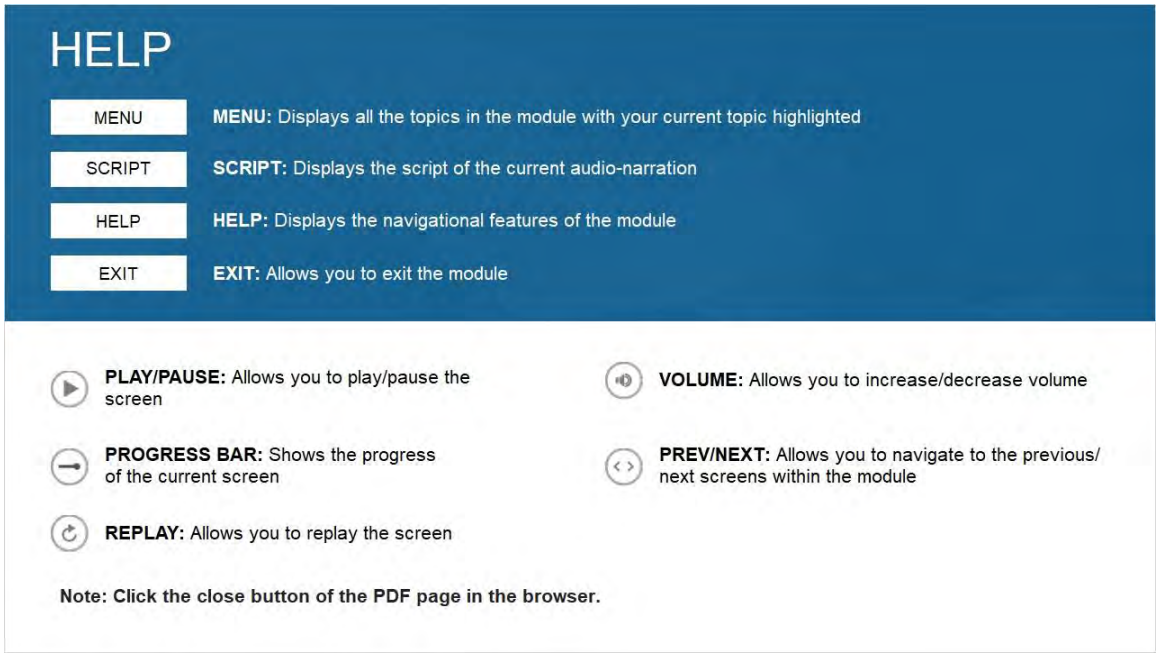
As a next step, you'll be diving into the Division-Specific Portion of the Annual Provider Training module.

Click the link to start with the next module 'Children & Youth Services Behavioral Health Services'.

All the best until then!

9. Help

9.1 Help



Notes: