

County of Marin

Behavioral Health and Recovery Services



TABLE OF CONTENTS

IMPORTANT PHONE NUMBERS	1
INTRODUCTION AND WELCOME	2
PRINCIPLES	3
PROVIDING AUTHORIZED OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES AS A FEE FOR SERVICE PROVIDER	4
FEE FOR SERVICE PROVIDERS	4
BECOMING A FEE FOR SERVICE PROVIDER	4
MEDICAL NECESSITY FOR SPECIALTY MENTAL HEALTH SERVICES	4
ACCESS TEAM	4
TREATMENT AUTHORIZATION	5
REAUTHORIZATION AND REQUESTS FOR CHANGE OF SERVICE MODALITY	6
FEE FOR SERVICE PROVIDER RESPONSIBILITIES	7
MEDICAL SITE CERTIFICATION REQUIREMENT	7
TIMELY AND ACCESSIBLE SERVICES	7
CLINICAL DOCUMENTATION/FISCAL RECORDS: CREATION, STORAGE AND RETENTION	7
PROTECTED HEALTH INFORMATION AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	8
BENEFICIARY INFORMING MATERIALS –POSTED AND AVAILABLE MATERIALS	8
BENEFICIARY INFORMING MATERIALS – PROVIDED MATERIALS	8
CONSUMER GRIEVANCE RESOLUTION	8
PAYMENT POLICIES AND PROCEDURES	9
ELIGIBILITY VERIFICATION	9
CLAIMS SUBMISSION	9
CLAIMS PAYMENT	9
BENEFICIARIES WITH OTHER INSURANCE	10
PROVIDER COMPLAINT RESOLUTION: AUTHORIZATION/PAYMENT APPEALS	10
QUALITY MANAGEMENT	10
PROVIDER NOTICES	11

APPENDIX DOCUMENTS

ADVANCE HEALTH CARE DIRECTIVE FORM
BHRS REAUTH REQUEST
BHRS STANDARDS FOR CLINICAL RECORDS
CHANGE OF PROVIDER REQUEST FORM
CMS 1500 BLANK FORM
CMS 1500 SAMPLE FORM
DHCS MEDI-CAL SITE CERTIFICATION-RECERTIFICATION PROTOCOL
GRIEVANCE BROCHURE
GRIEVANCE_APEAL_FAIR HEARING_COP_POSTER
HHS CONFIDENTIALITY AND PRIVACY IN HEALTHCARE
INCLUDED OUTPATIENT DIAGNOSES BHRS
MCO DISCHARGE FORM
MMHP BENEFICIARY BOOKLET
MMHP MEMBER HANDBOOK
MMHP PROVIDER LIST
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICES
UR GUIDELINES FOR FEE FOR SERVICE PROVIDERS

**Marin County Behavioral Health and Recovery Services
Outpatient Fee for Service Provider Network
Important Phone Numbers**

For Providers:

Access Team:

250 Bon Air Road, Greenbrae, CA 94904
Tel: 1-888-818-1115 (24 hours/7 days a week)
Fax: 415-473-2353

Access provides telephonic screening, information and referral services as well as in person assessments for consumers. Access provides Authorization/Reauthorization services for network providers, and is the point of entry into additional BHRS services. Access provides assessments on a walk-in basis on Monday, Wednesday and Friday mornings. Scheduled appointments are available for the remainder of the week.

Quality Management:

20 N. San Pedro Road, Suite 2028
San Rafael, CA 94903
Tel: (415) 473-2887
Fax: (415) 473-4216

Providers (currently contracted or interesting in contracting) seeking information about processes regarding participation in the Marin County Mental Health Plan such as credentialing, site certification, consumer grievance resolution, informing materials, utilization management, etc.

Accounting:

Jayne Carpenter
Tel: 415 473-3274

For providers who need assistance with checking monthly Medi-Cal eligibility or for help with questions regarding invoicing or to appeal payment decisions.

For Consumers:

Crisis Stabilization Unit:

250 Bon Air Road, Greenbrae, CA 94904 (24 hours/7 days a week)
Tel: 415-473-6666

Provides services to Marin County residents and visitors experiencing a mental health crisis, such as suicidal depression or psychotic behavior.

Adult Residential Detoxification Services:

Helen Vine Recovery Center
301 Smith Ranch Rd, San Rafael, CA 94903
Tel: (415) 492-0818

Non-medical detoxification program where adults under the influence of drugs and/or alcohol can safely withdraw from the ill effects of intoxication.

Mobile Crisis Response Team (MCRT)

7 days a week 1pm-9pm
Tel: 415-473-6392

Field-based team comprised of a licensed mental health practitioner and a peer provider. The team responds to individuals in the community who are in crisis.

Community Action Marin Warmline:

Phone Support for Peers (7 days a week 1pm-9pm):
Tel: 415-459-6330

National Suicide Prevention Lifeline:

Tel: 1-800-273-8255 (24 hours/7 days a week)

Marin County Patient's Rights Advocate:

(415) 526-7525



INTRODUCTION

As a result of the Medi-Cal Specialty Mental Health Services Consolidation Phase II that took effect on June 1, 1998, all non-hospital Specialty Mental Health Services are administered and provided through the Marin County Mental Health Plan (MHP) for consumers with severe mental health conditions. As of January 1, 2014, those consumers who are determined to have mild to moderate conditions in Marin County are to be served through Partnership Healthplan of California (PHC). These mild to moderate outpatient mental health services are provided through a contract with Beacon Health Options (and, on a more limited basis, by Kaiser Permanente.) The MHP and PHC have entered into a Memorandum of Understanding (MOU) that outlines how consumers are transitioned between the two plans as needed to address their mental health needs.

WELCOME

The Marin MHP (hereafter referred to as Behavioral Health and Recovery Services or BHRS) administers the County of Marin's Specialty Mental Health Medi-Cal program, as well as providing services directly. Outpatient mental health services, inpatient services, as well as other services in the system of care, must be viewed as components in a total continuum of care for all of Marin County's Medi-Cal beneficiaries who meet medical necessity criteria for specialty mental health services. This manual describes the responsibilities of Fee for Service Providers as part of this system of care. It mandates a collaborative partnership in which family/client and both county and contract service providers work together to achieve desired outcomes by providing quality services that are accessible, cost effective, and culturally competent.

Thank you for your decision to become a Fee for Service Provider for the Marin County Mental Health Plan. As an important link in Marin County's Division of Behavioral Health and Recovery Service's system of care, your successful participation in the Mental Health Outpatient Network is vital to our success. We look forward to working with you to ensure the delivery of Specialty Mental Health Services to eligible Medi-Cal beneficiaries. Should you have any questions, comments or suggestions regarding the information in this manual, please direct your calls to the Access Team at 1- 888-818-1115

PRINCIPLES

BHRS is guided by the following principles at all levels of consumer services:

1. Services are provided to consumers with respect and dignity.
2. Services focus on consumers' strengths and abilities.
3. Services are provided in a culturally competent manner.
4. Services are provided in an organized, collaborative, coordinated, and cost-effective approach to care and treatment.
5. Services are consumer-driven and family-focused, and aim to achieve positive mental health outcomes for culturally diverse populations across all age groups.
6. The emphasis when serving adults with serious and persistent mental illnesses and children and adolescents with serious emotional disturbances is through a comprehensive, community-based, coordinated system of care.
7. The service system is "user-friendly" with easy access for consumers and a "seamless" interface with the physical health services provided to restore balance and wellness.
8. The service delivery system is accountable for quality services and has defined outcomes a way of measuring effectiveness and efficiency.
9. The system is responsive to the consumer through evaluating measurements of consumer satisfaction and having a process for approaching consumer grievance resolution.

PROVIDING AUTHORIZED OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES AS A FEE FOR SERVICE PROVIDER:

FEE FOR SERVICE PROVIDERS

Outpatient Fee for Service providers deliver time-limited, evidence-based individual and group psychotherapy services for Marin Medi-Cal beneficiaries. All services provided by Fee for Service Providers must be performed by practitioners licensed to practice psychotherapy independently. Agency providers may use interns to provide services to Medi-Cal beneficiaries. All interns must have completed an appropriate graduate degree, work within the scope of their practice and be supervised according to the requirements of the Board of Behavioral Sciences. These mental health professionals provide services to beneficiaries in accordance with legal and ethical standards and with all relevant professional, federal, state, and/or local regulatory and statutory requirements.

BECOMING A FEE FOR SERVICE PROVIDER

Qualified individual and small agency providers may apply for the opportunity to provide services as Fee for Service Providers. Qualified providers include Psychiatrists (MD/DO), Licensed Psychologists (PsyD/ PhD), Licensed Clinical Social Workers (LCSW), and Licensed Marriage and Family Therapists (LMFT) who have been credentialed by BHRS Quality Management. Interested professionals should submit a completed credentialing application to begin the process of becoming a provider. The credentialing process verifies educational history, relevant licenses and certifications, education/continuing education, work/military history, admitting privileges, professional memberships and malpractice insurance history and includes malpractice actions, disciplinary actions, and criminal offenses. Once the potential provider completes the credentialing process, BHRS checks the required excluded provider databases, and enters into a contractual relationship with the provider. To begin this process, contact Access at 1-888-818-1115.

MEDICAL NECESSITY FOR SPECIALTY MENTAL HEALTH SERVICES:

All Marin Medi-Cal beneficiaries are eligible for an assessment to determine medical necessity for mental health services. Assessments to determine medical necessity are provided by the BHRS Access Team, which can be reached at 1-888-818-1115.

ACCESS TEAM

The BHRS Access Team functions as the point of entry for outpatient specialty mental health services. The Access Team provides 24/7 information, screenings and referrals by phone as well as walk-in face to face assessments during business hours for adults and children who are Marin County Medi-Cal beneficiaries. The Access Team provides referrals and authorizations for Specialty Mental Health Services that may be provided by county programs and/or a network of organizational and individual providers. Callers requesting mental health and/or substance use treatment services may be provided

screening, referral, and coordination with services from other entities (such as educational, housing and vocational rehabilitative services) if the nature and severity of the mental health and/or substance use impairment of the individuals does not require specialty services. Callers may be referred to PHC for primary care or the appropriate Medi-Cal managed care plan for mild or moderate services as warranted.

Medical necessity determinations include three main components:

1. **Diagnosis:** Does the beneficiary meet criteria for a mental health condition that is an included diagnosis for specialty mental health services. (see "*Specialty Mental Health Outpatient Services ICD-10 Covered Diagnosis Table*" **Appendix A**)
2. **Functional Impairments:** Are the functional impairments that the beneficiary is experiencing as a result of the included mental health diagnosis(es):
 - (a) Significant impairments in important areas of life functioning OR
 - (b) Represent the probability of significant deterioration in an area of life functioning OR
 - (c) For children/youth under age 21, is there a probability that the child/youth will not progress developmentally as individually appropriate.
3. **Interventions:** Is it expected that the proposed mental health interventions will address and significantly diminish the impairment (for children/youth: correct or ameliorate the impairment). Importantly, is the condition not responsive to physical healthcare-based treatment?

If the assessment indicates medical necessity, the beneficiary is authorized to receive a defined set of services for a specified period of time. Services may continue beyond the initial authorization period if those services are requested in a timely way and demonstrated to be medically necessary. When no medical necessity for additional mental health services exists, the beneficiary may be referred to other county or community service, social welfare and protective or health care entities as necessary.

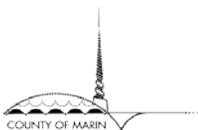
TREATMENT AUTHORIZATION

Emergency Services:

Emergency services do not require prior authorization. Emergency psychiatric services are accessible 24 hours a day/seven days a week for all Marin residents at the Crisis Stabilization Unit at 250 Bon Air Road, Greenbrae, CA 94904, (415) 473-6666. Field-based crisis intervention services are available from the Mobile Crisis Response Team seven days a week from 1pm-9pm by calling 415-473-6392. Beneficiaries who are outside Marin County can obtain emergency mental health services through any facility designated to evaluate and treat clients under the Welfare and Institutions Code 5150.

Planned Services:

All planned services provided by Fee for Service Providers **must be pre-authorized** by the BHRS Access Team. Authorization for outpatient services must be preceded by a face to face assessment during which medical necessity and initial level of care are determined.



The BHRS Access Team refers eligible individuals to Fee for Service Providers to receive individual, family and/or group therapy services. Assignment of beneficiaries to a particular provider is based upon a number of factors including: client choice, past history of treatment, provider location, timely appointment availability, ability to provide cultural and/or linguistically relevant services as well as the provider's areas of specialty or expertise.

Services are authorized for a specified modality or modalities and a specified number of sessions. Authorizations are provided at six month intervals, and authorized services can be provided at any point during the six month period. Services that are provided that do not conform to the number and/or type of services authorized, or that are provided in the absence of a current authorization are not eligible for payment. Fee for Service Providers **may not** submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or person acting on behalf of the beneficiary for any specialty mental health services.

The BHRS Access Team faxes notification to the Fee for Service provider within 24 hours of the authorization. Written confirmation of authorization is sent by mail to the beneficiary and provider no later than ten working days of determination of need for services.

RE-AUTHORIZATIONS AND REQUESTS FOR CHANGE OF SERVICE MODALITY

A Fee for Service Provider and beneficiary agree that additional service or a different type of service are necessary, the provider can request an additional authorization(s) or a change in the modality of service authorized by submitting a written justification of continued medical necessity and need for treatment. This justification must include a current assessment and treatment plan (signed by the provider and consumer). The written request to re-authorize services must be received by Access at minimum two weeks prior to the current number of authorized sessions being provided and/or the current authorization's end date, whichever is relevant, to avoid an interruption in services. Written requests can be submitted via confidential fax or encrypted email. Contract providers and/or beneficiaries requesting re-authorization of services are informed in writing of the outcome before an authorization expires whenever possible, or within ten working days of the request.

Written requests for reauthorization/change of service modality must include:

A completed reauthorization request form including a current diagnosis. Diagnoses in the clinical record must be formulated using the most current version of the Diagnostic and Statistical Manual. See Appendix for reauthorization document ("*BHRS Reauth Request 2017*") and a list of include diagnoses ("*Included Outpatient Diagnoses*").

1. The most recent assessment.
2. A Client Plan that is valid for the dates of service, and includes the consumer's and provider's signatures.
3. When more information is needed to make a re-authorization decision, BHRS Access Team staff may request copies of progress notes or other case records to assist in determining medical necessity for continued treatment.
4. In consultation with the Fee for Service Provider, BHRS Access Team staff may obtain a second opinion with regard to the client's need for ongoing care.

FEE FOR SERVICE PROVIDER RESPONSIBILITIES:

MEDI-CAL SITE CERTIFICATION REQUIREMENT

All Fee for Service Providers are expected to insure compliance with Medi-Cal program certification requirements. (see *“DHCS Medi-Cal Site Certification-Recertification Protocol”*). Provider Medi-Cal sites are certified by BHRS Quality Management staff for a period of three years. Providers will receive notice from BHRS Quality Management staff regarding the timing of certification visits. Providers must allow BHRS staff access to their sites to allow for certification/recertification visits in order to maintain their status as Fee for Service Providers.

TIMELY AND ACCESSIBLE SERVICES

Providers will respond to new authorizations for services from BHRS Access in a timely manner. Providers will contact new beneficiaries within five working days of receiving a referral from the BHRS Access Team. Providers will offer a new beneficiary an initial appointment within ten working days of the referral for routine service requests.

Providers will attempt to contact a new client three times within the first ten working after receiving a referral. If the provider is unable to reach the beneficiary to schedule an appointment, or if the beneficiary does not initiate services, the provider will inform Access that treatment was not initiated and close the treatment episode. (See *“MCO Discharge Form”*)

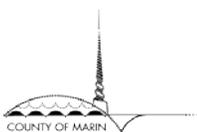
In the event that beneficiaries approach providers directly for services, the provider will assist the beneficiary in communicating with the BHRS Access Team to obtain and assessment and authorization as suitable. Providers will update BHRS Access Team regularly as to their availability to accept new clients.

CLINICAL DOCUMENTATION/FISCAL RECORDS: CREATION, STORAGE AND RETENTION

Fee for Service providers are required to keep medical records that document the provision of services. Records must be comply with BHRS standards (see *“BHRS Standards for Clinical Records”*) be legible and kept in detail consistent with appropriate professional practice in order to document client care and allow for appropriate follow up and or care transitions. Records must also be available in a format that allows for internal professional review and external audit.

A current Clinical Documentation Guide that provides information regarding the required documentation elements, including the components of assessments/reassessments, client plans and progress notes can be found at: <https://www.marinhhs.org/clinical-documentation-guide>

The contract provider must maintain clinical records for at least seven (7) years from the last date of service to the beneficiary (or age 18 plus one year for child records, whichever is later) and must make the books and records (which pertain to the services provided to members under the contract provisions with BHRS) available for inspection, examination or copying by BHRS staff, the State Department of Health Care Services (DHCS) and the U.S. Department of Health and Human Services; at all reasonable times at the provider’s place of business or at another mutually agreeable location; and in a form maintained in accordance with the general standards applicable to such record keeping.



PROTECTED HEALTH INFORMATION AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, requires all health care providers to make sure that individual medical information is kept private. Any information relating to an individual that has the possibility of tying that person to his/her health record is confidential. HIPAA applies to information communicated both orally and in writing. It applies to information housed in any files or depositories. It also applies to information stored in any electronic or recording device, database or transmitted through any electronic means. See *“HHS Confidentiality and Privacy in Healthcare”* in the Appendix for more information.

BENEFICIARY INFORMING MATERIALS -- POSTED AND AVAILABLE MATERIALS

Fee for Service Providers post or make available the following materials, which are available in the Appendix. Providers must post a notice explaining the grievance, appeal, expedited appeal and fair hearing process. (*“Grievance, Appeal, Fair Hearing, COP Poster”*) Providers must make available to beneficiaries the Grievance Brochure (along with a postage-paid envelope) (*“Grievance Brochure”*), the BHRS Member Handbook (*“MMHP Member Handbook”*), the Beneficiary Handbook (*“MMHP Beneficiary Booklet”*) and a current Provider List (*“MMHP Provider List”*). All materials are available in English, Spanish, Vietnamese, Large Font and audio formats upon request by calling Access at 1-888-818-1115.

BENEFICIARY INFORMING MATERIALS -- PROVIDED MATERIALS

Fee for Service Providers must provide Medi-Cal beneficiaries the following materials (which are provided in the Appendix) during their initial sessions, and must document receipt of the materials in the medical record. *“HIPAA Notice of Privacy Practices”* must be provided to all Medi-Cal beneficiaries or parent/guardians at the first face-to-face contact for services. Receipt must be documented by retaining a signed copy of the *“Notice of Privacy Practices Acknowledgement”*. The provider must also post the *“HIPAA Notice of Privacy”* in a clear and prominent location where individuals are likely to see it, as well as make the notice available to those who request a copy.

“Advance Health Care Directive” must be provided to all beneficiaries aged 18 and older at the first face-to-face services. Providing this information must be documented in the medical record.

All materials are available in English, Spanish, Vietnamese, Large Font and audio formats upon request by calling Access at 1-888-818-1115.

CONSUMER GRIEVANCE RESOLUTION

BHRS has established complaint/grievance procedures. These include preparation and distribution of materials concerning clients’ rights and the grievance process, as well as ongoing outreach to inform and educate clients and their families about how they can participate in that process. Additionally, this process includes mechanisms to monitor and take action to resolve disputes between beneficiaries and providers, and observes defined timelines and legal parameters to assure fair and equal treatment for all.

The complaint/grievance process is the responsibility of BHRS staff. It assures that all beneficiaries and providers have clear avenues to seek timely resolution of grievances and complaints. Both individuals and providers may contact BHRS at any time by phone (415) 473-2887 (Quality Management) or (888)-818-1115 (Access Team) or by mail to begin a problem resolution process. The consumer grievance resolution process can

be found in the Grievance Brochure. The Member Handbook describes how beneficiaries should proceed when they are not satisfied with their services.

PAYMENT POLICIES AND PROCEDURES

ELIGIBILITY VERIFICATION

Providers have a responsibility to verify ongoing Marin Medi-Cal (County Code 21) eligibility monthly for the beneficiaries they serve. Providers with a Medi-Cal provider number and PIN number can check eligibility using the the EDS Automated Eligibility Verification System (AEVS), <https://www.medi-cal.ca.gov/eligibility/login.asp> or by calling 1 (800) 456-2387. Providers can sign up for access to the system here: <http://www.medi-cal.ca.gov/signup.asp> or by calling 1-800-541-5555.

Providers who do not have access to the AEVS system, can call BHRS Accounting at 415 - 473-3274 for assistance. If you reach the confidential voice mail, you can leave: your name and phone number, and the Social Security Number/Client Index Number (CIN), last name and date of birth for the client for whom you need to check eligibility, as well as the month for which you are verifying eligibility.

PLEASE NOTE: Service authorization does not guarantee **on-going** Medi-Cal eligibility. The Access Team verifies eligibility prior to authorizing services; however, eligibility could change at any time. **It is the provider's responsibility to check eligibility on the first of every month to ensure that services are provided only to eligible beneficiaries.**

CLAIMS SUBMISSION

Submit payment requests using the Health Insurance Claim form CMS-1500 (02-12). (See ***"CMS Blank Form"*** and ***"CMS Sample Form"*** for guidance on how to use this form.)

Claim forms can be mailed or faxed to:

Marin Mental Health Plan Accounting

20 North San Pedro Road, Suite 2025A, San Rafael, CA 94903

Fax: (415) 473-5850

Claims are due **by the 10th day of the month that follows the month** in which the services are provided.

CLAIMS PAYMENT

BHRS pays claims by the last day of the month that follows the date of the receipt of a complete, accurate, claim for pre-authorized services. Payment is made for valid claims for mental health services if the following conditions apply: 1) Services were delivered by a contract provider, 2) services delivered were pre-authorized by the BHRS Access Team, 3) services were within the range of pre-selected service codes allowed by scope-of-practice and contract agreements; 4) services were provided in person (unless non-face to face services were pre-authorized) and 5) the client was a full scope Marin Medi-Cal beneficiary at the time of service.

Payment will not be made for:

- Missed appointments. Beneficiaries are encouraged to attend all scheduled appointments. Providers may not charge the MMHP or the beneficiary for missed appointments.
- Incorrect CPT codes. Providers will be paid only for those CPT codes listed in the contract and authorized by the BHRS Access Team.
- Clients in a lock out setting for Medi-Cal claiming, such as juvenile hall, jail, or prison. See the Clinical Documentation Guide for more information on claiming lock outs

<https://www.marinhhs.org/clinical-documentation-guide>

- Services are claimed for a different date of service than they were provided.

BENEFICIARIES WITH OTHER INSURANCE

Just as Medi-Cal eligibility can change, a person's overall health insurance can also change. Medi-Cal is the "payor of last resort", meaning that if a beneficiary has another health insurance plan, that health insurance must be billed first. It is only when another health insurance is billed, and that payor adjudicates the claim and provides a denial of payment that Medi-Cal can be billed.

BHRS cannot bill Medicare, or any other form of insurance on behalf of Fee for Service Providers. Providers who wish to take other forms of insurance are responsible for contacting those insurance carriers. Beneficiaries who have insurance in addition to Medi-Cal cannot receive services from Fee for Service Providers.

Individuals with Medi-Cal coverage who have an income above a certain level may be required to pay a monthly share of the cost of their services. Clients identified as Share-of-Cost beneficiaries are not referred to the outpatient provider network, but are served, when appropriate, within County-managed resources.

PROVIDER COMPLAINT RESOLUTION: AUTHORIZATION/PAYMENT APPEALS

Fee for Service providers may contact BHRS at any time to begin a problem resolution process. BHRS staff will work with the providers to resolve problems and concerns as quickly and as easily as possible. The provider may institute an appeal at any time during this process.

- Providers may appeal denied requests for authorization or payment, in writing, directly to Quality Management, at the above address.
- A written appeal shall be submitted to BHRS Quality Management within 90 calendar days of the date of receipt of the non-approval of the request for authorization or payment.
- BHRS Quality Management shall have 60 calendar days from receipt of the appeal to inform the provider, in writing, of the decision and its basis.
- BHRS Quality Management shall use personnel not involved in the initial decision to respond to the provider's appeal.
- If the appeal is not granted in full, the provider will be notified of their right to submit an appeal to DHCS. For appeals regarding disallowance of paid claims resulting from client record review findings, the provider may appeal to DHCS in accordance with Title 9, § 1850.350.
- If the appeal is approved, the provider is required to submit a revised request for payment authorization within 30 calendar days from receipt of the BHRS decision to approve the payment authorization request. BHRS will have 14 calendar days from the date of receipt of the provider's revised request for payment authorization to re-submit the claim that is required to process the payment.

QUALITY MANAGEMENT/UTILIZATION REVIEW (QM/UR)

BHRS QM/UR staff are responsible for assuring that high-quality services are provided to beneficiaries in a cost-effective and efficient manner. The QM/UR staff may review services and programs of Fee for Service providers in order to ensure services are accessible, culturally and linguistically competent, and produce desirable outcomes through the efficient use of resources. QM/UR provide periodic training in medical necessity criteria, documentation standards, patients' rights issues, and other quality components referenced in this manual. (See *"UR Guidelines for Fee for Service Providers"*)

BHRS QM/UR staff monitor beneficiaries' satisfaction with services they receive from contract providers. They also evaluate contract performance based on measurable objectives. If QM/UR staff find that a provider is deficient in providing care, or if other problem areas are discovered, appropriate investigative procedures are

initiated. If these deficiencies or problem areas are verified, corrective actions and sanctions may be applied. These sanctions may include mandatory review of all claims, periodic review of medical records, or termination of the provider's contract with the BHRS.

PROVIDER NOTICES

Provider Notices are distributed to providers to inform them of policy, administrative or financial changes and updates. All changes to the provider manuals that are disclosed in Provider Notices have the authority of policy and are binding, as indicated, to County and providers.



