Sonoma County

Mental Health Provider Manual

DECEMBER 2025

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

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Introduction

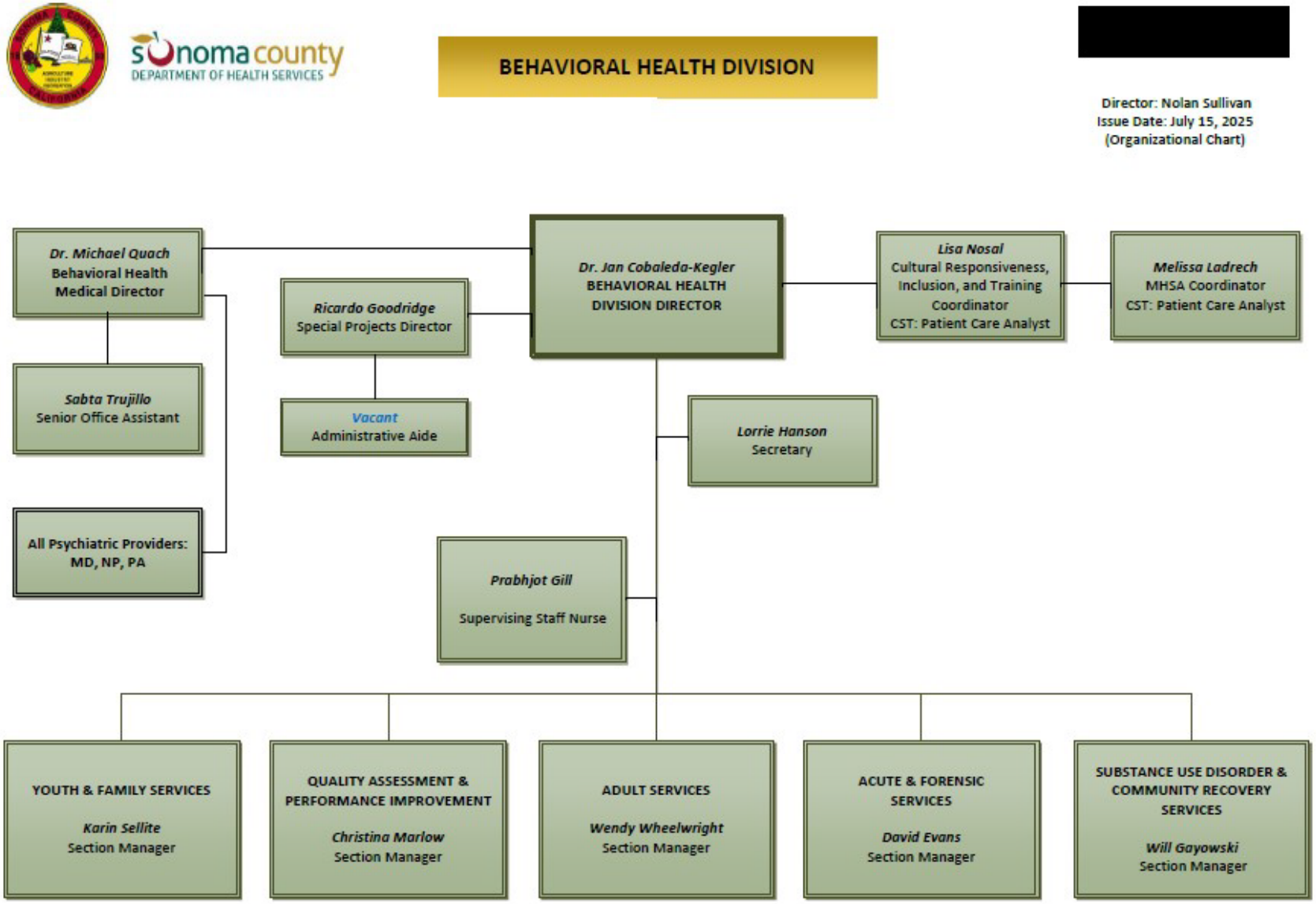
Thank you for your valuable partnership with the Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD). As a contracted provider, you are essential to delivering Specialty Mental Health Services (SMHS) to Medi-Cal members in Sonoma County. This manual offers guidance and instruction for navigating the requirements of being a Medi-Cal provider, supporting your day-to-day operations. It should be used in conjunction with Exhibit F of your DHS-BHD contract, which remains the definitive resource for all required activities. Please note that not all sections of this manual apply to every contracted provider. For any questions regarding its content, please contact our Quality Assurance (QA) staff at BHQA@sonomacounty.gov

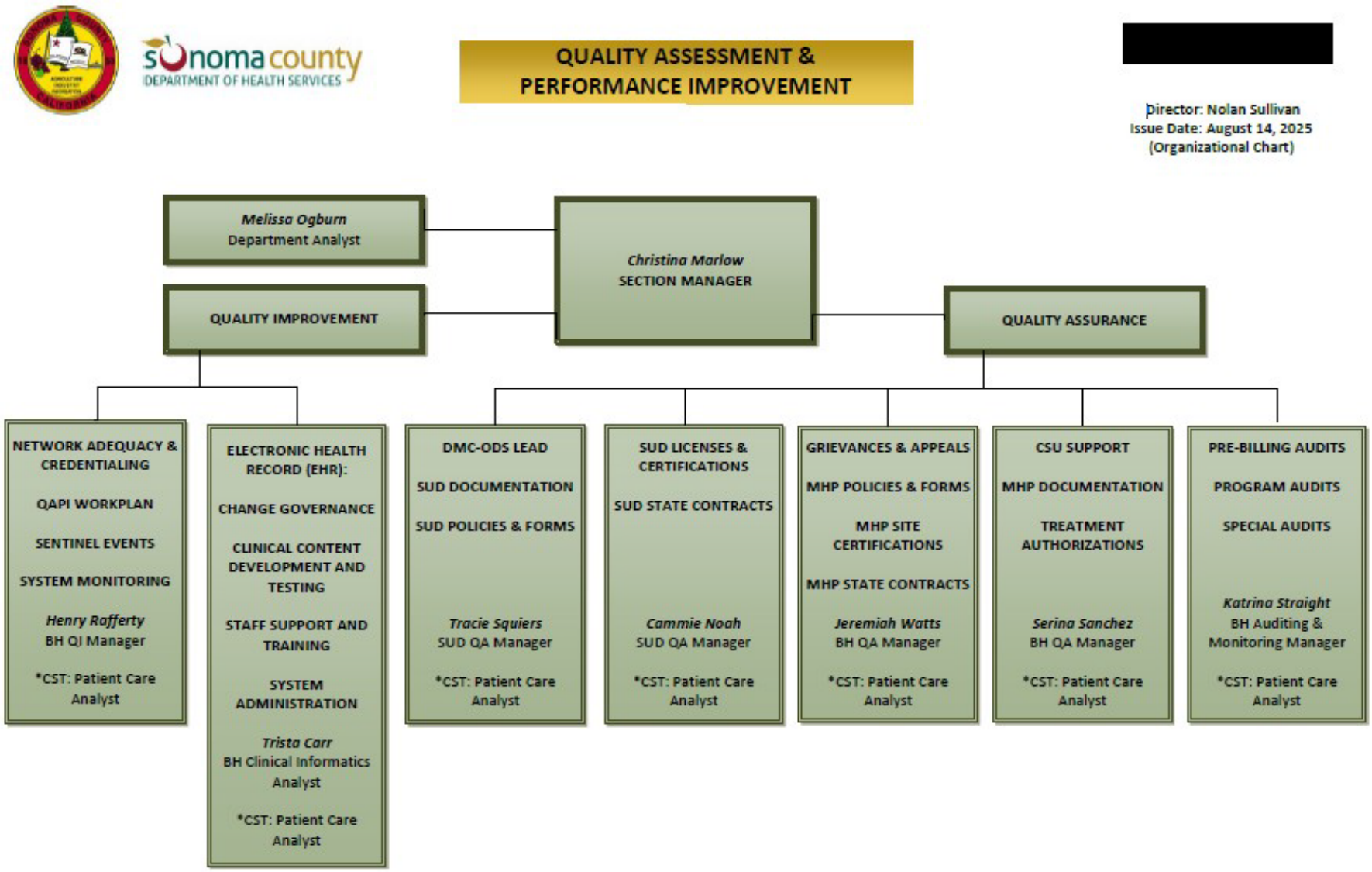
The Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) is committed to a collaborative partnership as they work together to provide quality healthcare services to Medi-Cal members in Sonoma County.

Mission Statement: The mission of the Department of Health Services, Behavioral Health Division is to promote recovery and wellness for Sonoma County residents.

Organizational Charts

Behavioral Health Division Management




sonoma county
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Issue Date: August 14, 2025
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PAVE

The Department of Health Care Services (DHCS) Provider Enrollment Division (DHCS PED) defines PAVE as Provider Application and Validation for Enrollment. The Federal Cures Act [42 CFR 438.602(b)] requires PAVE registration for Certified Nurse Practitioners, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Physicians (MD and DO), Physician Assistants, Psychologists and Registered Pharmacists, who provide SMHS to Medi-Cal beneficiaries. Interns, trainees, and associates are *not* eligible for PAVE enrollment.

PAVE's Ordering, Referring and Prescribing (ORP) application will fulfill the minimum federal enrollment requirement and, as such, DHCS PED recommends using the **PAVE ORP** no-cost application for eligible licensed individual practitioners listed above. Additionally, ORP providers are not required to meet Medi-Cal's established place of business requirements. Therefore, enrolling as an ORP provider allows licensed individuals to meet the enrollment requirement without submitting a complete billing application. Proof of professional liability insurance is not required for an ORP application. DHCS PED does not limit who can assist with the application process. However, the ORP provider is responsible for their enrollment including signing their application and attesting that all information provided in the application is true and accurate.

- Licensed practitioners described above who are required to enroll must enroll, regardless of whether they are billing the Medi-Cal program directly. DHCS PED will check to ensure enrollment status via DHCS' Provider Information Management System (PIMS).
- PAVE ORP application step-by-step tutorial and "how-to" instructions are available starting from slide 23 of the DHCS webinar slide deck: https://www.dhcs.ca.gov/Documents/Provider-Webinar-9-11-20.pdf

PAVE Enrollment Tips and Frequently Asked Questions

1. Are there any tips or suggestions on how to make enrolling in PAVE a smoother process for individual practitioners (as described above)?
Sonoma County's online Provider Credentialing website offers Credentialing Support Items at the bottom of the page. It is updated periodically.
Visit site here: https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/provider-credentialing

Please have the following information on hand prior to enrolling in PAVE ORP application, as practitioners will be asked to enter this information [PAVE Help Desk at (866) 252-1949 can also assist with Technical Support]:

- NPI number (Depending on when and where an NPI was created for you, the address on the NPPES system may not be your current place of employment and may need to get updated. It is recommended to review and update information on NPPES first: https://nppes.cms.hhs.gov/#/)

In addition, have the following documents ready to scan into PAVE:

- Copy of Current Driver's License or State-issued ID (cannot be expired)
- Professional License (this must be the issued license, not a print-out from the licensing board's website)

2. When enrolling in PAVE, is there a preferred web browser or email address type that practitioners should use?

Using Google Chrome as your web browser is recommended, as there have been reports of problems with the website when practitioners use Internet Explorer. PAVE also recommends that staff use a personal computer when initially enrolling in PAVE as some work and county computers may have firewalls and other security measures that may interfere with completing the PAVE online enrollment. Practitioners have the option of using either their personal or work email address when enrolling in PAVE. Practitioners should use the email address where they want to receive information about PAVE and their application status.

3. What help features are available in PAVE?

Call the PAVE Help Desk at (866) 252-1949, and one of the PAVE friendly experts will be happy to assist you with PAVE enrollment. The Help Desk is available Monday - Friday, 08:00 am - 06:00 pm Pacific time, excluding state holidays. PAVE has been specifically designed for ease of use, and also includes embedded in-context tutorial videos found in PAVE applications, as well as hover-help functionality. PAVE features secure login, document uploading, electronic signature, application progress tracking, intuitive guidance, social collaboration and much more. For additional detailed DHCS training materials, view the following:

- PAVE 101 Training Slides at https://www.dhcs.ca.gov/provgovpart/Pages/PAVE-101-Training-Slides.aspx; or
- PAVE Training Videos and other tutorials at https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

4. If I cannot complete the application in one sitting, will I have to start over?

No. You can stop and save your work at any time. Your application will be securely stored in PAVE until you are ready to resume completion.

5. Are individual licensed practitioners who work for county-operated facilities required to enroll via PAVE?

Yes, if they are included in the comprehensive list of providers who are eligible to enroll in the FFS Medi-Cal program on the PED website and are providing services to SMHS beneficiaries, then they are required to enroll. A comprehensive list of individual practitioner and entity types that are eligible and required to register in PAVE can be found on the DHCS PED website: https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx.

6. Are DHS-BHD-contracted agencies required to enroll?

Contracted organizational entities are not required to enroll as they are not directly providing services to SMHS beneficiaries. However, while DHS-BHD-contracted organizational entities are not required to enroll, *eligible licensed individuals who provide SMHS on behalf of that entity* **are** required to enroll as individual ORP providers in PAVE, as described in paragraph above, under "PAVE Enrollment Requirements for Individual Practitioners".

DHCS issued a list of Frequently Asked Questions (FAQ), which can be accessed at: https://www.dhcs.ca.gov/provgovpart/Documents/PAVE_Project_for_Provider_Enrollment_Division/PAVE_FAQ.pdf

Unusual Occurrences and Sentinel Events

Types of Unusual Occurrences and Sentinel Events

Unusual Occurrence: Is an event that: (a) causes a beneficiary direct or indirect harm or has the potential to do so and is outside of the beneficiary's established baseline and/or functioning or (b) involves a beneficiary causing direct or indirect harm, or the potential to do so, to individuals and/or staff. An unusual occurrence may include a sentinel event.

Sentinel Event: A clinical event that results in, or has the potential to result in, death; serious physical and/or psychological injury; including permanent loss of function or severe temporary harm. Sentinel events require timely review and response to reduce the likelihood of recurrence.

The following list of occurrences would be reported as a Sentinel Event or Unusual Occurrence if they resulted in or had the potential to result in death or serious harm:

- Adverse medication reactions, excluding common side effects.
- Medication Errors: Order / Transcription / Administration.
- Abuse of a client: physical or sexual.
- Assault by a client: physical or sexual.
- Community Care Licensing (CCL) reportable events.
- Death of a client (other than suicide or homicide).
- Elopements of clients from a 24-hour facility who are on Conservatorship or who are otherwise at risk of danger to self or others.
- Homicides or homicide attempts.
- Seclusion/Restraint resulting in client injury or death.
- Serious threats of harm to others, including Tarasoff-reportable events.
- Suicides or suicide attempts.
- Significant delays in treatment resulting in harm or exacerbation of condition.

Adverse Medication Reactions

This category only applies if Medication Support Services is part of your contract, or if Medication Monitoring is part of your program (for example, in a residential program). Adverse Medication Reaction is a broad term referring to unwanted, uncomfortable, or harmful effects that a medication may have. Most Adverse Medication Reactions are dose-related; others are allergic or idiosyncratic. Consult with appropriate medical practitioners if you suspect or if a client reports an Adverse Medication Reaction.

Medication Errors

This category only applies if Medication Support Services is part of your contract, or if Medication Monitoring is part of your program (for example, in a residential program). The pathway connecting a clinician's decision to prescribe a medication and the client actually receiving the medication consists of several steps:

- ***Ordering:*** the clinician must select the appropriate medication and the dose, frequency, and duration.

- ***Transcribing:*** in a paper-based system, an intermediary (such as a clerk or technician) must read and interpret the prescription correctly.
- ***Dispensing:*** the pharmacists must check for drug-drug interactions and allergies, then release the appropriate quantity of the medication in the correct form.
- ***Administration:*** the correct medication must be supplied to the correct client with the correct dose by the correct route at the correct time. In residential settings, this is generally the responsibility of nurses or other trained staff; in outpatient care the responsibility falls to clients or caregivers.

Medication Errors can occur at each stage of the pathway outlined above. To implement a prevention program to ensure safe medication management process, consider the following best practices:

Stage	*Safety Strategy*
Ordering	• Established practice guidelines and prescribing principles • Computerized provider order entry • Medication reconciliation at times of transitions in care
Transcribing	• Computerized provider order entry to eliminate handwriting errors • Medication charting review schedule
Dispensing	• Medication reconciliation between printed orders and program medication log
Administration	• Adherence to the "Five Rights" of medication safety (administer the Right Medication, in the Right Dose, at the Right Time, by the Right Route, to the Right Patient) • Minimize interruptions to allow nurses/staff to administer/monitor medications safely • Multicompartment medication devices (medisets/bubblepacks) for clients taking multiple medications • Medication education to improve client comprehension of administration instructions

Abuse of a Client

Client Abuse is any action which causes unreasonable suffering, misery, or harm to the client. Abuse includes physically striking or sexually assaulting a client. It also includes the intentional withholding of necessary food, physical care, and medical attention.

Assault by a Client

This category includes any Assault (physical or sexual) that is committed by a client against another client, a family member, a staff member, or a member of the public.

Community Care Licensing Reportable Event

This category only applies to programs licensed through the California Community Care Licensing (CCL) Division. Any unusual incident/injury reported to CCL on form LIC 624 would qualify as a unusual occurrence reported to DHS-BHD as the Placement Agency.

Death of a Client

Any client death, including from natural causes, is reportable as a unusual occurrence.

Elopements

This category only applies to 24-hour facilities. Elopement occurs when a client who is incapable of adequately protecting themselves departs from a program facility unsupervised and undetected. Elopements are reported for clients in the following two circumstances:

- Clients in conservatorship
- Clients who are at risk of danger to self or others

Serious Threats of Harm to Others

This category includes, but is not limited to, Tarasoff-reportable threats. Threat of harm is defined as all actions, statements, written or non-verbal messages conveying threats of physical or mental injury which are serious enough for a person to reasonably perceive a threat of injury. Threats of harm might be made against a specific individual, or a reasonably identifiable group.

Homicides/Attempts

Any death caused by a client is reportable as a unusual occurrence. Attempted homicide is reported when a client tries but fails to kill another person.

Seclusion/Restraint resulting in Injury/Death

Restraint and Seclusion are behavioral management interventions used as a last resort to control a behavioral emergency. Restraints include the use of physical force, mechanical devices, or chemicals to immobilize a person. Seclusion, a type of restraint, involves confining a person in a room from which the person cannot exit freely. Any injury or death caused by the use of Seclusion/Restraint is reportable as a unusual occurrence.

Suicides/Attempts

Suicide is death caused by injuring oneself with the intent to die. A suicide attempt occurs when someone harms themselves with any intent to end their life, but they do not die as a result of their actions. Non-suicidal self-injurious behavior would not qualify as a unusual occurrence, unless it results in injury requiring medical care.

Significant Delay in Treatment

A Delay in Treatment is when a client does not get a treatment – whether it be a medication, lab test, physical therapy treatment, or any kind of treatment – that had been ordered/authorized for them in the time frame in which it was supposed to be delivered. A delay in treatment is reportable as a unusual occurrence when the failure to respond to a treatment need causes harm to the client, or exacerbates an existing condition.

Reporting Unusual Occurrences and Sentinel Events

Occurrences must be reported via written incident report within 5 business days of knowledge of the occurrence. Unusual occurrences and/or Sentinel Event reports may be submitted by secure email, by FAX (707-565-2202) or by mail to: 2227 Capricorn Way, Santa Rosa, CA, 95407.

Reporting Forms

It is not required to utilize a specific County form for reporting unusual occurrences. Programs may use their own internal incident reporting forms for this purpose. For programs licensed through CCL, a copy of form LIC 624 is sufficient written notification of a Sentinel Event or unusual occurrence. This form can be located at the following link:

https://www.cdss.ca.gov/cdssweb/entres/forms/English/LIC624.PDF

Alternatively, a narrative report of the incident is acceptable, so long as it includes the following elements:

- Name of Program
- Names of Clients/Staff Involved
- Type of Incident
- Description of Incident
- Actions Taken to Address Incident

Reporting Past Incidents

Unusual occurrences are only reported for events that occur after a program begins a treating relationship with a client. Thus, if a client reports something on intake that occurred prior to engaging in treatment with the program (for example, a history of suicide attempts), that would not be reported as an unusual occurrence. This is true for all types of unusual occurrences, ***EXCEPT*** Abuse of a Client. If a client reports abuse that occurred in a prior program, it should be reported as a unusual occurrence. Also, please note that unusual occurrence reporting does not satisfy any Mandated Reporting requirements triggered during the course of intake/treatment.

Reviewing Unusual Occurrences

It is required that all treatment providing programs implement an incident review process to analyze unusual occurrences in order to institute prevention strategies. It is recommended that such reviews include fact finding, analysis, and action steps. The following guidelines may be helpful in developing a review process.

Fact Finding

Check the facts provided by your staff/clients.

- They may have misperceived a fact.
- They may have misreported a fact.
- They may have overlooked a fact.

Construct a timeline of events.

- What's missing from the timeline of events?
- Who would have/know the missing information?

- Are releases in place to obtain that information?
- Investigate further to fill in the holes

Review the Clinical Record.

- Is there documentation relevant to the event?
- Is any important documentation missing?
- How often was the client seen? Any missing appointments? Gaps in service?
- Are there risk assessments in the record? Safety planning in the record?
- Any clinically indicated services that weren't being provided?

Analysis

Examine any Indicators & Risk-Factors.

- Are there any chronic risk factors in play?
- Are there any emergent or acute risk factors in play?
- Did providers respond to these factors in a timely and appropriate manner?

Review the Impacts of the Event.

- Were there any consequences (medically, emotionally, etc.) to the client from this event?
- Were the consequences addressed in a timely and appropriate manner?

Review the Evidence of Response.

- Is there evidence of a response on the part of the provider?
- Is there documentation to support the response?

Conduct a System Analysis.

- Communication
    - Did problems in communication lines contribute to the event?
- Training
    - Is there a training issue revealed by the event?
    - Have training opportunities been given on this topic?
- Organizational
    - Are there issues regarding organizational procedures or workflow which contributed to this event?
- Forms
    - Are there any confusing/misleading elements on program forms which contributed to this event?

Action Steps

Identify Problem-Solution Steps.

- What has the program already done to address the identified problems?
- What is the program planning to do to prevent future occurrences?

- Are program staff waiting on someone else for needed information to address or identify problems?
    - What is the plan once the information is obtained?

Identify Notification Steps.

- Are any legal notifications required to address the event?
    - Tarasoff
    - Mandated Reporting
    - Other
- Are any internal notifications required to address the event?
    - Procedural/protocol changes

Conduct Debriefing, as applicable

- Was the client debriefed? (if appropriate)
- Were any other clients near who witnessed or were impacted by the event?
    - Were these clients debriefed? (if appropriate)
- Did staff get an opportunity to debrief?
    - Were staff directed to appropriate resources for self-care?

Network Adequacy

Definition

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network providers and services included under the terms of the contract. This includes ensuring consumers have access to needed care without unreasonable delay. In order to strengthen access to services in a managed care network, the Final Rule requires states to establish network adequacy standards in Medicaid managed care for key types of providers, including behavioral health providers.

Annual certification of the provider network involves review of compliance in the following areas:

- Network Capacity and Composition
- Time and Distance Standards
- Timely Access to Services
- Language Assistance Capabilities
- Mandatory Provider Types
- Transition of Care/Continuity of Care
- System Infrastructure

See DHCS Behavioral Health Information Notice 25-013 (or any subsequent BHIN).

BHIN 25-013 2025 Network Certification Requirements

Network Capacity and Composition

Sonoma County Mental Health Plan (MHP)/ Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to SMHS for all beneficiaries within Sonoma County, including those with limited English proficiency or physical or mental disabilities. To assist with this process, participating provider agencies should track and update monthly the following information about their organization, program sites, and individual providers.

Organizational Level Information

The term “Organization” refers to the parent organization and/or legal entity designation. The following elements are required to certify the Organizational Provider participation in the Provider Network.

- Organizational Provider Name
- Legal Entity Number assigned to the organization
- National Provider Identification Number (NPI –Type 2) assigned to the organization
- Tax ID number
- Provider Group Name/Affiliation (if applicable)
- Contract Effective and Expiration Dates
- Full Address
- Maximum number of Medi-Cal beneficiaries the Organizational Provider will accept
- Current number of Medi-Cal beneficiaries assigned to the Organizational Provider
- Ownership Type

- Name of CEO (or equivalent)
- Name of CFO (or equivalent)

Site Level Information

The term “site” refers to the physical location (i.e., clinic sites or satellite sites) where services are rendered to Medi-Cal beneficiaries. The following elements are required to certify the Program Site participation in the Provider Network.

- Site Name
- NPI Number Type 2 assigned to the site
- DEA Number (if applicable)
- Full address
- Site Provider Number
- Service Types offered at the Site
- Hours of operation
- ADA Compliance for Physical Plant
- TDD/TTY Equipment availability
- Distance between site and closest public transportation
- Telehealth Station/Equipment availability
- On-site Language Capacity
- Language Line availability

Individual Provider Level Information

The term “rendering service provider” refers to the individual practitioner, acting within their scope of practice, who is providing services directly to beneficiaries. This includes Telehealth practitioners. The following elements are required to certify an Individual Provider participating in the Provider Network.

- Provider’s first and last name
- NPI Number Type 1 associated with the individual provider
- NPI Number Type 2 associated with the sites served by the individual provider
- DEA Number (if applicable)
- Full address of sites where individual provider renders services
- Provider Type/Discipline
- Service Types offered by individual provider
- California Practitioner License Number (if applicable)
- Age Groups Served
- Full-Time Equivalent percentage available, by site, to serve beneficiaries of each age group
- Maximum caseload
- Current caseload
- Language Capacity
- Cultural Competence Training Hours Completed in the past 12 months
- Telehealth Provider status

- Field-Based services capacity
- Distance provider travels to deliver field-based services

Calculating Full-Time Equivalents

A provider may be counted as one Full-Time Equivalent (FTE) position if the individual's full-time job assignment is direct service delivery to Medi-Cal beneficiaries. In the case where an individual is assigned to direct service delivery on a part-time basis, the FTE should be calculated based on the percentage of time the individual could be dedicated to direct service delivery on an ongoing basis over the course of a year. A FTE position is 2,080 hours per year (i.e., 40 hours per week). Only direct providers of SMHS and Psychiatrist Services should be included as network providers.

Administrative Staff

These staff and/or members of leadership can only be included as network providers if they genuinely have capacity to serve clients on a regular and on-going basis. If an administrative staff employee is needed to function 100% in their administrative role (e.g., director, medical director, quality improvement manager) but could pick up a client on an emergency basis, the employee should not be included as they do not have actual capacity to serve clients. The FTE, if included, should accurately reflect the amount of time the individual can actually be available to directly provide services to a beneficiary over the course of a year.

Time and Distance Standards

DHCS has established time and distance standards for adult and pediatric behavioral health providers. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. The time and distance standards determined for Sonoma County Outpatient Mental Health Services (including Targeted Case Management, Crisis Intervention, and Psychiatrist Services) are up to **30 miles and 60 minutes** from the beneficiary's place of residence. Time and distance standards **DO NOT APPLY** to residential or inpatient settings, or to out-of-county provider sites.

Timely Access to Services

Sonoma County MHP and its provider network are required to meet State standards for timely access to care and services, taking into account the urgency of the need for services. The following table depicts timely access requirements by type of service and urgency level.

Appointment Type	Standards
Initial Request for Service/Assessment	Within 10 business days of the request for service
Urgent request for services that do not require prior authorization	Within 48 hours of the request for appointment
Urgent request for services that require prior authorization	Within 96 hours of the request for appointment
Request for Psychiatry Services	Within 15 business days of the request for appointment
Request for non-Psychiatry Services (i.e., therapy)	Within 10 business days of the request for appointment
Non-urgent Follow-up Appointments	Within 10 business days of the prior appointment

Please note that periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of their practice.

Provider sites shall ensure that hours of operation during which services are provided to Medi-Cal beneficiaries are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. It is essential that all treatment sites provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities.

Language Assistance Capabilities

DHS-BHD is required to report in the Provider Directory the cultural and linguistic capabilities of network providers. In support of this, program sites shall track and update monthly the language capabilities (including American Sign Language) offered by individual providers or skilled medical interpreters at the provider's office. Additionally, programs should record hours of cultural competence training completed by staff annually.

System Infrastructure

To certify system infrastructure, provider organizations shall maintain current provider directories and organizational charts detailing clinical teams, including identification of deputy directors, clinical managers/supervisors, clinicians, and staff. DHS-BHD maintains a network-wide provider directory that is updated monthly and posted at Medi-Cal Informing Materials. Contract providers should review their portion of the Provider Directory at least once per quarter and submit any corrections to BHQA@sonomacounty.gov

Reporting Requirements

DHS-BHD must submit provider data to the State using the 274 file generated from SmartCare on a monthly basis, in addition to submitting the annual network certification on July 1. Contracted providers who provide outpatient SMHS must ensure their provider information is up to date each month–no later than 7 days before the last day of the month–to allow for data entry, analysis, validation, and remediation.

Contracted providers must send notification of any staff changes, including but not limited to, departures, FTE alterations, license changes, and program transfers, to: RMU-Credentialing@sonomacounty.gov
Contracted providers may view their provider list with the "FTE by Site – Sonoma" report in SmartCare to confirm accuracy.

Medi-Cal Site Certification/Recertification Overview

In order for a provider to receive Medi-Cal beneficiary referrals from Sonoma County Department of Health Services Behavioral Health Division (DHS-BHD) and begin billing for services, the provider must first be Medi-Cal certified by the California Department of Health Care Services (DHCS) or its designee, DHS-BHD.

Providers must pass the Medi-Cal site certification in order to become a contracted Med-Cal provider with DHS-BHD. Compliance with site certification standards is monitored by DHS-BHD Quality Assurance (QA) staff. Providers will receive notice from DHS-BHD QA staff regarding the timing of certification visits. The exact timing of the site certification will be up to the discretion of DHS-BHD. Providers must allow DHS-BHD staff access to their sites to allow for certification/recertification visits in order to maintain their status as a DHS-BHD contracted provider.

DHS-BHD will conduct site certifications during new provider contract initiation and will conduct recertification as required to ensure compliance with all federal and state guidelines. At a minimum, contracted providers must be recertified once every three (3) years. Each contracted provider must remain in compliance with certification requirements at all times.

General Requirements

DHS-BHD QA staff shall certify providers that contract with DHS-BHD to provide covered services in accordance with Cal. Code Regs., tit. 9, §1810.435 (State Contract). The on-site review required by Cal. Code Regs., tit. 9, § 1810.435(e), shall be conducted of any site owned, leased, or operated by the provider (organization) and used to deliver covered services to beneficiaries, except that an on-site review is not required for public school or satellite sites. DHS-BHD shall complete any required on-site review of a provider's site(s) within six months of the date the provider begins delivering covered services to beneficiaries at the site (State Contract).

NOTE: "Satellite site" means a site owned, leased or operated by an organizational provider at which SMHS are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which SMHS are delivered by no more than two employees or contractors of the provider (State Contract).

DHS-BHD may allow a contracted provider to begin delivering covered services to beneficiaries at a site subject to on-site review prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on-site review is the latest of these three (3) dates: 1) the date the provider's request for certification is received by DHCS in accordance with DHS-BHD certification procedures; 2) the date the site was operational; or 3) the date a required fire clearance was singed as "granted."

DHS-BHD may allow a contracted provider to continue delivering covered services to beneficiaries at a site subject to on-site review as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances (State Contract).

As part of the Medi-Cal Site Certification process, DHS-BHD shall verify that each provider (CCR §1810.435):

- Possesses the necessary license to operate, if applicable, and any required certification.
- Property owned, leased or operated by the provider and used for services or staff meets local fire codes.
- Establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of beneficiaries and staff.
- Provides for appropriate supervision of staff.
- Has as Head of Service a licensed mental health professional (as defined in Cal. Code Regs., tit. 9, §622 through §630).
- Possesses appropriate liability insurance.
- Has a current administrative manual which includes: personnel policies and procedures (including staff screenings and licensure requirements), general operating procedures, service delivery policies, any required state or federal notices (DRA), and procedures for reporting unusual occurrences relating to health and safety issues. Store and dispense medications in compliance with all pertinent State and Federal standards.
- Maintains beneficiary records in a manner that meets State and Federal standards.
- Has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
- When applicable, stores and dispenses medications in compliance with all pertinent State and Federal standards.

In particular:

- All drugs obtained by prescription are labeled in compliance with Federal and State laws. Prescription labels are altered only by persons legally authorized to do so.
- Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.
- All drugs are stored at proper temperatures: room temperature drugs at59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
- Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.
- Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.
- A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.
- Policies and procedures are in place for dispensing, administering and storing medications.

The duration of the on-site review may vary depending on the size of the provider and the complexity of the Modes of Service to be certified. The certification process can take 60-90 calendar days to complete. This certification shall be performed prior to the date on which the provider begins to deliver services under the provider's contract at these sites and once every three years after that date, unless the DHS-BHD MHP determines an earlier date is necessary.

Additional certification review may be conducted when:

- The provider makes major staffing changes.
- The provider makes organizational and/or corporate structure changes (e.g., conversion from non-profit status).
- The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.
- There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
- There is change of ownership or location.
- There are complaints against the provider.
- There are unusual events, accidents or injuries requiring medical treatment for beneficiaries, staff or members of the community.

Certification Process: Overview

In order for the DHS-BHD QA to complete the Medi-Cal site certification process, the provider must:

1. Have a National Provider Identifier (NPI) number in the National Plan and provider Enumeration System (NPPES) that will be uniquely associated with only one active provider/site.
2. Ensure that their NPPES "Other Name" and "Primary Practice Address" are accurate.
3. Obtain a provider number from DHCS, requested by DHS-Revenue Management (RMU) as part of the Provider File Update (PFU) process.
4. Obtain a current and valid Fire Clearance (defined by DHCS as within 12 months of the certification on-site review).
5. Submit a Head of Service License (HOS). The HOS must be on the provider's official staff roster (either as an employee or through a contractual relationship) and meet DHS-BHD requirements.
6. Demonstrate compliance with the current DHCS Short-Doyle Medi-Cal (SD/MC) Certification Protocol.
7. Complete and submit all of the required documents included in the ***Site Certification Application Packet*** *(see Desk Review)*.
8. Successfully pass the Medi-Cal site certification desk and on-site review.

The following steps outline the DHS-BHD Medi-Cal certification process:

1. At the point of contract initiation, or amendment DHS-BHD Administrative Support staff will notify DHS-BHD RMU and DHS-BHD QA of the intent to contract with the provider.
2. At the time of contract initiation/amendment, or at the time of Medi-Cal recertification, DHS-BHD QA will contact the provider and e-mail to them the (*see* **Desk Review**).
3. DHS-BHD RMU will send to the provider the Rate and Cost Proposal template – *Contractor has (7) business days to complete and return the form to DHS-RMU.*
4. The provider must submit to DHS-BHD QA all the documents identified in the *Site Certification Application Packet*.
5. DHS-BHD QA will conduct a *desk review* of all documents obtained by way of the *Site Certification Application Packet* (*see Desk Review*).
6. DHS-BHD QA and the provider will coordinate the date/time of the on-site review.

7. DHS-BHD QA conducts the on-site review using the most current DHCS SD/MC Certification Protocol and DHS-BHD *QA Site Certification Documents Checklist* to ensure the provider meets all program and contractual requirements (see *On-site Review*).
8. Once the provider has successfully passed the desk and on-site reviews, DHS-BHD QA submits required documents to DHCS for approval. DHCS may take up to four weeks to complete the approval process (up to 3 months for STRTPs).
9. When DHS-BHD QA receives approval from DHCS, DHS-BHD QA informs DHS-BHD RMU and Administrative Support of the approval and provides them the supporting documents.
10. DHS-BHD Administrative Support will initiate final execution of the provider contract.
11. DHS-BHD RMU enters the necessary information into the DHS-BHD electronic system for billing and claiming.
12. DHS-BHD QA e-mails the Consolidated Medi-Cal Certification Approval Letter to the provider. The Letter serves as official notice of the approval for Medi-Cal site certification of the provider.
13. With each initial Medi-Cal certification that requires a new Provider Identification Number (PIN), the permanent Medi-Cal PIN is sent directly to the provider by DHCS. The PIN is required in order for the provider to check for the Medi-Cal eligibility of potential beneficiaries. A temporary PIN may be used while waiting for the permanent PIN.

The provider may submit claims back to the Medi-Cal Activation/Effective Date of Medi-Cal certification. The Activation/Effective Date of certification is the date designated as such on the Consolidated Medi-Cal Certification Approval Letter.

Desk Review

Prior to conducting the on-site review, DHS-BHD QA will e-mail to the provider the ***Site Certification Application Packet*** *and additional instructions*. This packet includes the DHCS SD/MC Certification Protocol, the **QA Site Certification Documents Checklist** and additional accompanying documents. The **QA Site Certification Documents Checklist** lists documents required to conduct the desk review portion of the certification. Below is a list of required documents listed in the **QA Site Certification Documents Checklist** and a description of each:

1. *MHS 154 Medi-Cal Certification/Recertification Application:* DHS-BHD form used to initiate Medi-Cal certification. It is a tool to gather information to verify Medi-Cal provider eligibility.

2. *MHS 155 Program Description:* DHS-BHD form used to verify that program services match the Medi-Cal certification and meet specific certification criteria (e.g. head of service, hours of operation, medication storage, building cleaning/maintenance, etc.).

3. *Informing Materials Check List and Instructions:* A list of required Medi-Cal informing materials the provider must have on-site. Provides directions for issuance and posting.

4. *Medi-Cal Policy and Procedure Documents:* In line with the DHCS SD/MC Protocol, providers must demonstrate compliance with specific requirements. As such, DHS-BHD requires the provider to have in place policies and/or procedures that cover the following areas:
    a. Confidentiality and Protected Health Information.

b. Emergency evacuation.
c. Screening licensed personnel/providers and checking the excluded provider lists, etc.
d. General Operating Procedures.
e. Maintenance of Facility (copy of maintenance & cleaning agreement if done by outside agency).
f. Services Delivery (types of service, intake process, referral and linkage, length of services, discharge, and discontinuation of services).
g. Unusual Occurrences Reporting.
h. Process for referring individuals to a psychiatrist when necessary.
i. Dispensing, administering, storing, and the disposal of medications.

5. *Staff List:* List of ***all*** provider employees. This list shall include identification of licensed employees and the NPI's for employees who are eligible to bill Medi-Cal (this list is cross referenced with exclusion screening results).
6. *Exclusion Screening Results:* The list of results from your exclusion screenings (Office of Inspector General, DHCS Medi-Cal List of suspended or ineligible providers, System for Award Management, and Social Security Death Master file) per each employee listed. Submit 1 per month (3 total) closest to certification or recertification (See exhibit F of your contract for frequency of screenings).

DHS-BHD QA staff will review the submitted documents for accuracy, completeness, and compliance with DHCS Medi-Cal site certification requirements. An on-site review will be conducted after the provider demonstrates full compliance with the desk review portion of the Medi-Cal site certification process.

On-site Review

DHS-BHD QA conducts the on-site review once the provider demonstrates compliance with the desk review portion of the Medi-Cal certification. To ensure full compliance with Medi-Cal certification requirements, DHS-BHD QA will use the DHCS SD/MC Provider Certification and Re-Certification Protocol, which includes review of the following areas:

1. Posted Brochures and Notices
    a. Client brochure, provider list, grievance/appeal/expedited appeal forms, etc.
2. Fire Safety Inspection
3. Physical Plant
    a. Cleanliness, structural integrity, safety, PHI security.
4. Policies and Procedures *(practice cross referenced with policies and procedures submitted as part of the desk review)*
    a. PHI, emergency evacuation, personnel, general operation, maintenance, service delivery, unusual occurrences reporting, referral to psychiatrist or physician, HOS.
5. Head of Service and Licensed Staff *(verification of appropriate HOS designation based on program specifics and setting)*
6. Medication Support Services *(practice cross referenced with policies and procedures submitted as part of the desk review)*
    a. Storage of medications on-site, labeling, medication logs, auditing supplies of controlled substances, medication disposal.

Medi-Cal Site Certification: Plan of Correction

Any items found out of compliance must be corrected by the provider and verified by DHS-BHD QA. The need for a Plan of Correction will cause a delay in the submission of documents to DHCS and may require an additional on-site review.

The provider is required to correct any deficiency(ies), and demonstrate compliance of site certification requirements to the DHS-BHD within 30 days of notification. Failure to provide evidence of correction of or compliance with the deficiencies within the 30 days will result in withholding of payments for current and future claims and/or contract termination.

Beneficiary/Client Rights

1. Be treated with respect and with due consideration for his or her dignity, and privacy.
2. Receive information on available treatment options and alternatives presented in a manner appropriate to their condition and ability to understand.
3. Participate in decisions regarding his or her health care, including the right to refuse treatment.
4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
5. Request and receive a copy of their medical records, and request that they be amended or corrected.
6. Ask for a provider who can communicate in their language.
7. Whenever possible, receive mental health services at times and places that are convenient for them.
8. Be told what their diagnosis means and get answers to questions.
9. Get a second opinion when the first assessment indicates no need for treatment
10. Change their treatment provider.
11. Know the benefits, risks, and costs of treatment before giving permission for services.
12. File a grievance about the services received or about the way that they were treated.
13. Choose another person to act as representative in the grievance process.
14. Have their mental health records and personal information kept private.
15. Be told about program rules and changes.
16. File an appeal when services are denied, in part or in whole.
17. Have access to the beneficiary handbook and materials on how to file a grievance, appeal, and State Fair Hearing.
18. Receive mental health services in accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.206 through 438.210, which cover requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, coverage and authorization of services and to receive information in accordance with Title 42, CFR, Section 438.10, which describes information requirements.

Beneficiary Request for Service (BRS) Overview

Sonoma County Department of Health Services – Behavioral Health Division (DHS-BHD) and contracted providers shall ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. Services shall be provided in accordance with the State Plan to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment.

DHS-BHD and its contracted providers must ensure that all Medi-Cal beneficiaries who are eligible for SMHS through the DHS-BHD network are informed of their right to request continued services (Continuity of Care – COC) when there is a pre-existing provider relationship, and to request for out-of-network (OON) services when covered services are unavailable in-network, or in a timely manner.

All Beneficiary Requests for Service (BRS) are processed in accordance with state and federal mandates. DHS-BHD contracted providers are required to process BRS when a DHS-BHD beneficiary requests services from the provider that are not included in the provider's contract with DHS-BHD, or not made available in a timely manner. DHS-BHD in partnership with contracted providers are required to make determinations about beneficiary requests for service within 14 calendar days from the date of request.

Medi-Cal beneficiaries are informed of access to care rights via provided Medi-Cal Informing Materials. Medi-Cal Informing Materials shall be made available in public spaces at provider sites (*see Medi-Cal Site Certification*). At the time of assessment contracted providers will offer Medi-Cal Informing Materials and inquire about pre-existing provider relationships. Contracted providers must document inquiry about pre-existing providers and availability of Informing Materials (Acknowledgement of Receipt).

Pre Existing Provider & Continuity of Care – Qualifying Event

A pre-existing provider is one that the beneficiary has engaged in treatment with at least once in the 12 months prior to transferring their care to DHS-BHD, or the contracted provider.

All beneficiaries who meet medical necessity for SMHS have a right to request COC with their pre-existing provider when any of the following Qualifying Events occurs:

1. The provider has voluntarily terminated employment or the contract with the MHP;
2. The provider's employment or contract has been terminated for a reason other than issues related to the quality of care or eligibly of their provider to participate in the Medi-Cal program;
3. The beneficiary is transitioning from one county MHP to another MHP due to a change in the beneficiary's county of residence;
4. The beneficiary is transitioning from a Managed Care Plan (MCP) to a MHP; or,
5. The beneficiary is transitioning from Medi-Cal Fee for Service (FFS) to a MHP.

A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a request with the provider for COC, in writing, or via telephone and shall not be required to submit an

electronic or written request. The provider shall deliver reasonable assistance to beneficiaries in completing requests for COC, including oral interpretation and auxiliary aids and services.

BRS Filing Process

At the time of a Qualifying Event, upon request for a service not currently provided to the beneficiary, or when required services are not available in a timely manner (see Timely Access Standards), the contracted provider shall offer appropriate and available services covered in the provider's DHS-BHD contract. If the beneficiary agrees to utilize the offered services, then no BRS form needs to be completed.

If the beneficiary declines offered services, then the provider shall process the beneficiary request for service by completing the digital Beneficiary Request for Services form on behalf of the service requester (beneficiary, or their representative).

If the provider determines that the requested service is ***not medically necessary, or clinically appropriate*** the provider shall either deny or modify the BRS. A denial is made when no additional services will be provided in response to the BRS. A modification is made when alternate covered services will be offered in response to the BRS – meaning more services that are covered in the CBO contract are offered to the beneficiary.

The provider shall verbally inform the requestor of this determination within 24 hours of the decision to deny, and issue the Service Denial or Modification Notice of Adverse Benefit Determination (NOABD) within **2 calendar days** of the decision to deny the request.

All denied or modified BRS forms should be submitted to DHS-BHD via the online form and the issued NOABDs should be uploaded into the beneficiary's electronic health record.
For contracted providers not utilizing SmartCare, a copy of the issued NOABD shall be submitted to DHS-BHD: dhs-bh-brs@sonomacounty.gov

If the provider determines that the requested service is ***medically necessary and clinically appropriate***, but the requested services are not covered in the provider's contract with DHS-BHD, then the provider shall complete the only BRS Form for processing.

The BRS form can be obtained here: New Beneficiary Request for Services Form

BRS Form Completion

The BRS form has 3 sections. Upon submission of Part 1, applicable approving staff will receive notification to review and approve subsequent sections (Section Management) *Section 1:* Contracted Provider Clinical staff completes (reviewed & approved by CBO Health Clinical Manager).

Sections 2 & 3: DHS-BHD Section Manager completes (reviewed & approved by DHS-BHD, view only unless staff is in a role of Section Manager).

*Section 1 (**Completed by the contracted provider**)* includes the following:

An * indicates a required field.

Beneficiary Information:

- Date of Service Request*: Date requested by client, client's legal representative, or provider.
- Client Medical Record Number*: If a SmartCare record number is available, please provide.
- Client Name*: First, last and if applicable preferred names of the client associated with the service request.
- Client Date of Birth*
- Client Primary* and Secondary Insurance, as applicable.
- Client Preferred Language and Cultural Considerations: Please enter client's preferred language and any cultural, this also can include trauma informed, considerations that may impact client's needs when coordinating services, for example client prefers a female provider. This section is optional and only needs to be filled out if applicable.
- Client Mailing Address: Confirm with client an active mailing address where they can receive status updates about their request, service determination outcomes will be mailed to the address entered here.
- Current Diagnosis: Include brief details on the diagnosis related to this request. Name of Person Making the Request*: Name of the person completing the BRS form on behalf of the requester, including contact information and relationship. If a staff member is completing, it is ok to enter the same information as provided for the Health Program Service Coordinator.
- Health Program Service Coordinator Name*: Health Service Coordinator or Case Manager as applicable. Please include first and last name.
- Health Program Service Coordinator Phone Number: Phone number of the person completing the BRS form on behalf of the requester. Program Name*: Name of the program entering and coordinating request with DHS-BHD.
- Program Manager First and Last Name*: The program manager of the program submitting the request for the client, this information will be used for routing the request for appropriate review and authorization.

Service Details:

- Request Type*: Indicate if the request B is for a service not available within network and/or for an in-network service outside of timeliness standards (BRS) or a request for continuation of care with an existing provider (COC).
- Standard or Urgent: Please indicate level of urgency of the service need based on level of risk. Consider the clinical implications of not having the services provided to the client.
- Requested Service: Please pick from the drop down or add a new service type to indicate what service the client is requesting.
- Proposed frequency*: From the provider's perspective, indicate the recommended number of times per week and hours per day, for example: X times weekly for up to X minutes/hours.

- Proposed duration: From the provider's perspective, indicate the recommended timeframe this frequency is indicated, for example: 4 weeks, 3 months, etc.

Clinical Rationale in Support of the Service Authorization

- Associated Impairments: Indicate impairments that would be reduced as a result of the requested service
- Clinical Rationale for Out-of-Network Service Request: What is the provider's clinical impression about the client's needs and the requested service.

Requested Service Provider Contact Information

- Contact information for the Requested Service Provider: Agency, email, phone number, mailing address the requested service provider.
- Is the client currently receiving services from the Requested Service Provider?
    - If "Yes" is entered to the question "Is the client currently receiving services from the Requested Service Provider?" fields will display to allow staff to document the dates of attempted contacts made to verify the existing relationship.

Program Managers and Section Managers are notified when a request is submitted and are prompted to complete Section 2, and Section 3 respectively. Program

DHS-BHD BRS Authorization Determination Process

When the contracted provider determines the requested service(s) is medically necessary and clinically appropriate, they shall submit the BRS to DHS-BHD for processing. Contracted providers must complete BRS forms promptly and submit them to DHS-BHD within 24 hours of the initial request . For continuity of care requests, contracted providers should submit to DHS-BHD within 10 days to allow time to confirm relationship with the existing provider.

Once the contracted provider submits the BRS to DHS-BHD, the Sonoma County MHP will review the BRS and issue a final decision regarding authorization.

If the BRS is ***denied***, DHS-BHD QAPI staff will inform the contracted provider of the denial and will issue the proper NOABD to the service requestor.

If the BRS is ***approved***:

- DHS-BHD QAPI staff will inform the contracted provider of the approval.
- The contracted provider will notify the service requestor of the determination related to the BRS and provide updates as needed.
- DHS-BHD Administrative Support & Contracts staff will steward the BRS through the contracting process and provide updates to the contracted provider and QAPI staff.
- As appropriate, the contracted provider will monitor the beneficiary's progress in treatment, verify that medical necessity for SMHS are met, and that the beneficiary is actively participating in and benefitting from the authorized service.

- As appropriate, the contracted provider will inform DHS-BHD QAPI staff of any expected/required changes to the terms of the BRS agreement (e.g. *term extension, termination of services, reduction, and/or addition of services*).
- DHS-BHD QAPI staff will work with the contracted provider to ensure the creation of a transition of care plan to ensure safe transfer to an in-network provider within the required timeframes.

Beneficiary Rights: Notice of Adverse Benefit Determination (NOABD)

Provision of Notice of Adverse Benefit Determination

An adverse benefit determination is the delay, denial, or limited authorization (modification) of a requested service, or previously authorized service. This includes determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. A Notice of Adverse Benefit Determination (NOABD) informs beneficiaries of a delay, denial, limitation, or change to their SMHS.

The provider shall issue a NOABD when authorization and timely access timeframes are not met and when there has been a denial, limitation, or change to of the beneficiaries SMHS due to medical necessity criteria not being met. NOABDs specify what action was taken, the clinical justifications, and cite the corresponding regulations. A NOABD also informs beneficiaries of their rights to appeal the determination and pursue a State Hearing. *NOTE: contracted providers are not responsible for processing or resolving appeals or State hearings.* Contracted providers must immediately forward any requests for appeals and State hearing to the DHS-BHD QA Manager via BHQA@sonomacounty.gov.

Providers shall issue a NOABD to beneficiaries under the following circumstances:

- Failure to provide services in a timely manner (see Timely Access to Services, p15).
- Failure to provide service authorizations in a timely manner (14 calendar days from the date of request receipt –see Beneficiary Request for Service, p24).
- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit (see Beneficiary Request for Service, p24).
- Reduction, suspension, or termination of a previously authorized service.
- Failure to resolve grievances in a timely manner (see Beneficiary Resolution Process, p36).

The provider must ensure timely issuance and adequate notice of an adverse benefit determination in writing using a NOABD. The NOABD must be available in the prevalent non-English languages in the providers particular service area (Sonoma County - Spanish). They must include taglines and be printed in a conspicuously visible font size. They must also explain the availability of written translation or oral interpretation to understand the information provided. NOABDs must be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. Alternative formats and language assistance must be made available upon request of the potential beneficiary or beneficiary at no cost.

The NOABD will either be hand-delivered to the beneficiary on the date of the adverse benefit determination or mailed. The written NOABD shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires. Decisions should be communicated first by telephone or in person within 24 hours of the determination, and then in writing per the issuance timeframes below (except for decisions rendered retrospectively).

The provider agrees to log all issued NOABDs, including the date of issuance and to whom the NOABD was sent. The provider shall retain copies of all issued NOABDs in a centralized file accessible to DHS-BHD. The

provider must allow DHS-BHD and DHCS to engage in reviews of the provider's records pertaining to NOABDs to ensure timely and accurate issuance. All issued NOABD and the corresponding quarterly report must be e-mailed to the DHS-BHD Grievance Coordinator on a quarterly basis (BHQA@sonomacounty.gov).

All email communications containing beneficiary identification or other health protected information must use encryption to secure transmitted electronic health information.

Format of NOABD

Providers must use the State Department of Health Care Services (DHCS) uniform NOABD templates, or the electronic equivalent of these templates generated from DHS-BHD. The notice templates include both the attached NOABD and "Your Rights" documents to notify beneficiaries of their rights in compliance with the federal regulations. All text must be at least 12 point font and the documents must be ADA complaint. https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/forms-and-materials

NOABD "Your Rights" Attachment

The "Your Rights" attachment is a new form that informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution (NAR). These attachments must be sent to beneficiaries with each NOABD or NAR.

The "NOABD Your Rights" attachment provides beneficiaries with the following required information pertaining to NOABD:

- The beneficiary's or provider's right to request an internal appeal with DHS-BHD within 60 calendar days from the date on the NOABD;
- The beneficiary's right to request a State hearing only after filing an appeal with DHS-BHD and receiving a notice that the Adverse Benefit Determination has been upheld;
- The beneficiary's right to request a State hearing if DHS-BHD fails to send a resolution notice in response to the appeal within the required timeframe;
- Procedures for exercising the beneficiary's rights to request an appeal;
- Circumstances under which an expedited review is available and how to request it; and,
- The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits (also known as "Aid Paid Pending").

Notice of Availability , Nondiscrimination Notice and Taglines

The provider will follow the requirements of DHCS MHSUDS Information Notice No. 25-014 regarding written material requirements for denial and termination NOABDs. Including availability in threshold languages and alternative formats, "Non-Discrimination Notice" and "Notice of Availability" taglines made available by DHCS or adapted for use by DHS-BHD, as permitted in DHCS MHSUDS Information Notice No.25-014.

Nondiscrimination Notice and Notice of Availability Taglines

Federal regulations require the provider to post nondiscrimination notice requirements and Notice of Availability taglines in significant communications to beneficiaries. Providers may utilize the templates provided by DHCS, or use the modified template created by DHS-BHD. The Nondiscrimination Notice and Notice of Availability Taglines must be sent in conjunction with each of the following significant notices sent to beneficiaries: *NOABD, grievance acknowledgment letter, appeal acknowledgment letter, grievance resolution letter, and NAR.*

NOABD Template Contents

The NOABD must explain the following:

- The adverse benefit determination the provider has made or intends to make.
- The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The beneficiary's right to request an appeal of the provider's adverse benefit determination, including information on exhausting the DHS-BHD one level of appeal and the right to request a State fair hearing.
- The procedures for exercising the rights related to the NOABD, appeal, and State Hearing.
- The circumstances under which an appeal process can be expedited and how to request it.
- The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

The following is a description of adverse benefit determinations and the corresponding NOABD template.

- ***NOABD Service Denial Notice****:* Denial of authorization for requested services
    - Use this template when the provider denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- ***NOABD Payment Denial Notice***: Denial of payment for a service rendered by provider
    - Use this template when the provider denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.
- ***NOABD Delivery System Notice****: Delivery system
    - Use this template when the provider has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the contracted provider. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

- ***NOABD Modification Notice****:* Modification of requested services
    - Use this template when the provider modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.
- ***NOABD Termination Notice****:* Termination of a previously authorized service
    - Use this template when the provider terminates, reduces, or suspends a previously authorized service.
- ***NOABD Authorization Delay Notice****: Delay in processing authorization of services
    - Use this template when there is a delay in processing a request for authorization of SMHS or substance use disorder residential services. When the provider extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.
        - For standard authorization decisions, the provider will provide notices as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days.
        - For expedited authorization decisions, the provider will provide notices as expeditiously as the beneficiary's health condition requires and within 72 hours following receipt of the request for service with a possible extension of up to 14 calendar days.
- ***NOABD Timely Access Notice****:* Failure to provide timely access to services
    - Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. Refer to DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No. 18-011 for the applicable timeframes, depending on the specific service provided by the MHP.
- ***NOABD Financial Liability Notice****:* Dispute of financial liability
    - Use this template when the contracted provider denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
- ***NOABD Grievance and Appeal Timely Resolution Notice***: Failure to timely resolve grievances and appeals
    - Use this template when the contracted provider does not meet required timeframes for the standard resolution of grievances (90 calendar days from when the contracted provider receives the grievance) and appeals (30 calendar days from when the contracted provider receives the appeal).

* *Contracted providers typically issue these types of NOABDs.* All other types are typically issued by DHS-BHD.

Timing of NOABD

Adverse benefit determinations should be communicated first by telephone or in person within 24 hours of the determination, and then in writing per the issuance timeframes below.

NOABD shall be issued within the following timeframes:

- For termination, suspension, or reduction of a previously authorized specialty mental health service, ***at least 10 days before the date of action***, except as permitted under 42 CFR §§ 431.213 (Exceptions from advanced notice) and 431.214 (Notice in cases of probable fraud);
- For denial of payment, at the time of any action denying the provider's claim; or,
- For decisions resulting in denial, delay, or modification of all or part of the requested SMHS, ***within two business days of the decision***.
    - The contracted provider must also communicate the decision to the affected provider within 24 hours of making the decision.
- For standard service authorizations that deny or limit services, ***as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days*** following the receipt for request for services. (42 C.F.R. § 438.404(c)(3); 42 C.F.R. 438.210(d)(1).)

- If a provider indicates, or the contracted provider determines, that following the standard service authorization timeframe could seriously jeopardize the beneficiary's life or health or his or her ability to attain, maintain, or regain maximum function, the contracted provider must make an expedited service authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. 438.210(d)(2)(i).)
    - The contracted provider may extend the 14 calendar day notice of adverse benefit determination timeframe for standard service authorization decisions that deny or limit services up to 14 additional calendar days if the contracted provider justifies a need to the Department, upon request, for additional information and shows how the extension is in the beneficiary's best interest. (42 C.F.R. § 438.404(c)(4); 42 C.F.R. 438.210(d)(1)(ii).)
    - The contracted provider may extend the 72 hour expedited service authorization decision time period by up to 14 calendar days if the beneficiary requests an extension, or if the contracted provider justifies to the Department, upon request, a need for additional information and how the extension is in the beneficiary's interest. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. § 210(d)(2)(ii).) 10)
    - Written notice must include the reason for the extension and inform the beneficiary of the right to file a grievance if they disagree with the decision; (42 C.F.R. § 438.404(c)(4)(i); 42 C.F.R. 438.210(d)(1)(ii).) Provider must issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date of the extension. (42 C.F.R. § 438.404(c)(4)(ii); 42C.F.R. 438.210(d)(1)(ii).)
    - The contracted provider shall give notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations. (42 C.F.R. § 438.404(c)(5).)

- The contracted provider shall deposit the NOABD with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires. (Cal. Code Regs., tit. 9, § 1850.210(f).)

NOABD Quarterly Reporting

Per California Code of Regulations, Title 9, Chapter 11 Section 1810.375(a) DHS-BHD must submit NOABD data to Department of Health Care Services (DHCS) on an annual basis. This report runs from July 1 of the previous year through June 30 of the current year, and must be submitted to DHCS by October 1st of each year. Included in this report are a count of NOABDs filed concerning services delivered by DHS-BHD contracted providers.

The DHS-BHD Grievance Coordinator distributes the NOABD Quarterly Report with instructions to providers via e-mail. All contracted providers are required to complete this quarterly report and submit copies of all related documents to DHS-BHD within the timeframes noted below (retain originals for your records).

Below is the NOABD Quarterly Reporting schedule, including reporting periods, and the corresponding due date.

Quarterly Reporting Schedule	
	Report Due to SCBH
Quarter 1: July 1st – September 30th	October 1st
Quarter 2: October 1st – December 31st	January 1st
Quarter 3: January 1st – March 30th	April 1st
Quarter 4: April 1st – June 30th	July 1st
Submit Completed Report and All Supporting Documents (via secure e-mail) to: BHQA@sonomacounty.gov	

NOABD Issuance Tracking

For each reporting period the contracted provider shall input a count of NOABDs into the appropriate NOABD subcategories by quarter. Each quarter's information shall be retained in the report and all data fields should contain a response, enter (0) if no NOABDs were obtained. At the end of the 4th quarter, all data fields should be completed.

Contracted Provider Name:				
NOABD CATEGORY	**REPORTING PERIOD**			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Service Denial Notice				
Delivery System Notice				
Modification Notice				
Termination Notice				
Authorization Delay Notice				
Timely Access Notice				
Financial Liability Notice				
TOTAL	0	0	0	0

Beneficiary Problem Resolution Process

Consumer Grievance Overview

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) must have a grievance system in place to ensure that consumers and beneficiaries are informed about their rights and procedures to resolve grievances, and to assure compliance with State and Federal regulations and guidelines. The grievance resolution process is a shared responsibility between DHS-BHD and contracted providers. This includes distribution of materials concerning beneficiaries' rights and the grievance process. Additionally, this process includes adhering to DHS-BHD processes for ensuring timely resolution of grievances to assure fair and equal treatment for all. DHS-BHD contracted providers are also responsible for submitting grievance forms and data to DHS-BHD in a timely manner.

A grievance is an individual's verbal or written expression of dissatisfaction about any matter other than a matter covered by a Notice of Adverse Benefit Determination (see *Notice of Adverse Benefit Determination*). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights regardless of whether remedial action is requested.

There is no distinction between an informal and formal grievance. A consumer does not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. A complaint shall be considered a grievance unless it meets the definition of an appeal to a Notice of Adverse Benefit Determination (see *Notice of Adverse Benefit Determination*). A grievance filer cannot appeal a Grievance Resolution. They can only file a new grievance. Anyone can file a grievance, however, appeals and expedited appeals are only available to DHS-BHD Medi-Cal beneficiaries.

DHS-BHD and contracted providers shall not discourage the filing of grievances. Even if a consumer expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievances will be analyzed by DHS-BHD to monitor trends. System of care trends identified through the DHS-BHD Consumer Grievance process will be forwarded to the Quality Improvement Committee (QIC), Behavioral Health Plan Administration Committee (BHPA) and Quality Improvement Steering (QIS) Committee for review and, if applicable, used to inform subsequent system changes.

All contracted providers must inform consumers of the Grievance Resolution process. Grievance related information is available to consumers through the required Medi-Cal informing materials that contracted providers shall make freely available in lobbies, office areas, or other public waiting areas. Notices explaining the grievance process shall be posted in prominent locations at all contracted Medi-Cal provider sites.

These Informing Materials are:

- Sonoma County Behavioral Health Member Handbook 2024
- Member Rights Poster
- Member Rights and Grievance/Appeal Process and Form, including self-addressed, no postage necessary envelopes (available for beneficiaries to pick up at all provider sites without having to make a verbal or written request)

Informing Materials can be found at:
https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

Consumer Grievance Filing and Reporting Process

If an individual is dissatisfied with the service delivered by the contracted provider, the provider shall offer the member the DHS-BHD grievance form (BHD-406) to complete. The grievance form can be completed by either the consumer, their treatment provider, family member/friend, or by a community member. Grievances can be filed verbally (in person or over the phone), or in writing. The provider shall offer assistance with completing the grievance form and shall provide assistance if asked.

Individuals who choose to file a grievance will have the opportunity to present information at any time during the resolution process. Grievance filers are encouraged (but not required) to discuss their grievance with staff or an agency representative.

Upon receipt of a grievance, the provider shall ensure that all sections of the grievance form are completed. If the grievance is filed verbally, the provider shall attempt to resolve the grievance with the filer by inquiring about what actions the provider can take to address the complaint. If the grievance is filed in writing via physical mail, the provider shall forward the submitted grievance form to the DHS-BHD Grievance Coordinator for resolution.

Exempt Grievances

With verbal grievances, when appropriate, the provider will work to resolve the grievance to the satisfaction of the filer by the end of next business day – making the grievance ***exempt***. An ***exempt grievance*** does not require a full investigation on the part of the DHS-BHD Grievance Coordinator.

When the provider satisfactorily resolves the grievance, they shall document on the grievance form the support provided to the filer in an effort to resolve the grievance (do not include any identifying information about staff cited in the grievance itself). If the grievance is ***resolved*** by the end of the next business day, the provider shall:

1. Mark the “grievance” box at the top of the form.
2. In Section 3 indicate what action was taken by the provider to resolve the grievance.
3. In the Staff Use Only Section
    a. Check the “Exempt” box
    b. Note the date the grievance was resolved
4. Send the completed form to the DHS-BHD Grievance Coordinator immediately: E-mail to BHQA@sonomacounty.gov.

Upon receipt of the grievance, the DHS-BHD Grievance Coordinator will follow-up with the provider to obtain additional information when necessary.

Non-Exempt Grievances

If the filer submits a grievance via physical mail, or if after speaking with the provider the filer remains unsatisfied with the provided resolution, the grievance is ***non-exempt***. A ***non-exempt grievance*** is a complaint that was not resolved to the satisfaction of the filer by the end of the next business day following the filing of the grievance. When filers mail grievances, the next business day timeframe is exceeded and therefore it

cannot be exempt. All ***non-exempted grievances*** require a full investigation on the part of the DHS-BHS Grievance Coordinator. If the grievance is ***non-exempt***, the provider shall:

1. Mark the "grievance" box at the top of the form.
2. In the Staff Use Only Section
    a. Check the "Non-Exempt" box
3. Send the completed form to the DHS-BHD Grievance Coordinator immediately: E-mail to BHQA@sonomacounty.gov. (ensure e-mail is sent *Secure*).

Upon receipt of the grievance, the DHS-BHD Grievance Coordinator will send an acknowledgement letter to the grievance filer, within **5 calendar** days from the grievance filing date. Within **30 calendar days**, DHS-BHD Grievance Coordinator will review and investigate the grievance, and a written Notice of Grievance Resolution (NGR) will be provided to the grievance filer, or their authorized representative.

Referred Grievances

If a filer submits a grievance that is not associated with a complaint about the contracted provider, or DHS-BHD, this is considered a ***referred grievance***. While grievances in this category are not within the provider's jurisdiction to resolve, the provider shall refer the grievance to the appropriate agency or department. Also, the provider shall ensure that a completed grievance form is submitted to the DHS-BHD Grievance Coordinator. If the grievance is ***referred***, the provider shall:

1. Mark the "grievance" box at the top of the form.
2. In the Staff Use Only Section
    a. Check the "Exempt" box and write "***referred***"
    b. Note the date the grievance was referred and to whom.
3. Send the completed form to the DHS-BHD Grievance Coordinator immediately: E-mail to BHQA@sonomacounty.gov. (ensure e-mail is sent *Secure*).

Quarterly Reporting

Per California Code of Regulations, Title 9, Chapter 11 Section 1810.375(a) DHS-BHD must submit grievance data to Department of Health Care Services (DHCS) on an annual basis. This report runs from July 1 of the previous year through June 30 of that year, and must be submitted to DHCS by October 1st of each year. Included in this report are a count of grievances filed concerning services of DHS-BHD contracted Medi-Cal providers.

The DHS-BHD Grievance Coordinator distributes the Grievance Quarterly Report with instructions to providers via e-mail. All contracted Medi-Cal providers are required to complete this quarterly report and submit copies of all related documents to DHS-BHD within the timeframes noted below (retain originals for your records).

Documents Submittal Timeframe - Grievance Forms to DHS-BHD:

Due immediately, or by the end of the next business day (ensure e-mail is sent ***Secure***)

Quarterly Reporting Schedule	
Quarter 1: July 1st – September 30th	October 1st
Quarter 2: October 1st – December 31st	January 1st
Quarter 3: January 1st – March 30th	April 1st
Quarter 4: April 1st – June 30th	July 1st
Submit Completed Report and All Supporting Documents (via secure e-mail) to: BHQA@sonomacounty.gov	

For each reporting period the provider shall input a count of grievances into the appropriate grievance subcategories by quarter. Each quarter's information shall be retained in the report and all data fields should contain a response, enter (0) if no Grievances were obtained. At the end of the 4th quarter, all data fields should be completed.

CATEGORY	REPORTING PERIOD			
ACCESS	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Service Not Available				
Service Not Accessible				
Timeliness of Services				
24/7 Toll-free Access Line				
Linguistic Services				
Other Access Issues				
TOTAL	0	0	0	0
QUALITY OF CARE	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Staff Behavior Concerns				
Treatment Issues or Concerns				
Medication Concerns				
Cultural Appropriateness				
Other Quality of Care Issues				
TOTAL	0	0	0	0
CHANGE OF PROVIDER	Quarter 1	Quarter 2	Quarter 3	Quarter 4
TOTAL	0	0	0	0
CONFIDENTIALITY CONCERN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
TOTAL	0	0	0	0
OTHER	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial				
Lost Property				
Operational				
Patients' Rights				
Peer behaviors				
Physical environment				
Other grievance not listed above				
TOTAL	0	0	0	0
GRAND TOTAL	0	0	0	0

Additionally, in the Disposition section of the report, the provider shall input by quarter and type the count of grievances that were **Resolved** by the provider (**Exempt**) or **Referred** (**Exempt**).

CATEGORY		
ACCESS	Resolved Quarter 1	Referred Out Quarter 1
Service Not Available		
Service Not Accessible		
Timeliness of Services		
24/7 Toll-free Access Line		
Linguistic Services		
Other Access Issues		
TOTAL	0	0
QUALITY OF CARE	Resolved Quarter 1	Referred Out Quarter 1
Staff Behavior Concerns		
Treatment Issues or Concerns		
Medication Concerns		
Cultural Appropriateness		
Other Quality of Care Issues		
TOTAL	0	0
	Resolved Quarter 1	Referred Out Quarter 1
CHANGE OF PROVIDER		
TOTAL	0	0
	Resolved Quarter 1	Referred Out Quarter 1
CONFIDENTIALITY CONCERN		
TOTAL	0	0
OTHER	Resolved Quarter 1	Referred Out Quarter 1
Financial		
Lost Property		
Operational		
Patients' Rights		
Peer behaviors		
Physical environment		
Other grievance not listed above		
TOTAL	0	0
GRAND TOTAL	0	0

The final component of the Disposition section of the report is the number of grievances that are **Pending** resolution at the close of the quarter. Grievances in the **Pending** category are those that were filed on the day the report was sent to DHS-BHD and the provider is working to resolve with the filer (see **Exempt Grievances** above).

CATEGORY	
ACCESS	Pending Close of Quarter 1
Service Not Available	
Service Not Accessible	
Timeliness of Services	
24/7 Toll-free Access Line	
Linguistic Services	
Other Access Issues	
TOTAL	0
QUALITY OF CARE	Pending Close of Quarter 1
Staff Behavior Concerns	
Treatment Issues or Concerns	
Medication Concerns	
Cultural Appropriateness	
Other Quality of Care Issues	
TOTAL	0
	Pending Close of Quarter 1
CHANGE OF PROVIDER	
TOTAL	0
	Pending Close of Quarter 1
CONFIDENTIALITY CONCERN	
TOTAL	0
OTHER	Pending Close of Quarter 1
Financial	
Lost Property	
Operational	
Patients' Rights	
Peer behaviors	
Physical environment	
Other grievance not listed above	
TOTAL	0
GRAND TOTAL	0

Provider Problem Resolution & Payment Appeal Process

Sonoma County Department of Health Service Behavioral Health Division (DHS-BHD) has established a process for identifying and resolving provider concerns and problems regarding payment, other complaints and concerns. Providers may contact DHS-BHD at any time to begin a problem resolution process. DHS-BHD staff will work with providers to resolve problems and concerns as quickly and as easily as possible.

Provider concerns/complaints, or appeals may be submitted to DHS-BHD Provider Relations by telephone, in person, or in writing (mail, fax, or e-mail) by using the Provider Problem Resolution & Payment Appeal form, located at https://sonomacounty.ca.gov/Health/Behavioral-Health/Forms-and-Materials/

The completed form may be returned by mail to:

Sonoma County DHS-BHD
ATTN: Provider Relations
2227 Capricorn Way
Santa Rosa CA 95407

Tel: (707) 565-4767
Fax: (707) 565-2202
Email: SCBHProviderRelation@sonomacounty.gov

All e-mail communications containing beneficiary identification or other health-protected information must use encryption to secure transmitted electronic health information.

Provider Problem Resolution Process

Provider concerns/complaints may address, but are not limited to, the following issues:

- Contracts, including, but not limited to, payment agreement, scope of work, etc.
- Disagreement with monitoring/audit review findings by DHS-BHD Quality Assurance staff (monitoring/audit review appeals are due *within 15 business days* of the provider's receipt of findings/audit report).
- Disagreement with service decisions made by DHS-BHD staff
- Any other concerns/complaints

Efforts will be made to resolve concerns/complaints at the lowest level of DHS-BHD involvement, though the provider has the option of submitting a Provider Problem Resolution & Payment Appeal form at any time. When efforts to resolve concerns/complaints at an informal level have failed to achieve a resolution of the issue, DHS-BHD staff will direct the provider to complete the Provider Problem Resolution & Payment Appeal form and return the completed form to DHS-BHD Provider Relations.

Provider Payment Appeal Process

Providers have the right to initiate the provider payment appeal process at any time before, during, or after the provider problem resolution process has begun. DHS-BHD Provider Relations will inform the provider whether initiating the provider problem resolution process will affect the provider's timelines for accessing the provider payment appeal process.

Providers may only file a payment appeal for the following three reasons:

- Denied request for payment
- Modified request for payment
- Dispute concerning the processing or payment of a provider's claim including, but not limited to, a delay in payment

Providers ***must*** submit a completed Provider Problem Resolution & Payment Appeal form to DHS-BHD Provider Relations within:

- 90 calendar days of the receipt or fax date of notification of payment denial/modification, or
- 90 calendar days of DHS-BHD's failure to act upon the request for payment

Providers must include, with the completed Provider Problem Resolution & Payment Appeal form, written statements, chart documentation and/or other materials in support of the provider's claim.

The Behavioral Health Plan Administration committee (BHPA) shall review the appeal and make a recommendation of resolution to DHS Compliance and BHD Senior Administrators, who will provide the final decision on payment appeals to Quality Assurance (QA). A final written decision concerning the appeal resolution will be issued to the provider within (60) calendar days from receipt of the appeal. This written response will include a statement of the reasons for the decision that addresses each issue raised by the provider and any action required by the provider to implement the action. If a response is not issued to the provider within (60) calendar days from receipt of the appeal, the appeal will be considered denied in full.

DHS-BHD staff involved in the initial denial of the request for payment will not participate in the appeal resolution decision.

Revised Request for Payment

- If the appeal in approved in full, no further action is required.
- If the appeal is modified, a provider shall submit a revised request within (30) calendar days of receipt of appeal decision. The DHS Revenue Management Unit will process the provider's revised request for payment within (14) calendar days from the date of receipt of a provider's revised request.

Clinical Documentation & Training

DHS-BHD leverages resources from the California Mental Health Services Authority (CalMHSA) for clinical documentation and training purposes. The 2025 Clinical Documentation Guide serves as the primary resource for providers of SMHS, complemented by documentation training available through CalMHSA's Learning Management System (LMS).

In addition to these foundational resources, QA provides supplemental guidance and training on Sonoma-specific documentation practices, including annual documentation trainings.

Note: State requirements are subject to change. DHS-BHD updates Sonoma-specific training materials periodically. The list below reflects what training is available as of September 2025. Please refer to our website for the most current training materials.

Resource	Information	Links
CalMHSA	Documentation Guides, Screening & Transition Tools, Documentation Training, CPT Coding	Clinical Practice - California Mental Health Services Authority
BHINs	All DHCS Information Notices	Behavioral Health Information Notice
SCBH Documentation Resources	Procedure Code List, Sample Notes, Progress Note Guidance, Miscellaneous Documentation Tips	Sonoma County Behavioral Health Documentation Resources
GLAAD Media Reference Guide	Offers education and guidance from the perspective of LGBTQ community by sharing stories	GLAAD Media Reference Guide
DHCS Medi-Cal Manual for ICC, IHBS, TFC	Information regarding ICC, IHBS, and TFC	https://www.dhcs.ca.gov/services/MH/Pages/Manuals_And_Guides.aspx
Recovery Oriented Language Resources	The guide provides information on how words matter and how use of recovery-oriented language can convey hope, optimism and support, and promote a culture that fosters recovery and well-being	https://mhcc.org.au/resource/recovery-oriented-language-guide-resources/
Mobile Crisis Documentation Training	Recording of the DHS-BH Mobile Crisis Documentation Training	https://youtu.be/9_zpg8A1l4k
DHCS FAQs	DHCS developed these Frequently Asked Questions (FAQs) to provide more detailed clarification on multiple topics relating to Behavioral Health Payment Reform	https://www.dhcs.ca.gov/Pages/CalAIM_Behavioral_Health_Payment_Reform_Frequently_Asked_Questions.aspx

SmartCare Electronic Health Record

The County of Sonoma's Department of Health Services Behavioral Health Division (DHS-BHD), along with 25 other counties across the state, has partnered with the California Mental Health Services Authority (CalMHSA) in a semi-statewide electronic health record (EHR) project aimed at improving public behavioral health care practices. The enterprise solution, SmartCare, unites clinical, financial, and administrative data in a single platform working across mental health and substance use disorder treatment delivery systems. Additionally, with the use of Mental Health Services Act (MHSA, soon to be BHSA) Innovation funding, DHS-BHD has been able to extend the use of SmartCare to our contracted partner providers – truly unifying the care our clients receive and making care coordination comprehensive for our providers.

In addition to meeting the clinical, fiscal, and administrative demands inherent in County behavioral health, with this semi-statewide EHR project CalMHSA also provides a way for Counties and our contracted partners to abide by state and federal data-sharing and interoperability mandates via CalMHSA Connex. As such, all DHS-BHD partners directly entering data into SmartCare can be assured of meeting these requirements. Any contracted agencies that do not directly enter service data into SmartCare are responsible for ensuring that they meet all necessary regulatory and technical requirements noted in BHINs No: 22-068 and No: 23-032 (see the Interoperability Memo sent 03/01/2024, for details).

Staff Access to SmartCare

Staff Onboarding:

To onboard new staff who need access to SmartCare, please send an email to: DHS-RMU-Credentialing@sonomacounty.gov, copying BHEHR@sonomacounty.gov and BHQA@sonomacounty.gov on the email. In the email, please include the following information:

- Employee Name
- Job Classification
- License Type
- Supervisor Name
- Program
- Start Date

Attach to this email the required documentation listed on the County website here: https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/provider-credentialing

Staff who will be using SmartCare for any data entry will be required to complete trainings found on the CalMHSA learning management system, Moodle (https://moodle.calmhsalearns.org/). The Moodle courses will be assigned based on the job classification and license type (if applicable) of the new staff person. Additional training videos located on the SoCo Cloud may also be required for new employee training. A link to those videos will be sent to staff as needed. Staff will also be given a user login for our SmartCare Train environment in which they can practice the skills they are learning in the CalMHSA Moodle courses and adjunct SoCo Cloud videos.

Unauthorized User or Forgot Password:

If staff who have access to SmartCare have forgotten their passwords or have had too many unsuccessful attempts at logging into SmartCare, they should go to the https://2023.calmhsa.org website and click on the Live Chat button in the bottom right corner of the page. The CalMHSA Live Chat Support helpdesk can get staff logged back into SmartCare whenever they get locked out of the system during normal business hours (08:00-17:00, Monday through Friday, except holidays). If for any reason the CalMHSA team is unable to help a staff member, they will redirect the staff back to the DHS-BHD Clinical Informatics Analyst or the BHEHR@sonomacounty.gov inbox for assistance.

SmartCare Issues, Errors, or Technical Difficulties

If any issues with SmartCare arise, please go to the https://2023.calmhsa.org website and click on the Live Chat button in the bottom right corner of the page to report the issue. The CalMHSA Live Chat Support helpdesk can help troubleshoot the issues during normal business hours (08:00-17:00, Monday through Friday, except holidays). If for any reason the CalMHSA team is unable to help with a problem in SmartCare, they will redirect the staff person reporting the issue back to the DHS-BHD Clinical Informatics Analyst or the BHEHR@sonomacounty.gov inbox for assistance. Please reach out directly to the DHS-BHD Clinical Informatics Analyst if issues arise with SmartCare outside of normal business hours or on holidays.

Contracted Providers Not Using SmartCare

Contracted providers who are not using SmartCare for direct entry of all clinical service data are required to ensure that their EHR system is able to export the necessary service data needed to upload into SmartCare via the Batch Upload process. The County Revenue Management Unit (RMU) team, with support from the DHS-BHD Clinical Informatics Analyst, will train the appropriate agency staff on how to perform the batch upload.

Additionally, as stated above, all contracted partners not directly entering data into SmartCare are fully responsible for ensuring their EHR and medical records system(s) comply with all state and federal regulatory requirements for interoperability.

General SmartCare Resources

For more information about the CalMHSA EHR Project, visit https://www.calmhsa.org/electronic-health-records/

For more information about CalMHSA Connex, visit https://www.calmhsa.org/interoperability-api/ or https://2023.calmhsa.org/calmhsa-connex/

For step-by-step instructions, troubleshooting tips, and access to the Live Chat Support, SmartCare users can visit https://2023.calmhsa.org

To access the CalMHSA learning management system, Moodle, go here: https://moodle.calmhsalearns.org/login/index.php

Visit https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/about-us/quality-assessment-and-performance-improvement/smartcare-resources for Sonoma County-specific SmartCare information and updates.

Credentialing

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services as part of the Sonoma County Behavioral Health provider network. Credentials are documented evidence of licensure, education, training, experience, or other qualifications.

Please see our Provider Credentialing Webpage here:
https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/provider-credentialing

Types of Providers

Providers of SMHS fall into five credentialing categories, outlined below.

Provider Categories	Provider Types
Licensed Staff	Physician (MD/DO) Licensed Psychologist (PhD/PsyD) Licensed Clinical Social Worker (LCSW) Licensed Marriage and Family Therapist (LMFT) Licensed Professional Clinical Counselor (LPCC) Registered Nurse (RN) Licensed Vocational Nurse (LVN) Psychiatric Technician (PT) Other Medical Professionals (i.e., PA/NP)
Waivered Professionals	Registered Psychologist Registered Psychological Assistant Out of State Licensees
Registered Associates	Registered Associate Marriage and Family Therapist (AMFT) Registered Associate Clinical Social Workers (ASW) Registered Associate Professional Clinical Counselor (APCC)
Clinical Trainee	Master's and Doctoral Degree Candidates
Unlicensed Workers	Certified Medical Assistant (CMA) Mental Health Rehabilitation Specialists (MHRS) Certified Peer Support Specialist (CPS) Other Qualified Provider (OQP)

Credentialing Process

To add new staff to the provider network, Contractors are to complete form BHD 144 SmartCare Staff Access Request Form: https://sonomacounty.ca.gov/Health/Behavioral-Health/Forms-and-Materials/ and submit it (along with the required documents for their credentialing category) to the Revenue Management Unit (RMU) (DHS-RMU-Credentialing@sonomacounty.gov). When approved, a staff number will be issued to the provider along with an effective date. Services may be provided and claimed for by the provider using the assigned staff number beginning with the effective date. Any services provided prior to the effective date are not billable.

Required Documents for All Staff

For any staff participating in the provider network, maintain documentation of the following:

1. BHD 144 Staff Number & SmartCare Request Form.
2. Current resume/ relevant work history of the provider.
3. Signed credentialing attestation form specifying the following:
    1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
    2. A history of loss of license or felony conviction;
    3. A history of loss or limitation of privileges or disciplinary activity;
    4. A lack of present illegal drug use; and
    5. The application's accuracy and completeness.
4. Copies of pre-screening checks: review of published Federal and State lists regarding the sanctioning, suspension, or exclusion of individuals or entities, specifically:
    - The Office of Inspector General List of Excluded Individuals/Entities (LEIE)
    - DHCS Medi-Cal List of Suspended or Ineligible Providers (LSIP)
    - System for Award Management (SAM)
    - Social Security Death Master File (DMF)
5. Evidence of any history of liability claims filed against the provider (applicable if indicated on credentialing attestation).
6. A National Provider Number (NPI) verified in the National Plan and Provider Enumeration (NPPES) system with the correct taxonomy.
7. Any additional requirements for the provider type listed below.

Additional Required Documents by Provider Type

The following table outlines additional required documentation to be submitted for each provider type.

Provider Type	Required Documents
Physician	Copy of current Drug Enforcement Administration (DEA) license Copy of current Physician license from the Medical Board of California Evidence of completing an accredited psychiatry residency program (certificate, letter, OR Board Certification in Psychiatry) Evidence of registration with Controlled Substance Utilization Review and Evaluation System (CURES 2.0) Evidence of PAVE application
Psychologist	Copy of current license from the California Board of Psychology Evidence of PAVE application
LCSW/LMFT/LPCC	Copy of current license from the California Board of Behavioral Sciences Evidence of PAVE application
Registered Nurse	Copy of license from the California Board of Registered Nursing
Licensed Vocational Nurse and Psychiatric Technician	Copy of license from the California Board of Vocational Nursing and Psychiatric Technicians
Other Medical Professionals: PA/NP	Copy of current Drug Enforcement Administration (DEA) license Copy of current Physician license from the Medical Board of California Evidence of registration with Controlled Substance Utilization Review and Evaluation System (CURES 2.0) Evidence of PAVE application
Registered Psychologists and Psychological Assistants	DHCS Waiver (requested by Sonoma County Department of Health Care Services Behavioral Health Division (DHS-BHD) Credentialing Manager) Copy of current registration with the California Board of Psychology as a Registered Psychologist or Psychological Assistant. Diploma or transcripts showing at least 48 semester/trimester or 72 quarter units of graduate coursework completed, not including thesis, internship or dissertation Employment/Internship start date

Provider Type	Required Documents
Out of State Licensees	DHCS Waiver (requested by DHS-BHD Credentialing Manager) Letter from the appropriate California licensing board stating that the licensee has sufficient experience to gain admission to the licensing examination Copy of license/registration with their respective state licensing board Contractor Attestation Form Proof of Malpractice insurance provided by the individual or organization Copy of required education (diploma)
AMFT/ASW/APPC	Copy of current registration from California Board of Behavioral Sciences
Clinical Trainee	Name of graduate school and type of degree program (e.g., Master's, Doctorate, clinical psychology or school counseling) Year in the above program (e.g., first-year, second-year student in a two-year program) Name, and license number of primary clinical supervisor (supervisor must meet all licensing board requirements for supervision of interns) Effective dates of employment (start date and end date, if known) The above information must be submitted annually until job class update/change or staff number termination
Medical Assistant (CMA)	Copy of Medical Assistant Certification Copy of required education (Diploma)
Mental Health Rehabilitation Specialist	Job title and description Evidence of meeting one of the following combinations of education and experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment: A bachelor's degree and four years of experience A master's degree and two years of experience An associate's degree and six years of experience
Certified Peer Support Specialist	Job Title and Description Diploma or Equivalent Degree Certification from program approved by DHCS for Peer Support Specialist *Peer Support Specialists can only provide Peer Support Specialist Activities such as Self-Help Peer Services and Prevention Education Services

Provider Type	Required Documents
Other Qualified Provider	Must be 18 years of age Must have two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient). Diploma or equivalent degree Job Title and Description Current resume Plan of Supervision

Authorization and Review Requirements for Specialty Mental Health Services (SMHS)

Prior authorization is not required for the following services:

- Crisis Intervention, including community based mobile crisis services
- Crisis Stabilization
- Mental Health Services: including initial assessment and plan development
- Targeted Case Management Intensive Care Coordination Medication Support Services
- Peer Support Services

Prior authorization and/or referral is required for the following services:

- Intensive Home-Based Services (IHBS)
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care
- Crisis Residential
- Adult Residential
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)

Authorization Guidance and Points of Contact:

The Sonoma County Department of Health Services – Behavioral Health Division (DHS-BHD) is currently developing standardized procedures and workflows for authorizing all Specialty Mental Health Services (SMHS). During this implementation phase, not all service types have established authorization processes.

If a provider is uncertain whether an authorization is required for a particular service, or how to process an authorization request, please contact the Quality Assurance team for clarification and assistance.

Authorization Inquiries: BHQA@sonomacounty.gov

The DHS-BHD Quality Assurance team will review inquiries and provide direction based on current policy, applicable DHCS guidance, and internal workflows. Updated procedures and reference materials will be shared with contracted providers as the authorization framework is finalized.

Auditing & Monitoring

The Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) Quality Assessment Program Improvement (QAPI) program provides risk management to DHS-BHD through the auditing and monitoring of Federal Health Care Programs (FHCP) for Mental Health and Substance Use Disorder services. QAPI is committed to ensuring that its audits of Sonoma County contractor partners are accurate, methodical and consistent. These programs have specific risks and requirements that are addressed with audit tools and monitoring processes, designed to meet regulatory requirements as well as state and county contractual agreements. Audit tools and monitoring processes are updated as needed to ensure compliance with changes to these standards. Areas of audit focus and associated evidence that is reviewed are listed in the following table**.**

SUBSTANCE USE DISORDER

Intake/Admission/Assessment/Treatment Plan Documents

- Consent for Treatment
- Admission Agreement
- Evidence client was provided/offered:
  - Fair Hearing Rights and Grievance Procedures
  - Client rights
  - Program rules, expectations, and regulations
  - Appeal process for involuntary discharge
  - Notice of Privacy Practices and HIPAA Notifications
  - Directory of community resources
- Evidence client was informed of the following:
  - Admission criteria
  - Share of cost
  - Medi-Cal is payment in full
  - Documentation health questionnaire, physical examination, medical evaluation and/or medical clearance for admission as required
- For perinatal clients:
  - Physician substantiation of pregnancy (if applicable)
  - Evidence of last day of pregnancy (if applicable)
  - Evidence of client's most recent physical examination
- Evidence of ASAM
- Assessment for Tobacco Use Disorder and follow up, as necessary
- Initial/Updated treatment plans (if required)
- For NTP Providers:
  - Evidence of documentation needed to determine admission criteria is met, including adherence to applicable 9CCR 10210 Detection of Multiple Registration requirements
  - Documentation verifying adherence to treatment requirements for special populations (patients under 18 years of age, pregnant/parenting patients)

Ongoing Service Provision

- Evidence of Drug Medi-Cal Eligibility check for each month
- Documentation of referrals

- Progress notes
- Care plans for Targeted Case Management services
- Discharge plans/summaries
- For NTP Providers:
    - Methadone maintenance dose adjustment order/form(s)
    - Methadone dosing chart/calendar

Program Administration Documents

- Agency operations policies/procedures/handbooks
    - Client Handbook
    - Employee Handbook
    - Documentation requirements
    - Data Collection and Reporting
    - Staff training calendar and records of attendance
    - Perinatal, Special Populations and Priority Admissions
    - Volunteer Program
- Evidence of Capacity Management System
    - Verification of necessary referrals
    - Verification of Wait List maintenance
    - Verification of provision of Interim Services
- Medical Director Requirements
    - Signed Code of Conduct
    - Signed Role and Responsibilities
    - Evidence/proof of annual completion of 5 hours Continuing Medical Education (CME) in addiction medicine

MENTAL HEALTH DISORDER

Intake/Admission/Assessment/Treatment Plan Documents

- Consent for Treatment
- Acknowledgement of receipt of informing materials
- Documentation of client's preferred language
- Initial Assessment/CANS/ANSA
- Assessment for Tobacco Use Disorder and follow up, as necessary
- Initial/Updated treatment plans (if required)

Ongoing Service Provision

- Documentation of referrals
- Progress notes
- Care plans for Targeted Case Management services
- Evidence of informed consent for psychotropic medication
- Discharge plans/summaries

Telehealth

Telehealth means contact with a beneficiary via synchronous audio and video by a provider and is an alternative to health care provided in-person, particularly to underserved areas. Telehealth is not a distinct service, but a way that providers deliver health care to their beneficiaries that approximates in-person care. The standard of care is the same whether the beneficiary is seen in-person or through telehealth, and the use of telehealth must be clinically appropriate and safe for the beneficiary.
State law defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." To preserve the beneficiary's right to access covered services in person, a provide furnishing services through telehealth must offer those same services via in-person, face-to-face contract or arrange for a referral to, and a facilitation of, in-person care that does not require a beneficiary to independently contact a different provider to arrange for that care.

Sonoma County telehealth procedure:

1. CBO will request from the DHS-BHD contract manager the need for telehealth services.
2. DHS-BHD contract manager will collaborate with the CBO to agree on the telehealth services that are needed for each applicable reporting unit.
3. DHS-BHD Contract liaison will email a telehealth information packet to CBO, which will include the following attachments:
    a. Privacy and Security Handbook for Telehealth Providers
    b. 7.1.8: Telehealth Services
    c. MHS 148 (01-15): Consent for Telehealth Services
    d. Telehealth Site Review Self-Assessment (to be returned to Privacy)
4. CBO will return requested documentation directly to the DHS Privacy Officer via email
5. DHS Privacy Officer will work with the CBO to review, assess and complete the telehealth review process.
6. DHS Privacy Officer will inform CBO contractor of approval / denial to provide services via telehealth.

For any questions about this telehealth procedure, please contact your contract liaison (see page 8 of this manual or your contract directly). Additional information from DHCS about telehealth can be found on their website: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx