AGREEMENT BETWEEN THE COUNTY OF TEHAMA AND REMI VISTA, INC.

This agreement is entered into between the County of Tehama, through its Health Services Agency, ("County") and Remi Vista, Inc. ("Contractor") for the provision of Medi-Cal EPSDT/Specialty Mental Health Services for eligible children.

1. RESPONSIBILITIES OF CONTRACTOR

During the term of this agreement, Contractor agrees to provide Medi-Cal EPSDT/Specialty Mental Health Services that comply with ICPM, CCR, MHSA, standards to Children who have Full-Scope Medi-Cal and are eligible for enrollment in the Tehama County (COUNTY 52 Medi-Cal) Mental Health Plan.

Contractor shall treat children who meet medical necessity as defined by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medi-Cal Specialty Mental Health services to children under age 21 and in need of intensive mental health services and those meeting the MHSA definition of Children (0-15). Mild and moderate mental health services will not be reimbursed under this agreement. All referrals to this program will come from TCHSA-BH.

Medically necessary services to uninsured or non-Medi-Cal eligible children may be reimbursed under this agreement on a case-by-case basis if the Contractor receives written authorization from County prior to providing such services. Educationally related mental health services are not covered by this contract, and County shall not be obligated to pay for such services under the contract. Further, this contract shall not cover services provided to any children placed in Contractor's facility pursuant to an Individualized Education Plan, and County shall not be obligated to pay for such services under the contract.

Contractor shall perform the following services outlined below in Section 3. COMENSATION of this agreement for the target population as outlined in the Contractors Request for Proposal (RFP-BH-20-01) response. Contractor shall document all services in the client record in accordance with the MHP documentation requirements.

Contractor shall provide only those services for which a written authorization from the County has been received. Services provided without prior written authorization from the County will be the responsibility of the Contractor and will not be reimbursed by the County.

Contractor understands that court-ordered assessments, written reports, expert witness testimony, case conferences or other forensic or administrative professional activities shall not be considered reimbursable activities under this agreement.

Contractor shall comply with:

A. Applicable Medi-Cal Specialty Mental Health Services regulations, section 14680 of the Welfare and Institutions Code and the California Code of Regulations, Title 9, Division 1, Chapter 11;

B. Applicable sections of the Tehama County Mental Health Plan ("MHP") as approved by the California Department of Mental Health, the Tehama County Mental Health Quality Assurance Plan, the Tehama County Cultural Competency Plan, and the various policies and procedures established by the Tehama County Mental Health Director for the administration of public mental health services within Tehama County, as hereafter amended; and

C. The most current Tehama County Health Services Agency - Behavioral Health Member Handbook ("Handbook") – Exhibit D.

Contractor shall be liable for State Department of Health Care Services audit exceptions due to inadequate documentation as per medical necessity requirements and shall reimburse County for any recoupments ordered by the State within sixty (60) days of the date of the State or County's notice of such recoupment order. If Contractor fails to reimburse County within such period, County may offset the unpaid amount against any sums due from County to Contractor pursuant to this agreement or any other agreement of obligation.

2. RESPONSIBILITIES OF THE COUNTY

County shall compensate Contractor as set forth in section 3 of this agreement. Contractor acknowledges Tehama County Health Services Agency Executive Director's ("Director") responsibility for implementing, operating, managing, and overseeing the Mental Health Plan ("MHP") and compliance with California Welfare and Institutions Code, and Title 9, California Code of Regulations ("Title 9, CCR"). Director retains the right to restrict payment under this agreement to medically necessary services that meet MHP and Title 9, CCR requirements for preauthorization and retrospective review.

County agrees to pay Contractor at the rates listed in section 3 of this agreement for authorized services. In the event that the State of California shall establish a maximum allowance for any service listed in section 1 that is lower than the rate established by this agreement the maximum allowance established by the State of California shall prevail.

County will provide Contractor with the Handbook, attached hereto as Exhibit D, and by this reference made a part hereof.

County will follow the Provider Problem Resolution Process described in the Handbook when Contractor disputes denial of payment. If a Federal or State audit exception is created due to error of omission or commission on the part of the County, the County will be held responsible for the audit exception.

3. COMPENSATION

County shall compensate Contractor for services rendered pursuant to the terms described in the current Handbook, attached as Exhibit D and incorporated herein. County shall pay Contractor the rates set forth in Exhibit B.

A. The total compensation for this agreement shall not exceed $650,000.00 during any fiscal year, further defined as July 1, 2026 through June 30, 2027 and July 1, 2027 through June 30, 2028. The Maximum Compensation shall not exceed $1,300,000.00.

B. Rates set forth in Exhibit B may change upon agreement by Contractor and County.

C. Contractor shall include the Reporting Unit, Sub-Reporting Unit, and Service Activity Code, as well as the duration of each billable service delivered.

Reporting Unit (RU) Name	RU #	Sub-RU #
MHSA Full Service Partnership (FSP) - Child	3575	322
MHSA Evidence Based TF-CBT - Child	3576	342
MHSA Evidence Based PCIT - Child	3576	343
MHSA Evidence Based CPT - Child	3576	351
MHSA Parenting	3576	341
MHSA Suicide Prevention (ASSIST, Safetalk)	3576	345
MHSA Teen Risk Screening (Teen Screen)	3576	340
EPSDT	3042	NA

*Other coding may be added upon mutual agreement of County and Contractor.

D. Cost Reports

Effective July 1, 2022, MHPs, DMCODS/DMC counties will no longer be required to submit an annual Medi-Cal cost report. This policy change will eliminate the need for counties to collect and submit cost reports from subcontracted network providers for purposes of Medi-Cal reimbursement. However, counties may still need to collect cost information from subcontracted network providers for a variety of reasons, including, but not limited to:

- MHPs and DMC-ODS/DMC counties are required to continue to collect cost reports from network providers in compliance with DHCS cost reporting policies for services rendered prior to the date Behavioral Health Payment Reform is implemented on July 1, 2023.
- When cost reporting is required by state or federal law.

4. BILLING AND PAYMENT

Contractor shall submit to County a monthly invoice of direct client rendered services by the thirtieth (30th) day following the last day of the month in which the services were delivered. County shall make payment within 30 days of the date the services were approved for payment on the basis of retrospective review described in paragraph 12, PAYMENT AUTHORIZATION, below. County shall not be obligated to pay for services billed later than the thirtieth day following the last day of the month in which the services were delivered except in the case of beneficiaries covered by both Medi-Cal and a third-party payer. If a beneficiary is covered by both Medi-Cal and a third-party payer, Contractor will bill third party payer and receive an Explanation of Benefits (EOB) from the third-party payer prior to billing County. Submission to County shall be considered timely when a billing invoice (accompanied by an EOB indicating payment or denial) is submitted: (1) no later than the thirtieth day following the last day of the month in which Contractor received an EOB for the billed service from the third-party payer, and (2) no later than the 120th day following the last day of the month in which services were delivered.

Contractor will be responsible to submit to County a monthly invoice for MHSA FSP Services Non-Billable to Medi-Cal using the invoice attached herein as Exhibit E.

When, on the basis of retrospective review, it has been determined that Contractor has failed to meet service standards or documentation standards established by the MHP and Title 9, California Code of Regulations, payment will be denied on the basis of audit exception. Payment will not be made on the basis of added, amended, or altered records presented after the date of the retrospective review.

Whenever there is audit exception against the County resulting from a claim for funding for an expenditure by the Contractor that is not allowable, the County may offset reimbursement to the Contractor for the exception.

5. TERM OF AGREEMENT

This agreement shall commence on July 1, 2026, and shall terminate June 30, 2028, unless terminated in accordance with section 6 below.

6. TERMINATION OF AGREEMENT

If Contractor fails to perform his/her duties to the satisfaction of the County, or if Contractor fails to fulfill in a timely and professional manner his/her obligations under this agreement, or if Contractor violates any of the terms or provisions of this agreement, then the County shall have the right to terminate this agreement effective immediately upon the County giving written notice thereof to the Contractor. Either party may terminate this agreement on 30 days' written notice. County shall pay contractor for all work satisfactorily completed as of the date of notice. County may terminate this agreement immediately upon oral notice should funding cease or be materially decreased or should the Tehama County Board of Supervisors fail to appropriate sufficient funds for this agreement in any fiscal year.

The County's right to terminate this agreement may be exercised by the Health Services Agency's Executive Director

7. ENTIRE AGREEMENT; MODIFICATION

This agreement for the services specified herein supersedes all previous agreements for these services and constitutes the entire understanding between the parties hereto. Contractor shall be entitled to no other benefits other than those specified herein. No changes, amendments or alterations shall be effective unless in writing and signed by both parties. Contractor specifically

acknowledges that in entering into and executing this agreement, Contractor relies solely upon the provisions contained in this agreement and no other oral or written representation.

8. NONASSIGNMENT OF AGREEMENT

Inasmuch as this agreement is intended to secure the specialized services of Contractor, Contractor may not assign, transfer, delegate or sublet any interest herein without the prior written consent of the County.

9. EMPLOYMENT STATUS

Contractor shall, during the entire term of this agreement, be construed to be an independent contractor and nothing in this agreement is intended nor shall be construed to create an employer-employee relationship, a joint venture relationship, or to allow County to exercise discretion or control over the professional manner in which Contractor performs the services which are the subject matter of this agreement; provided always, however, that the services to be provided by Contractor shall be provided in a manner consistent with the professional standards applicable to such services. The sole interest of the County is to ensure that the services shall be rendered and performed in a competent, efficient, and satisfactory manner. Contractor shall be fully responsible for payment of all taxes due to the State of California or the Federal government, which would be withheld from compensation of Contractor, if Contractor were a County employee. County shall not be liable for deductions for any amount for any purpose from Contractor's compensation. Contractor shall not be eligible for coverage under County's Workers Compensation Insurance Plan nor shall Contractor be eligible for any other County benefit.

10. INDEMNIFICATION

Contractor shall defend, hold harmless, and indemnify Tehama County, its elected officials, officers, employees, agents, and volunteers against all claims, suits, actions, costs, expenses (including but not limited to reasonable attorney's fees of County), damages, judgments, or decrees by reason of any person's or persons' injury, including death, or property (including property of County) being damaged, arising out of contractor's performance of work hereunder or its failure to comply with any of its obligations contained in this agreement, whether by negligence or otherwise. Contractor shall, at its own expense, defend any suit or action founded

upon a claim of the foregoing. Contractor shall also defend and indemnify County against any adverse determination made by the Internal Revenue Service or the State Franchise Tax Board and/or any other taxing or regulatory agency against the County with respect to Contractor's "independent contractor" status that would establish a liability for failure to make social security or income tax withholding payments, or any other legally mandated payment.

Contractor shall defend and indemnify Tehama County for any recoupment of funding resulting from periodic audit by the State of California, or United States of America and arising from Contractor's negligent acts, willful acts, or errors or omissions or such acts of Contractor's subcontractors, any person employed under Contractor, or under any subcontractor. Should County become subject to such recoupment Contractor shall reimburse County for recouped funds in proportion to Contractor's share of audit exceptions to the total audit exceptions charged against County.

11. INSURANCE

Contractor shall procure and maintain insurance pursuant to Exhibit A, "Insurance Requirements For Contractor," attached hereto and incorporated by reference.

12. PREVAILING WAGE

Contractor certifies that it is aware of the requirements of California Labor Code Sections 1720 et seq. and 1770 et seq., as well as California Code of Regulations, Title 8, Section 16000 et seq. ("Prevailing Wage Laws"), which require the payment of prevailing wage rates and the performance of other requirements on certain "public works" and "maintenance" projects. If the Services hereunder are being performed as part of an applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws, and if the total compensation is $1,000 or more, Contractor agrees to fully comply with and to require its subcontractors to fully comply with such Prevailing Wage Laws, to the extent that such laws apply. If applicable, County will maintain the general prevailing rate of per diem wages and other information set forth in Labor Code section 1773 at its principal office and will make this information available to any interested party upon request. Contractor shall defend, indemnify, and hold the County, its elected officials, officers, employees and agents free and harmless from any claims, liabilities, costs, penalties, or interest arising out of any failure or alleged failure of the Contractor or its subcontractors to comply with the Prevailing Wage Laws. Without limiting the generality of the

foregoing, Contractor specifically acknowledges that County has not affirmatively represented to contractor in writing, in the call for bids, or otherwise, that the work to be covered by the bid or contract was not a "public work." To the fullest extent permitted by law, Contractor hereby specifically waives and agrees not to assert, in any manner, any past, present, or future claim for indemnification under Labor Code section 1781.

Contractor acknowledges the requirements of Labor Code sections 1725.5 and 1771.1 which provide that no contractor or subcontractor may be listed on a bid proposal or be awarded a contract for a public works project unless registered with the Department of Industrial Relations pursuant to Labor Code section 1725.5, with exceptions from this requirement specified under Labor Code sections 1725.5(f), 1771.1(a) and 1771.1(n).

If the services are being performed as part of the applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws, Contractor acknowledges that this project is subject to compliance monitoring and enforcement by the Department of Industrial Relations.

13. NON-DISCRIMINATION

Contractor shall not employ discriminatory practices in the treatment of persons in relation to the circumstances provided for herein, including assignment of accommodations, employment of personnel, or in any other respect on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex, age, or sexual orientation.

14. GREEN PROCUREMENT POLICY

Through Tehama County Resolution No. 2021-140, the County adopted the Recovered Organic Waste Product Procurement Policy (available upon request) to (1) protect and conserve natural resources, water and energy; (2) minimize the jurisdiction's contribution to pollution and solid waste disposal; (3) comply with state requirements as contained in 14 CCR Division 7, Chapter 12, Article 12 (SB 1383); (4) support recycling and waste reduction; and (5) promote the purchase of products made with recycled materials, in compliance with the California Integrated Waste Management Act of 1989 (AB 939) and SB1382 when product fitness and quality are equal and they are available at the same or lesser cost of non-recycled products. Contractor shall adhere to this policy as required therein and is otherwise encouraged to conform to this policy.

15. COMPLIANCE WITH LAWS AND REGULATIONS

All services to be performed by Contractor under to this Agreement shall be performed in accordance with all applicable federal, state, and local laws, ordinances, rules, and regulations. Any change in status, licensure, or ability to perform activities, as set forth herein, must be reported to the County immediately.

16. LAW AND VENUE

This agreement shall be deemed to be made in and shall be governed by and construed in accordance with the laws of the State of California (excepting any conflict of laws provisions which would serve to defeat application of California substantive law). Venue for any action arising from this agreement shall be in Tehama County, California.

17. AUTHORITY

Each party executing this Agreement and each person executing this Agreement in any representative capacity, hereby fully and completely warrants to all other parties that he or she has full and complete authority to bind the person or entity on whose behalf the signing party is purposing to act.

18. NOTICES

Any notice required to be given pursuant to the terms and provisions of this agreement shall be in writing and shall be sent first class mail to the following addresses:

If to County:	Tehama County Health Services Agency Attn: Executive Director P.O. Box 400 Red Bluff, CA 96080 (530) 527-8491
If to Contractor:	Stephanie Holmes, Chief Executive Officer Remi Vista, Inc. Post Office Box 494100 (393 Marina Circle) Redding, CA 96049-4100

Notice shall be deemed to be effective two days after mailing.

19. NON-EXCLUSIVE AGREEMENT

Contractor understands that this is not an exclusive agreement, and that County shall have the right to negotiate with and enter into agreements with others providing the same or similar services to those provided by Contractor, or to perform such services with County's own forces, as County desires.

20. STANDARDS OF THE PROFESSION

Contractor agrees to perform its duties and responsibilities pursuant to the terms and conditions of this agreement in accordance with the standards of the profession for which Contractor has been properly licensed to practice.

21. LICENSING OR ACCREDITATION

Where applicable the Contractor shall maintain the appropriate license or accreditation through the life of this contract.

22. RESOLUTION OF AMBIGUITIES

If an ambiguity exists in this Agreement, or in a specific provision hereof, neither the Agreement nor the provision shall be construed against the party who drafted the Agreement or provision.

23. NO THIRD-PARTY BENEFICIARIES

Neither party intends that any person shall have a cause of action against either of them as a third-party beneficiary under this Agreement. The parties expressly acknowledge that is not their intent to create any rights or obligations in any third person or entity under this Agreement. The parties agree that this Agreement does not create, by implication or otherwise, any specific, direct or indirect obligation, duty, promise, benefit and/or special right to any person, other than the parties hereto, their successors and permitted assigns, and legal or equitable rights, remedy, or claim under or in respect to this Agreement or provisions herein.

24. HAZARDOUS MATERIALS

Contractor shall provide to County all Safety Data Sheets covering all Hazardous Materials to be furnished, used, applied, or stored by Contractor, or any of its Subcontractors, in connection with the services on County property. Contractor shall provide County with copies of any such Safety Data Sheets prior to entry to County property or with a document certifying that no Hazardous Materials will be brought onto County property by Contractor, or any of its Subcontractors,

during the performance of the services. County shall provide Safety Data Sheets for any Hazardous Materials that Contractor may be exposed to while on County property.

25. HARASSMENT

Contractor agrees to make itself aware of and comply with the County's Harassment Policy, TCPR §8102: Harassment, which is available upon request. The County will not tolerate or condone harassment, discrimination, retaliation, or any other abusive behavior. Violations of this policy may cause termination of this agreement.

26. SERVICE STANDARDS

Contractor agrees to abide by the same standards of care under which county provides service through programs staffed by County employees. Standards of care are communicated to Contractor via the Handbook, orientation, site certification process, retrospective reviews by the MHP, and training as new standards of care are implemented.

27. AUTHORIZATION

Contractor retains responsibility for obtaining evidence that County has authorized all services delivered under this agreement prior to their delivery. Authorization as used here means that County has provided written evidence to Contractor that it has completed an assessment and has determined that the beneficiary is eligible to receive the services, and that MHP and Title 9, CCR medical necessity criteria have been met.

Contractor will have 60 days from the date of the assessment to render initial counseling services and develop a treatment plan. If, due to extenuating circumstances, Contractor cannot complete the treatment plan within 60 days from the date of assessment, Contractor shall request additional time, specifying the reasons for the extension. County will review the request and notify Contractor of denial or further authorization, with a maximum of an additional 30 days.

The treatment plan shall set forth the specific, observable, and measurable goals of treatment that relate to the beneficiary’s diagnosis and that address improvement in functioning, the specific services to be provided, the period of time for the services, the frequency of services and the cumulative total hours of service. The County must provide written authorization of the

treatment plan prior to the delivery of ongoing treatment services by the Contractor within one week of receipt of the treatment plan.

28. PAYMENT AUTHORIZATION

County shall render payment as described in the current Handbook for services provided under this agreement that were authorized and that meet service standards and documentation standards established by the Tehama County MHP and Title 9, CCR. Compliance with MHP and Title 9, CCR service standards and documentation standards shall be established on the basis of retrospective reviews performed by Director or his or her designee. All claims for reimbursement under this agreement shall be submitted together with an Assurance of Compliance and Letter of Transmittal (see Handbook).

29. CODE OF CONDUCT

Tehama County Health Services Agency (TCHSA) maintains high ethical standards and is committed to complying with all applicable statutes, regulations, and guidelines. The TCHSA and each of its employees and contractors shall follow an established Code of Conduct.

PURPOSE

The purpose of the TCHSA Code of Conduct is to ensure that all TCHSA employees and contractors are committed to conducting their activities in accordance with the highest levels of ethics and in compliance with all applicable State and Federal statutes, regulations, and guidelines. The Code of Conduct also serves to demonstrate TCHSA's dedication to providing quality care to its patients.

CODE OF CONDUCT – General Statement

The Code of Conduct is intended to provide TCHSA employees and contractors with general guidelines to enable them to conduct the business of TCHSA in an ethical and legal manner;

- Every TCHSA employee and contractor is expected to uphold the Code of Conduct;
- Failure to comply with the Code of Conduct or failure to report non-compliance may subject the TCHSA employee or contractor to disciplinary action, up to or including termination of employment or contracted status.

CODE OF CONDUCT

All TCHSA employees and contractors:

- Shall perform their duties in good faith and to the best of their ability.
- Shall comply with all statutes, regulations, and guidelines applicable to Federal health care programs, and with TCHSA's own policies and procedures.
- Shall refrain from any illegal conduct. When an employee or contractor is uncertain of the meaning or application of a statute, regulation, or guideline, or the legality of a certain practice or activity, he or she shall seek guidance from his or her immediate Supervisor, Division Director, the Quality Assurance Manager, the Compliance Auditor, the Assistant Executive Director-Programs, or the Assistant Executive Director-Administration.
- Shall not obtain any improper personal benefit by virtue of their employment or contractual relationship with TCHSA;
- Shall notify their Supervisor, Division Director, Assistant Executive Director-Administration, the Assistant Executive Director-Programs, or Agency Executive Director immediately upon receipt (at work or at home) of any inquiry, subpoena, or other agency or governmental request for information regarding TCHSA;
    - Shall not destroy or alter TCHSA information or documents in anticipation of, or in response to, a request for documents by any applicable governmental agency or from a court of competent jurisdiction;
    - Shall not engage in any practice intended to unlawfully obtain favorable treatment or business from any entity, physician, patient, resident, vendor, or any other person or entity in a position to provide such treatment or business;
    - Shall not accept any gift of more than nominal value or any hospitality or entertainment, which because of its source or value, might influence the employee's or contractor's independent judgment in transactions involving TCHSA;
    - Shall disclose to their Division Director any financial interest, official position, ownership interest, or any other relationship that they (or a member of their immediate family) has with TCHSA vendors or contractors;
    - Shall not participate in any false billing of patients, governmental entities, or any other party;
    - Shall not participate in preparation of any false cost report or other type of report submitted to the government;

- Shall not pay or arrange for TCHSA to pay any person or entity for the referral of patients to TCHSA, and shall not accept any payment or arrangement for TCHSA to accept any payment for referrals from TCHSA:
- Shall not use confidential TCHSA information for their own personal benefit or for the benefit of any other person or entity while employed at or under contract to TCHSA, or at any time thereafter;
- Shall not disclose confidential medical information pertaining to TCHSA's patients or clients without the express written consent of the patients or clients or pursuant to court order and in accordance with the applicable law and TCHSA applicable policies and procedures;
- Shall promptly report to the Compliance Auditor any and all violations or suspected violations of the Code of Conduct;
- Shall promptly report to the Compliance Auditor any and all violations or suspected violations of any statute, regulation, or guideline applicable to Federal health care programs or violations of TCHSA's own policies and procedures;
- Shall not engage in or tolerate retaliation against employees or contractors who report or suspect wrongdoing.

30. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

The Contractor acknowledges that it is a "health care provider" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations. The Contractor agrees to use individually identifiable healthcare information obtained from the County only for purposes of providing diagnostic or treatment services to patients.

Contractor agrees to report to County any security incident or any use or disclosure of PHI (in any form) not provided for by this Agreement. Security incidents include attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. Contractor shall make this report by the next business day following discovery of the use, disclosure, or security incident.

31. CULTURAL COMPETENCY

Contractor shall ensure that services delivered under the terms of this agreement reflect a comprehensive range of age appropriate, cost-effective, high quality intervention strategies directed

so as to promote wellness, avert crises, and maintain beneficiaries within their own communities. Contractor shall make every effort to deliver services which are culturally sensitive and culturally competent, and which operationalize the following values:

A. Services should be delivered in the client's primary language or language of choice since language is the primary "carrier of culture,"

B. Services should encourage the active participation of individuals in their own care, protect confidentiality at all times, and recognize the rights of all individuals regardless of race, ethnicity, cultural background, disability or personal characteristics,

C. Service delivery staff should reflect the racial, ethnic, and cultural diversity of the population being served,

D. Certain culturally sanctioned behaviors, values, or attitudes of individuals legitimately may conflict with "mainstream values" without indicating psychopathology or moral deviance,

E. Service delivery systems should reflect cultural diversity in methods of service delivery as well as policy,

F. The organization should instill values in staff which encourage them to confront racially or culturally biased behavior in themselves and others and which encourage them to increase their sensitivity and acceptance of culturally based differences.

G. Contractor's staff shall receive cultural competency training and Contractor shall provide evidence of such training to County upon request.

32. DOCUMENTS AND RECORDS

A. Upon written request, Contractor agrees to permit County, State, and/or Federal agencies authorized by the Director, to inspect, review, and copy all records, notes, and writing of any kind in connection with the services provided by Contractor under this agreement. All such inspections and copying shall occur during normal business hours.

B. If the California Department of Health Care Services, Center for Medicare and Medicaid Services (CMS), or Office of the Inspector General of the US Department of Health and Human Services determines there is a reasonable

possibility of fraud or similar risk, the State, SMC or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

C. Contractor shall preserve all records relating to the services provided pursuant to this agreement until at least ten years from the final date of the contract period or ten years from the date of completion of any audit, whichever is later.

D. At the end of the period required for record retention, Contractor shall destroy all records made pursuant to this agreement in accordance with the California Code of Regulations, the California Welfare and Institutions Code, and Contractor's State licensing requirements.

E. Contractor shall document compliance with all contractual requirements. Such documentation shall be provided to County upon request.

33. CLINICAL RECORDS

Contractor shall maintain adequate records. Patient records must comply with all appropriate State and Federal requirements. Individual records shall contain intake information, interviews, and progress notes. Program records shall contain detail adequate for the evaluation of the service. Contractor agrees that its inability to produce records adequate for evaluation of the service shall constitute ground for audit exception and denial of Contractor's claim for payment for those services. Contractor shall provide monthly reports to the Director in conformance with the Client and Service Information (CSI) System as prescribed by the State Department of Mental Health.

If Contractor maintains an Electronic Health Record (EHR) with Protected Health Information (PHI), and an individual request a copy of such information in an electronic format, Contractor shall provide such information in an electronic format to enable the County to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. Section 17935(e) and the HIPAA regulations.

34. CONFIDENTIALITY OF PATIENT INFORMATION

All information and records obtained in the course of providing services under this agreement shall be confidential and Contractor shall comply with State and Federal requirements regarding confidentiality of patient information (including but not limited to section 5328 of the Welfare and Institutions Code, and Title 45, Code of Federal Regulations, section 205.50 for MediCal-

eligible patients) including all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All applicable regulations and statutes relating to patients' rights shall be adhered to. This provision shall survive the termination, expiration, or cancellation of this agreement.

35. SEVERABILITY

If any portion of this agreement or application thereof to any person or circumstance is declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal or state statute or regulation or County ordinance, the remaining provisions of this agreement, or the application thereof, shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this agreement are severable.

36. PARTICIPATION IN FEDERAL HEALTHCARE PROGRAMS

A. In entering into this agreement, Contractor acknowledges that County intends to seek reimbursement from Federal Healthcare programs for services provided directly by Contractor. Contractor acknowledges County's intent to comply with all rules and regulations pertaining to Federal Healthcare Programs. Contractor agrees to comply, and to require its employees who are considered "Covered Individuals" to comply with all policies and procedures of the Compliance Program. "Covered Individuals" are defined as employees or independent contractors of the Contractor with responsibilities pertaining to the ordering, provision, documentation, coding, or billing of services payable by a Federal Healthcare program for which County seeks reimbursement from the Federal Healthcare programs.

B. Contractor agrees to provide copies of the Code of Conduct to all Covered Individuals and to obtain (subject to review by County and/or Office of Inspector General [OIG]) signed certifications from each individual certifying that they have received, read, and understand the Code of Conduct and agree to abide by all rules and regulations pertaining to participation in Federal Healthcare programs. Contractor will submit the signed certifications to TCHSA's Compliance Officer within thirty (30) days after the effective date of this agreement for all current employees who are "Covered Individuals" and within thirty (30) days after the

start date of any newly-hired employees or independent contractors who are "Covered Individuals".

C. Contractor shall neither employ nor enter into an agreement with any provider who is, or at any time has been, excluded from participation in any federally funded healthcare program, including, without limitation, Medicare or Medi-Cal in accordance with Exhibit C.

D. Contractor shall provide assurances of compliance with current State of California and Federal regulations regulating the reimbursement and delivery of healthcare services. These assurances are in the following forms which are provided in the Handbook:

(1) Statement of Understanding and Compliance – signed by each service provider for every day he/she provides a service to a beneficiary. This Statement shall be attached to or printed on the service provider's daily time sheet, service activity log, or billing record. If Contractor does not use a daily time sheet, service activity log, or billing record, Contractor may, after approval from County (which may be obtained via email), have each service provider sign a monthly Statement of Understanding and Compliance. Contractor shall make signed Statements available to County upon request.

(2) Assurance of Compliance and Letter of Transmittal – signed by an officer of the corporation. This must accompany each claim for reimbursement.

37. AGREEMENT SUPERVISION

A. The Director, or his/her designee, shall be the County employee authorized and assigned to represent the interests of the County and to ensure that the terms and conditions of this agreement are carried out.

B. County shall monitor the kind, quality, and quantity of Contractor's services and criteria for determining the persons to be served and length of treatment for patients covered under the terms of this agreement.

38. PERSONNEL

A. Contractor shall furnish such qualified professional personnel as prescribed in Title 9 of the California Code of Regulations required for the type of services described in Section 1.

B. All Contractor's personnel (including independent contractors) shall have the appropriate current State licensure required for their given profession.

C. Contractor shall comply with all applicable Federal and/or State laws, rules, and regulations in regard to nondiscrimination in employment on the basis of race, color, ancestry, national origin, religion, sex, marital status, sexual orientation, age, medical condition, or disability (including compliance with the Federal Rehabilitation Act of 1973, section 504.

39. CERTIFICATION & LICENSING REQUIREMENTS

Contractor shall maintain a facility in Tehama County that complies with all city, county and state building standards and is accessible to Tehama County beneficiaries in accordance with the MPH time and distance requirements.

Contractor shall comply with all necessary County or State certification and licensing requirements and must obtain appropriate certification and or licenses and display same in a location that is reasonably conspicuous. Contractor shall abide by the Welfare and Institutions Code, section 5600 et. seq., Title 9 and Title 22 of the California Code of Regulations, the State Cost Reporting/Data Collection Manual (CR/DC), and State Department of Mental Health Policy Letters.

Contractor shall only use licensed, registered, or waivered providers acting within their scope of practice for services that require a license, waiver, or registration. (Cal. Code Regs., tit. 9, § 1840.314(d).) The Contractor shall ensure that providers are enrolled with the state as Medi-Cal providers consistent with the requirements of DHCS PAVE system.

40. AGREEMENT PREPARATION

It is agreed and understood by the parties hereto that this agreement has been arrived at through negotiation and that neither party is to be deemed the party which created any uncertainty in this agreement within the meaning of Civil Code section 1654.

41. TAXES

Contractor agrees to file Federal and State tax returns and pay all applicable State and Federal taxes on amounts paid pursuant to this agreement. In case County is audited for compliance regarding withholding or other applicable taxes, Contractor agrees to furnish County with proof of payment of taxes on those earnings.

42. PATIENTS' RIGHTS

Contractor shall give beneficiaries notice of their rights as contained in the Tehama County Guide to Medi-Cal Mental Health Services (available upon request from County in electronic or paper form). In addition, in all facilities providing the services described herein the Contractor shall have prominently posted in the predominant languages of the community a list of the patients' rights.

43. COMPLIANCE WITH LAW

A. Contractor shall observe and comply with all applicable County, State and Federal laws, ordinances, rules and regulations now in effect or hereafter enacted, each of which are hereby made a part hereof and incorporated herein by reference including, but not limited to, California Code of Regulations, Title 9, section 1810.436(a)(1)-(5), which provides that:

(1) Beneficiaries shall receive the same level of care as provided to all other patients served; and

(2) Medi-Cal beneficiaries shall not be discriminated against in any manner; and

(3) Contractor shall make all records, program compliance, and beneficiary complaints available for authorized review and fiscal audit whenever requested to do so by County, State, or Federal authorities; and

(4) The rate paid is considered to be payment in full, subject to third party liability and beneficiary share-of-cost for the specialty mental health services provided; and contractor shall adhere to Title 19 of the Social Security Act and conform to all other applicable Federal and State statutes and regulations.

(5) The rights and duties of the parties to this agreement are additionally governed by the specific, additional terms mutually agreed to and listed in Exhibit D and by this reference made a part hereof.

44. TELEHEALTH

Telehealth is a modality (live video/store-and-forward) for delivering medically necessary services and shall only be utilized if the services can be properly provided and a client is unable to access in-person services. The standard of care is the same whether the patient is seen in-person or through telehealth. Contractor shall use a HIPAA compliant product to provided telehealth services under this contract.

Contractor shall comply with all applicable state and federal telehealth regulations and utilize the resources provided by DHCS as the standard when providing telehealth services to Tehama County beneficiaries.

Contractor shall inform the patient about the use of telehealth and obtain verbal or written consent from the client for the use of telehealth as an acceptable mode of delivering mental health services. Consent must be documented in the client records.

Contractor shall maintain appropriate documentation to substantiate the telehealth services that were delivered to the client in accordance with the Medi-Cal telehealth standards.

45. AUDITING, MONITORING AND SITE INSPECTIONS

The County, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed.
The County shall conduct reviews of access to and quality of care. When monitoring activities identify areas of non-compliance, the County shall issue reports to the Contractor detailing findings, recommendations, and corrective action.

If any inspection or evaluation is made of the premises of the Contractor, the Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized

representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

The Contractor shall prepare and submit a report to the County that provides response to any areas of non-compliance, and plan of correction in accordance with the timelines indicated in the monitoring reports provided to the Contractor by the County.

46. REPORTING REQUIREMENTS

The Contractor shall ensure collection and maintenance of any data, documentation, or information relating to the performance of the services provided under this contract and as required by MHP contract and MHSA state reporting requirements including but not limited to: MHSA Key Event Tracking Form (KET), MHSA Quarterly Assessment Form (3M), and MHSA Individual Services and Supports Plan (ISSP)

The Contractor shall submit data, documentation, or information to the County in a format that is compliant with the State and Federal reporting standards, and at a frequency and level specified by the County.

47. TRAFFICKING VICTIMS PROTECTION ACT OF 2000

Contractor and its Subcontractors that provide services covered by this Contract shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104)."

48. BYRD ANTI-LOBBYING AMENDMENT (31 USC 1352)

Contractor certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 USC 1352. Contractor shall also disclose to DHCS any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

49. HATCH ACT

County agrees to comply with the provisions of the Hatch Act (USC, Title 5, Part III, Subpart F., Chapter 73, Subchapter III), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

50. COUNTERPARTS, ELECTRONIC SIGNATURES –BINDING

This agreement may be executed in any number of counterparts, each of which will be an original, but all of which together will constitute one instrument. Each Party of this agreement agrees to the use of electronic signatures, such as digital signatures that meet the requirements of the California Uniform Electronic Transactions Act ((“CUETA”) Cal. Civil Code §§ 1633.1 to 1633.17), for executing this agreement. The Parties further agree that the electronic signatures of the Parties included in this agreement are intended to authenticate this writing and to have the same force and effect as manual signatures. Electronic signature means an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record pursuant to the CUETA as amended from time to time. The CUETA authorizes use of an electronic signature for transactions and contracts among Parties in California, including a government agency. Digital signature means an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature, and shall be reasonably relied upon by the Parties. For purposes of this section, a digital signature is a type of “electronic signature” as defined in subdivision (i) of Section 1633.2 of the Civil Code. Facsimile signatures or signatures transmitted via pdf document shall be treated as originals for all purposes.

51. EXHIBITS

Contractor shall comply with all provisions of Exhibits A through E, attached hereto and incorporated by reference. In the event of a conflict between the provisions of the main body of this Agreement and any attached Exhibit(s), the main body of the Agreement shall take precedence.

IN WITNESS WHEREOF, County and Contractor have executed this agreement on the day and year set forth below.

COUNTY OF TEHAMA

Date: 6/17/26

Michelle D. Schmidt

~~Jayme S. Bottke~~, Executive Director

Michelle D. Schmidt, Interim Executive Director

REMI VISTA, INC., a California corporation

Date: 06/10/26

Stephanie Holmes, CEO

Stephanie Holmes, Chief Executive Officer

105130
Vendor Number

Budget Account Number

Standard Form of Agreement – Services adopted 12/08/22

Exhibit A

INSURANCE REQUIREMENTS FOR CONTRACTOR

Contractor shall procure and maintain, for the duration of the contract, insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work described herein and the results of that work by Contractor, his/her agents, representatives, employees, or subcontractors. At a minimum, Contractor shall maintain the insurance coverage, limits of coverage and other insurance requirements as described below.

Commercial General Liability (including operations, products and completed operations) $1,000,000 per occurrence for bodily injury, personal injury, and property damage. If coverage is subject to an aggregate limit, that aggregate limit will be twice the occurrence limit, or the general aggregate limit shall apply separately to this project/location.

Automobile Liability

Automobile liability insurance is required with minimum limits of $1,000,000 per accident for bodily injury and property damage, including owned and non-owned and hired automobile coverage, as applicable to the scope of services defined under this agreement.

Workers' Compensation

If Contractor has employees, he/she shall obtain and maintain continuously Workers' Compensation insurance to cover Contractor and Contractor's employees and volunteers, as required by the State of California, as well as Employer's Liability insurance in the minimum amount of $1,000,000 per accident for bodily injury or disease.

Professional Liability (Contractor/Professional services standard agreement only)

If Contractor is a state-licensed architect, engineer, contractor, counselor, attorney, accountant, medical provider, and/or other professional licensed by the State of California to practice a profession, Contractor shall provide and maintain in full force and effect while providing services pursuant to this contract a professional liability policy (also known as Errors and Omissions or Malpractice liability insurance) with single limits of liability not less than $1,000,000 per claim and $2,000,000 aggregate on a claims made basis. However, if

coverage is written on a claims-made basis, the policy shall be endorsed to provide coverage for at least three years from termination of agreement.

If Contractor maintains higher limits than the minimums shown above, County shall be entitled to coverage for the higher limits maintained by Contractor.

All such insurance coverage, except professional liability insurance, shall be provided on an "occurrence" basis, rather than a "claims made" basis.

Endorsements: Additional Insureds

The Commercial General Liability and Automobile Liability policies shall include, or be endorsed to include "Tehama County, its elected officials, officers, employees and volunteers" as an additional insured.

The certificate holder shall be "County of Tehama."

Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions of $25,000 or more must be declared to, and approved by, the County. The deductible and/or self-insured retentions will not limit or apply to Contractor's liability to County and will be the sole responsibility of Contractor.

Primary Insurance Coverage

For any claims related to this project, Contractor's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be excess of Contractor's insurance and shall not contribute with it.

Coverage Cancellation

Each insurance policy required herein shall be endorsed to state that "coverage shall not be reduced or canceled without 30 days' prior written notice certain to the County."

Acceptability of Insurers

Contractor's insurance shall be placed with an insurance carrier holding a current A.M. Best & Company's rating of not less than A:VII unless otherwise acceptable to the County. The County reserves the right to require rating verification. Contractor shall ensure that the insurance carrier shall be authorized to transact business in the State of California.

Subcontractors

Contractor shall require and verify that all subcontractors maintain insurance that meets all the requirements stated herein.

Material Breach

If for any reason, Contractor fails to maintain insurance coverage or to provide evidence of renewal, the same shall be deemed a material breach of contract. County, in its sole option, may terminate the contract and obtain damages from Contractor resulting from breach. Alternatively, County may purchase such required insurance coverage, and without further notice to Contractor, County may deduct from sums due to Contractor any premium costs advanced by County for such insurance.

Policy Obligations

Contractor's indemnity and other obligations shall not be limited by the foregoing insurance requirements.

Verification of Coverage

Contractor shall furnish County with original certificates and endorsements effecting coverage required herein. All certificates and endorsements shall be received and approved by the County prior to County signing the agreement and before work commences. However, failure to do so shall not operate as a waiver of these insurance requirements.

The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications at any time.

Exhibit B

Contract Exhibit - Rates
Provider: Remi Vista

Code	Modifier	Format	Time Associated with Code (Mins) for Purposes of Rate	Type of Serivce	Service Description	Modifier Description	Provider Type	Rate FY 26-27
90791		90791	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	59	90791:59	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	59,95	90791:59:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	59,95,HK	90791:59:95:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	59,HK	90791:59:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Distinct Procedural Service in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	95	90791:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	95,HK	90791:95:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	HK	90791:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	HL	90791:HL	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	HL,59	90791:HL:59	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern and Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	HL,59,95	90791:HL:59:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern and Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90791	HL,95	90791:HL:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885		90885	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	59	90885:59	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	59,95	90885:59:95	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	59,95,HK	90885:59:95:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	59,HK	90885:59:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	95	90885:95	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	95,HK	90885:95:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	HK	90885:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	HL	90885:HL	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Intern	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90885	HL,59	90885:HL:59	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Intern and Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110		96110:	15	Assessment Codes	Developmental Screening, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	59	96110:59	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	59:95	96110:59:95	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	59:95:HK	96110:59:95:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	59:HK	96110:59:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	95	96110:95	15	Assessment Codes	Developmental Screening, 15 Minutes	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	95:HK	96110:95:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96110	HK	96110:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96116		96116:	60	Assessment Codes	Neurobehavioral Status Exam, First Hour		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96116	59	96116:59	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96116	59:95	96116:59:95	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96116	59:95:HK	96116:59:95:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96116	59:HK	96116:59:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96116	95	96116:95	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96116	95:HK	96116:95:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32

96116	HK	96116:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96121		96121:	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96121	95	96121:95	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96121	95:HK	96121:95:HK	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96121	HK	96121:HK	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.32
96127		96127:	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	59	96127:59	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	59:95	96127:59:95	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	59:95:HK	96127:59:95:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	59:HK	96127:59:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	95	96127:95	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	95:HK	96127:95:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96127	HK	96127:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
98966	93	98966:93	8	Assessment Codes	Telephone Assessment and Management Service, 5-10 Minutes	Telephone only	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 40.18
98967	93	98967:93	16	Assessment Codes	Telephone Assessment and Management Service, 11-20 Minutes	Telephone only	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 80.35
98968	93	98968:93	26	Assessment Codes	Telephone Assessment and Management Service, 21-30 Minutes	Telephone only	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 130.57
H0031		H0031	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H0031	HK	H0031:HK	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2000		H2000	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2000	HK	H2000:HK	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90839		90839:	52	Crisis Intervention Codes	Psychotherapy for Crisis, First 30-74 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 261.15
90839	59	90839:59	52	Crisis Intervention Codes	Psychotherapy for Crisis, First 30-74 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 261.15
90840		90840:	30	Crisis Intervention Codes	Psychotherapy for Crisis, Each Additional 30 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.66
90840	59	90840:59	30	Crisis Intervention Codes	Psychotherapy for Crisis, Each Additional 30 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.66
H2011		H2011	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2011	GT	H2011:GT	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2011	SC	H2011:SC	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes	Telephone only	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H0033		H0033	15	Medication Support Codes	Oral Medication Administration, Direct Observation, 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H0033	HK	H0033:HK	15	Medication Support Codes	Oral Medication Administration, Direct Observation, 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
99366		99366:	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	27	99366:27	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	27:59	99366:27:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M and Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	27:59:95	99366:27:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	27:59:95:HK	99366:27:59:95:H	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	59	99366:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	59:95	99366:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	59:95:HK	99366:59:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	95	99366:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	95:HK	99366:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99366	HK	99366:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368		99368:	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	27	99368:27	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	27:59	99368:27:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M and Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	27:59:95	99368:27:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33

99368	27:59:95:HK	99368:27:59:95:H	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	59	99368:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	59:95	99368:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	59:95:HK	99368:59:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	95	99368:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	95:HK	99368:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99368	HK	99368:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99484		99484:	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99484	95	99484:95	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99484	95:HK	99484:95:HK	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
99484	HK	99484:HK	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
H0032		H0032	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H0032	HK	H0032:HK	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
T1017		T1017	15	Referral Codes	Targeted Case Management, Each 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
T1017	HK	T1017:HK	15	Referral Codes	Targeted Case Management, Each 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2017		H2017	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes		LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2017	HQ	H2017:HQ	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Group setting	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
H2017	HK	H2017:HK	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2017	HK:HQ	H2017:HK:HQ	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Specialized MH program in a Group setting	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
H2021		H2021	15	Rehabilitation Codes	Community-Based Wrap-Around Services, per 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2021	HK	H2021:HK	15	Rehabilitation Codes	Community-Based Wrap-Around Services, per 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90785		90785:	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90785	95	90785:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90785	95:HK	90785:95:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video - High Risk	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90785	HK	90785:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - High Risk	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90785	HL	90785:HL	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90785	HL:93	90785:HL:93	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Telephone	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90785	HL:95	90785:HL:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Tele Video	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 10.82
90887		90887:	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	59	90887:59	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	59:95	90887:59:95	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	59:95:HK	90887:59:95:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	59:HK	90887:59:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	95	90887:95	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	95:HK	90887:95:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	HK	90887:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	HL	90887:HL	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	HL:59	90887:HL:59	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern and Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90887	HL:95	90887:HL:95	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33

90887	HL:59:95	90887:HL:95:59	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern and Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161		96161:	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	59	96161:59	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	59:95	96161:59:95	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	59:95:HK	96161:59:95:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	59:HK	96161:59:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	95	96161:95	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	95:HK	96161:95:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
96161	HK	96161:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
T1013		T1013	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 19.67
T1013	HK	T1013:HK	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 19.67
H2019		H2019	15	Therapeutic Behavioral Services (TBS) Code	Therapeutic Behavioral Services per 15 Minute		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
H2019	HK	H2019:HK	15	Therapeutic Behavioral Services (TBS) Code	Therapeutic Behavioral Services per 15 Minute	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90832		90832	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 150.66
90832	59	90832:59	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90832	59:95	90832:59:95	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90832	59:95:HK	90832:59:95:HK	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90832	59:HK	90832:59:HK	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90832	95	90832:95	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90832	95:HK	90832:95:HK	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90832	HK	90832:HK	30	Therapy Codes	Psychotherapy, 30 Minutes with Patient	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 150.67
90834		90834	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	59	90834:59	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	59:95	90834:59:95	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	59:95:HK	90834:59:95:HK	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	59:HK	90834:59:HK	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	95	90834:95	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	95:HK	90834:95:HK	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90834	HK	90834:HK	45	Therapy Codes	Psychotherapy, 45 Minutes with Patient	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 226.00
90837		90837	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	59	90837:59	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	59:95	90837:59:95	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	59:95:HK	90837:59:95:HK	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	59:HK	90837:59:HK	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	95	90837:95	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	95:HK	90837:95:HK	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90837	HK	90837:HK	60	Therapy Codes	Psychotherapy, 60 Minutes with Patient	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90845		90845:	15	Therapy Codes	Psychoanalysis, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	59	90845:59	15	Therapy Codes	Psychoanalysis, 15 Minutes	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	59:95	90845:59:95	15	Therapy Codes	Psychoanalysis, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	59:95:HK	90845:59:95:HK	15	Therapy Codes	Psychoanalysis, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	59:HK	90845:59:HK	15	Therapy Codes	Psychoanalysis, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	95	90845:95	15	Therapy Codes	Psychoanalysis, 15 Minutes	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	95:HK	90845:95:HK	15	Therapy Codes	Psychoanalysis, 15 Minutes	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90845	HK	90845:HK	15	Therapy Codes	Psychoanalysis, 15 Minutes	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 75.33
90847		90847	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patien Present), 50 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	59	90847:59	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	59:95	90847:59:95	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	59:95:HK	90847:59:95:HK	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	59:HK	90847:59:HK	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	95	90847:95	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	95:HK	90847:95:HK	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90847	HK	90847:HK	50	Therapy Codes	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 251.11
90849		90849	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90849	59	90849:59	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90849	59:95	90849:59:95	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74

90849	59:95:HK	90849:59:95:HK	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90849	59:HK	90849:59:HK	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90849	95	90849:95	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90849	95:HK	90849:95:HK	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90849	HK	90849:HK	15	Therapy Codes	Multiple-Family Group Psychotherapy, 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853		90853	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group) 15 Minutes		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	59	90853:59	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Two Procedures in a Day	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	59:95	90853:59:95	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Two Procedures in a Day w/Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	59:95:HK	90853:59:95:HK	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	59:HK	90853:59:HK	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Two Procedures in a Day in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	95	90853:95	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Telemedicine	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	95:HK	90853:95:HK	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Telemedicine in Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90853	HK	90853:HK	15	Therapy Codes	Group Psychotherapy (Other Than of a Multiple Family Group), 15 Minutes	Specialized MH program	LCSW / MFT / LPCC (Licensed, Waivered, or Registered)	$ 16.74
90880		90880:		Therapy Codes	Hypnotherapy		LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	59	90880:59		Therapy Codes	Hypnotherapy	Two Procedures in a Day	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	59:95	90880:59:95		Therapy Codes	Hypnotherapy	Two Procedures in a Day w/Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	59:95:HK	90880:59:95:HK		Therapy Codes	Hypnotherapy	Two Procedures in a Day w/Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	59:HK	90880:59:HK		Therapy Codes	Hypnotherapy	Two Procedures in a Day in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	95	90880:95		Therapy Codes	Hypnotherapy	Telemedicine	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	95:HK	90880:95:HK		Therapy Codes	Hypnotherapy	Telemedicine in Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
90880	HK	90880:HK		Therapy Codes	Hypnotherapy	Specialized MH program	LCSW / LMFT / LPCC (Licensed, Waivered, or Registered)	$ 301.33
H0031		H0031	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
H0031	HK	H0031:HK		Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
H2000		H2000	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
H2000	HK	H2000:HK	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialis	$ 56.73
H2011		H2011	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
H2011	GT	H2011:GT	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes	Telemedicine	Mental Health Rehabilitation Specialist	$ 56.73
H2011	SC	H2011:SC	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes	Telephone only	Mental Health Rehabilitation Specialist	$ 56.73
H0033		H0033	15	Medication Support Codes	Oral Medication Administration, Direct Observation, 15 Minutes		Mental Health Rehabilitation Specialist	$ 56.73
H0033	HK	H0033:HK	15	Medication Support Codes	Oral Medication Administration, Direct Observation, 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
H0034		HOO34	15	Medication Support Codes	Medication Training and Support, per 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
H0034	HQ	H0034:HQ	15	Medication Support Codes	Medication Training and Support, per 15 Minutes	Group setting	Mental Health Rehabilitation Specialis	$ 12.60
H0034	HK	H0034:HK	15	Medication Support Codes	Medication Training and Support, per 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
H0034	HQ:HK	H0034:HQ:HK	15	Medication Support Codes	Medication Training and Support, per 15 Minutes	Specialized MH program in a Group setting	Mental Health Rehabilitation Specialist	$ 12.60
H0032		H0032	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes		Mental Health Rehabilitation Specialist	$ 56.73
H0032	HK	HOO32:HK	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
T1017		T1017	15	Referral Codes	Targeted Case Management, Each 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
T1017	HK	T1017:HK	15	Referral Codes	Targeted Case Management, Each 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
H2017		H2017	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
H2017	HK	H2017:HK	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
H2017	HQ	H2017:HQ	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Group setting	Mental Health Rehabilitation Specialist	$ 12.60
H2017	HQ:HK	H2017:HQ:HK	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Specialized MH program in a Group setting	Mental Health Rehabilitation Specialist	$ 12.60
H2021		H2021	15	Rehabilitation Codes	Community-Based Wrap-Around Services, per 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
H2021	HK	H2021:HK	15	Rehabilitation Codes	Community-Based Wrap-Around Services, per 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialis	$ 56.73
90785		90785:	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity	Mental Health Rehabilitation Specialis	$ 10.83
90785	95	90785:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video	Mental Health Rehabilitation Specialis	$ 10.83
90785	95:HK	90785:95:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video - High Risk	Mental Health Rehabilitation Specialis	$ 10.83
90785	HK	90785:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - High Risk	Mental Health Rehabilitation Specialis	$ 10.83
90785	HL	90785:HL	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern	Mental Health Rehabilitation Specialis	$ 10.83
90785	HL:93	90785:HL:93	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Telephone	Mental Health Rehabilitation Specialis	$ 10.83
90785	HL:95	90785:HL:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Tele Video	Mental Health Rehabilitation Specialis	$ 10.83
T1013		T1013	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes		Mental Health Rehabilitation Specialis	$ 56.73
T1013	HK	T1013:HK	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes	Specialized MH program	Mental Health Rehabilitation Specialis	$ 56.73
H2019		H2019	15	Therapeutic Behavioral Services (TBS) Code	Therapeutic Behavioral Services per 15 Minute		Mental Health Rehabilitation Specialist	$ 56.73
H2019	HK	H2019:HK	15	Therapeutic Behavioral Services (TBS) Code	Therapeutic Behavioral Services per 15 Minute	Specialized MH program	Mental Health Rehabilitation Specialist	$ 56.73
H0025		H0025		Peer Support Services Codes	Behavioral health prevention education service (delivery o services with target population to affect knowledge, attitude and/or behavior)		Peer Support Specialist	$ 13.12
H0025	HK	H0025:HK		Peer Support Services Codes	Behavioral health prevention education service (delivery o services with target population to affect knowledge, attitude and/or behavior)	Specialized MH program	Peer Support Specialist	$ 13.12
H0038		H0038	15	Peer Support Services Codes	Self-help/peer services per 15 minutes		Peer Support Specialist	$ 59.06
H0038	HK	H0038:HK	15	Peer Support Services Codes	Self-help/peer services per 15 minutes	Specialized MH program	Peer Support Specialist	$ 59.06

H0031		H0031	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes		Other Qualified Practitioner	$ 56.27
H0031	HK	H0031:HK	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
H2000		H2000	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes		Other Qualified Practitioner	$ 56.27
H2000	HK	H2000:HK	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
H2011		H2011	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes		Other Qualified Practitioner	$ 56.27
H2011	GT	H2011:GT	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes	Telemedicine	Other Qualified Practitioner	$ 56.27
H2011	SC	H2011:SC	15	Crisis Intervention Codes	Crisis Intervention Service, per 15 Minutes	Telephone only	Other Qualified Practitioner	$ 56.27
H0033		H0033	15	Medication Support Codes	Oral Medication Administration, Direct Observation, 15 Minutes		Other Qualified Practitioner	$ 56.26
H0033	HK	H0033:HK	15	Medication Support Codes	Oral Medication Administration, Direct Observation, 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.26
H0034		HOO34	15	Medication Support Codes	Medication Training and Support, per 15 Minutes		Other Qualified Practitioner	$ 56.27
H0034	HQ	H0034:HQ	15	Medication Support Codes	Medication Training and Support, per 15 Minutes	Group setting	Other Qualified Practitioner	$ 12.50
H0034	HK	H0034:HK	15	Medication Support Codes	Medication Training and Support, per 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
H0034	HQ:HK	H0034:HQ:HK	15	Medication Support Codes	Medication Training and Support, per 15 Minutes	Specialized MH program in a Group setting	Other Qualified Practitioner	$ 12.50
H0032		H0032	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes		Other Qualified Practitioner	$ 56.27
H0032	HK	H0032:HK	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
T1017		T1017	15	Referral Codes	Targeted Case Management, Each 15 Minutes		Other Qualified Practitioner	$ 56.27
T1017	HK	T1017:HK	15	Referral Codes	Targeted Case Management, Each 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
H2017		H2017	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes		Other Qualified Practitioner	$ 56.27
H2017	HK	H2017:HK	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
H2017	HQ	H2017:HQ	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Group setting	Other Qualified Practitioner	$ 12.50
H2017	HQ:HK	H2017:HQ:HK	15	Rehabilitation Codes	Psychosocial Rehabilitation, per 15 Minutes	Specialized MH program in a Group setting	Other Qualified Practitioner	$ 12.50
H2021		H2021	15	Rehabilitation Codes	Community-Based Wrap-Around Services, per 15 Minutes		Other Qualified Practitioner	$ 56.27
H2021	HK	H2021:HK	15	Rehabilitation Codes	Community-Based Wrap-Around Services, per 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 56.27
90785		90785:	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity	Other Qualified Practitioner	$ 10.74
90785	95	90785:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video	Other Qualified Practitioner	$ 10.74
90785	95:HK	90785:95:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video - High Risk	Other Qualified Practitioner	$ 10.74
90785	HK	90785:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - High Risk	Other Qualified Practitioner	$ 10.74
90785	HL	90785:HL	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern	Other Qualified Practitioner	$ 10.74
90785	HL:93	90785:HL:93	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Telephone	Other Qualified Practitioner	$ 10.74
90785	HL:95	90785:HL:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Tele Video	Other Qualified Practitioner	$ 10.74
T1013		T1013	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes		Other Qualified Practitioner	$ 19.52
T1013	HK	T1013:HK	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes	Specialized MH program	Other Qualified Practitioner	$ 19.52
H2019		H2019	15	Therapeutic Behavioral Services (TBS) Code	Therapeutic Behavioral Services per 15 Minute		Other Qualified Practitioner	$ 56.27
H2019	HK	H2019:HK	15	Therapeutic Behavioral Services (TBS) Code	Therapeutic Behavioral Services per 15 Minute	Specialized MH program	Other Qualified Practitioner	$ 56.27
90791		90791	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
90791	59	90791:59	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
90791	59,95	90791:59:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90791	59,95,HK	90791:59:95:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90791	59,HK	90791:59:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Distinct Procedural Service in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90791	95	90791:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90791	95,HK	90791:95:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90791	HK	90791:HK	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90791	HL	90791:HL	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern	Psychologist (Licensed or Waivered)	$ 106.55
90791	HL,59	90791:HL:59	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
90791	HL,59,95	90791:HL:59:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern and Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90791	HL,95	90791:HL:95	15	Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	Intern w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90885		90885	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
90885	59	90885:59	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
90885	59,95	90885:59:95	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90885	59,95,HK	90885:59:95:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90885	59,HK	90885:59:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90885	95	90885:95	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90885	95,HK	90885:95:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55

90885	HK	90885:HK	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90885	HL	90885:HL	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Intern	Psychologist (Licensed or Waivered)	$ 106.55
90885	HL,59	90885:HL:59	15	Assessment Codes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Intern and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
96105		96105:	60	Assessment Codes	Assessment of Aphasia, per Hour		Psychologist (Licensed or Waivered)	$ 426.21
96105	95	96105:95	60	Assessment Codes	Assessment of Aphasia, per Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96105	95:HK	96105:95:HK	60	Assessment Codes	Assessment of Aphasia, per Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96105	HK	96105:HK	60	Assessment Codes	Assessment of Aphasia, per Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96110		96110:	15	Assessment Codes	Developmental Screening, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
96110	59	96110:59	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
96110	59:95	96110:59:95	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96110	59:95:HK	96110:59:95:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96110	59:HK	96110:59:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96110	95	96110:95	15	Assessment Codes	Developmental Screening, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96110	95:HK	96110:95:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96110	HK	96110:HK	15	Assessment Codes	Developmental Screening, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96112		96112:	60	Assessment Codes	Developmental Testing, First Hour		Psychologist (Licensed or Waivered)	$ 426.21
96112	59	96112:59	60	Assessment Codes	Developmental Testing, First Hour	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96112	59:95	96112:59:95	60	Assessment Codes	Developmental Testing, First Hour	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96112	59:95:HK	96112:59:95:HK	60	Assessment Codes	Developmental Testing, First Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96112	59:HK	96112:59:HK	60	Assessment Codes	Developmental Testing, First Hour	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96112	95	96112:95	60	Assessment Codes	Developmental Testing, First Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96112	95:HK	96112:95:HK	60	Assessment Codes	Developmental Testing, First Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96112	HK	96112:HK	60	Assessment Codes	Developmental Testing, First Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96113		96113:	30	Assessment Codes	Developmental Testing, Each Additional 30 Minutes		Psychologist (Licensed or Waivered)	$ 213.11
96113	95	96113:95	30	Assessment Codes	Developmental Testing, Each Additional 30 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 213.11
96113	95:HK	96113:95:HK	30	Assessment Codes	Developmental Testing, Each Additional 30 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96113	HK	96113:HK	30	Assessment Codes	Developmental Testing, Each Additional 30 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96116		96116:	60	Assessment Codes	Neurobehavioral Status Exam, First Hour		Psychologist (Licensed or Waivered)	$ 426.21
96116	59	96116:59	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96116	59:95	96116:59:95	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96116	59:95:HK	96116:59:95:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96116	59:HK	96116:59:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96116	95	96116:95	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96116	95:HK	96116:95:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96116	HK	96116:HK	60	Assessment Codes	Neurobehavioral Status Exam, First Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96121		96121:	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour		Psychologist (Licensed or Waivered)	$ 426.21
96121	95	96121:95	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96121	95:HK	96121:95:HK	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96121	HK	96121:HK	60	Assessment Codes	Neurobehavioral Status Exam, Each Additional Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96125		96125:	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour		Psychologist (Licensed or Waivered)	$ 426.21
96125	59	96125:59	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96125	59:95	96125:59:95	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96125	59:95:HK	96125:59:95:HK	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96125	59:HK	96125:59:HK	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96125	95	96125:95	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96125	95:HK	96125:95:HK	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96125	HK	96125:HK	60	Assessment Codes	Standardized Cognitive Performance Testing, per Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96127		96127:	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
96127	59	96127:59	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
96127	59:95	96127:59:95	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96127	59:95:HK	96127:59:95:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96127	59:HK	96127:59:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96127	95	96127:95	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96127	95:HK	96127:95:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96127	HK	96127:HK	15	Assessment Codes	Brief Emotional/Behavioral Assessment, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96130		96130:	60	Assessment Codes	Psychological Testing Evaluation, First Hour		Psychologist (Licensed or Waivered)	$ 426.21
96130	59	96130:59	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96130	59:95	96130:59:95	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96130	59:95:HK	96130:59:95:HK	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96130	59:HK	96130:59:HK	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Distinct Procedural Service in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96130	95	96130:95	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96130	95:HK	96130:95:HK	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96130	HK	96130:HK	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96130	HL	96130:HL	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Intern	Psychologist (Licensed or Waivered)	$ 426.21
96130	HL:59	96130:HL:59	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Intern and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96130	HL:93	96130:HL:93	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Intern and Telephone onl	Psychologist (Licensed or Waivered)	$ 426.21
96130	HL:93:59	96130:HL:93:59	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Intern and Two Procedures w/Telephone onl	Psychologist (Licensed or Waivered)	$ 426.21

96130	HL:59	96130:HL:95	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Intern w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96130	HL:95:59	96130:HL:95:59	60	Assessment Codes	Psychological Testing Evaluation, First Hour	Intern and Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96131		96131:	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour		Psychologist (Licensed or Waivered)	$ 426.21
96131	59	96131:59	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96131	59:95	96131:59:95	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96131	59:95:HK	96131:59:95:HK	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96131	59:HK	96131:59:HK	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Distinct Procedural Service in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96131	95	96131:95	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96131	95:HK	96131:95:HK	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96131	HK	96131:HK	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96131	HL	96131:HL	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Intern	Psychologist (Licensed or Waivered)	$ 426.21
96131	HL:59	96131:HL:59	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Intern and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96131	HL:93	96131:HL:93	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Intern and Telephone onl	Psychologist (Licensed or Waivered)	$ 426.21
96131	HL:93:59	96131:HL:93:59	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Intern and Two Procedures w/Telephone onl	Psychologist (Licensed or Waivered)	$ 426.21
96131	HL:59	96131:HL:95	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Intern w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96131	HL:95:59	96131:HL:95:59	60	Assessment Codes	Psychological Testing Evaluation, Each Additional Hour	Intern and Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96132		96132:	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour		Psychologist (Licensed or Waivered)	$ 426.21
96132	59	96132:59	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
96132	59:95	96132:59:95	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96132	59:95:HK	96132:59:95:HK	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96132	59:HK	96132:59:HK	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96132	95	96132:95	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96132	95:HK	96132:95:HK	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96132	HK	96132:HK	60	Assessment Codes	Neuropsychological Testing Evaluation, First Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96133		96133:	60	Assessment Codes	Neuropsychological Testing Evaluation, Each Additional Hour		Psychologist (Licensed or Waivered)	$ 426.21
96133	95	96133:95	60	Assessment Codes	Neuropsychological Testing Evaluation, Each Additional Hour	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
96133	95:HK	96133:95:HK	60	Assessment Codes	Neuropsychological Testing Evaluation, Each Additional Hour	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96133	HK	96133:HK	60	Assessment Codes	Neuropsychological Testing Evaluation, Each Additional Hour	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
96136		96136:	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes		Psychologist (Licensed or Waivered)	$ 213.11
96136	59	96136:59	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 213.11
96136	59:95	96136:59:95	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 213.11
96136	59:95:HK	96136:59:95:HK	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96136	59:HK	96136:59:HK	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96136	95	96136:95	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 213.11
96136	95:HK	96136:95:HK	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96136	HK	96136:HK	30	Assessment Codes	Psychological or Neuropsychological Test Administration, First 30 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96137		96137:	30	Assessment Codes	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes		Psychologist (Licensed or Waivered)	$ 213.11
96137	95	96137:95	30	Assessment Codes	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 213.11
96137	95:HK	96137:95:HK	30	Assessment Codes	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96137	HK	96137:HK	30	Assessment Codes	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 213.11
96146		96146:	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
96146	59	96146:59	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
96146	59:95	96146:59:95	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96146	59:95:HK	96146:59:95:HK	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96146	59:HK	96146:59:HK	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96146	95	96146:95	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96146	95:HK	96146:95:HK	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96146	HK	96146:HK	15	Assessment Codes	Psychological or Neuropsychological Test Administration, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
98966	93	98966:93	8	Assessment Codes	Telephone Assessment and Management Service, 5-10 Minutes	Telephone only	Psychologist (Licensed or Waivered)	$ 56.83
98967	93	98967:93	16	Assessment Codes	Telephone Assessment and Management Service, 11-20 Minutes	Telephone only	Psychologist (Licensed or Waivered)	$ 113.66
98968	93	98968:93	26	Assessment Codes	Telephone Assessment and Management Service, 21-30 Minutes	Telephone only	Psychologist (Licensed or Waivered)	$ 184.69
H0031		H0031	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
H0031	HK	H0031:HK	15	Assessment Codes	Mental Health Assessment by Non Physician, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55

H2000		H2000	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
H2000	HK	H2000:HK	15	Assessment Codes	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
99366		99366:	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More		Psychologist (Licensed or Waivered)	$ 426.21
99366	27	99366:27	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M	Psychologist (Licensed or Waivered)	$ 426.21
99366	27:59	99366:27:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
99366	27:59:95	99366:27:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
99366	27:59:95:HK	99366:27:59:95:H	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99366	59	99366:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
99366	59:95	99366:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
99366	59:95:HK	99366:59:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99366	95	99366:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
99366	95:HK	99366:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99366	HK	99366:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99368		99368:	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More		Psychologist (Licensed or Waivered)	$ 426.21
99368	27	99368:27	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M	Psychologist (Licensed or Waivered)	$ 426.21
99368	27:59	99368:27:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
99368	27:59:95	99368:27:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
99368	27:59:95:HK	99368:27:59:95:H	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Multiple E/M and Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99368	59	99368:59	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
99368	59:95	99368:59:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
99368	59:95:HK	99368:59:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99368	95	99368:95	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21

99368	95:HK	99368:95:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99368	HK	99368:HK	60	Plan Development Codes	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non Physician. Patient and/or Family Not Present. 30 Minutes or More	Specialized MH program	Psychologist (Licensed or Waivered)	$ 426.21
99484		99484:	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***		Psychologist (Licensed or Waivered)	$ 426.21
99484	95	99484:95	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 426.21
99484	95:HK	99484:95:HK	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
99484	HK	99484:HK	60	Plan Development Codes	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes***	Telemedicine	Psychologist (Licensed or Waivered)	$ 426.21
H0032		H0032	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
H0032	HK	H0032:HK	15	Plan Development Codes	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90785		90785:	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity	Psychologist (Licensed or Waivered)	$ 9.90
90785	95	90785:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video	Psychologist (Licensed or Waivered)	$ 9.90
90785	95:HK	90785:95:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - Tele Video - High Risk	Psychologist (Licensed or Waivered)	$ 9.90
90785	HK	90785:HK	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity - High Risk	Psychologist (Licensed or Waivered)	$ 9.90
90785	HL	90785:HL	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern	Psychologist (Licensed or Waivered)	$ 9.90
90785	HL:93	90785:HL:93	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Telephone	Psychologist (Licensed or Waivered)	$ 9.90
90785	HL:95	90785:HL:95	Occurrence	Supplemental Services Codes	Interactive Complexity	Interactive Complexity -Intern-Tele Video	Psychologist (Licensed or Waivered)	$ 9.90
90887		90887:	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
90887	59	90887:59	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
90887	59:95	90887:59:95	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90887	59:95:HK	90887:59:95:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90887	59:HK	90887:59:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90887	95	90887:95	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90887	95:HK	90887:95:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90887	HK	90887:HK	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90887	HL	90887:HL	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern	Psychologist (Licensed or Waivered)	$ 106.55
90887	HL:59	90887:HL:59	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern and Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
90887	HL:95	90887:HL:95	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90887	HL:59:95	90887:HL:95:59	15	Supplemental Services Codes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Intern and Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96161		96161:	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes		Psychologist (Licensed or Waivered)	$ 106.55
96161	59	96161:59	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55
96161	59:95	96161:59:95	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96161	59:95:HK	96161:59:95:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96161	59:HK	96161:59:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96161	95	96161:95	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
96161	95:HK	96161:95:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
96161	HK	96161:HK	15	Supplemental Services Codes	Caregiver Assessment Administration of Care Giver Focused Risk Assessment, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
T1013		T1013	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes		Psychologist (Licensed or Waivered)	$ 18.00
T1013	HK	T1013:HK	15	Supplemental Services Codes	Sign Language or Oral Interpretive Services, 15 Minutes	Specialized MH program	Psychologist (Licensed or Waivered)	$ 18.00
90880		90880:	15	Therapy Codes	Hypnotherapy		Psychologist (Licensed or Waivered)	$ 106.55
90880	59	90880:59	15	Therapy Codes	Hypnotherapy	Two Procedures in a Day	Psychologist (Licensed or Waivered)	$ 106.55

90880	59:95	90880:59:95	15	Therapy Codes	Hypnotherapy	Two Procedures in a Day w/Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90880	59:95:HK	90880:59:95:HK	15	Therapy Codes	Hypnotherapy	Two Procedures in a Day w/Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90880	59:HK	90880:59:HK	15	Therapy Codes	Hypnotherapy	Two Procedures in a Day in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90880	95	90880:95	15	Therapy Codes	Hypnotherapy	Telemedicine	Psychologist (Licensed or Waivered)	$ 106.55
90880	95:HK	90880:95:HK	15	Therapy Codes	Hypnotherapy	Telemedicine in Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55
90880	HK	90880:HK	15	Therapy Codes	Hypnotherapy	Specialized MH program	Psychologist (Licensed or Waivered)	$ 106.55

Exhibit C

COMPLIANCE AND PROGRAM INTEGRITY

Evidence of Contractual Compliance

Contractor shall document evidence of compliance with all contractual provisions and provide to County upon request.

Exclusions Checks

Consistent with the requirements of 42 Code of Federal Regulations, (C.F.R.) part 455.436, Contractor shall confirm the identity and determine the exclusion status of all providers (employees and subcontractors), as well as any person with an ownership or control interest, or who is an agent or managing employee of Contractor through monthly checks of Federal and State databases. The databases to be included are:

A. The Social Security Administration's Death Master File
B. The National Plan and Provider Enumeration System (NPPES)
C. The Office of Inspector General's List of Excluded Individuals/Entities (LEIE)
D. The System for Award Management (SAM)
E. The California Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List (S & I List)

Contractor shall retain evidence of monthly checks and provide to County upon request. If the Contractor finds a party that is excluded, Contractor shall notify the County within one (1) business day. Contractor shall not permit an excluded provider to render services to a County client.

Ownership Disclosure

Pursuant to the requirements of 42 C.F.R. § 455.104, Contractor must make disclosures regarding any person (individual or corporation) who has an ownership or control interest in the Contractor, whether the person (individual or corporation) is related to another person with an ownership or control interest in the Contractor as a spouse, parent, child, or sibling, or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

The term "person with an ownership or control interest" means, with respect to the Contractor, a person who:

A. Has directly or indirectly an ownership of five percent (5%) or more in the Contractor; or
B. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured in whole (or in part) by the Contractor or any property of or assets thereof, which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets or the entity; or

C. Is an officer or director of the Contractor if the Contractor is organized as a corporation; or
D. Is a partner in the Contractor, if the Contractor is organized as a partnership

Contractor will provide County the following disclosures prior to the execution of this contract (and annually thereafter), prior to its extension or renewal (and annually thereafter), and within thirty five (35) days after any change in Contractor ownership:

A. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
B. Date of birth and Social Security Number (in the case of an individual);
C. Other tax identification number [in the case of a corporation with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five percent (5%) or more interest];
D. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling;
E. The name of any other disclosing entity in which the Contractor has an ownership or control interest. Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
    (1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
    (2) Any Medicare intermediary or carrier; and
    (3) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
    (4) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

Business Transactions Disclosure

Contractor must submit disclosures and updated disclosures to County regarding certain business transactions within thirty five (35) days, upon request. The following must be disclosed:

A. The ownership of any subcontractor with whom Contractor had business transactions totaling more than $25,000 during the 12-month period ending on the date of request; and
B. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of request.

Persons Convicted of Crimes Disclosure

Contractor shall submit the following disclosures to County regarding Contractor's management prior to execution of this contract and at any time upon County request:

(A) The identity of any person who is a managing employee of Contractor who has been convicted of a crime related to federal health care programs. [42 C.F.R. § 455.106(a)(1), (2).]

(B) The identity of any person who is an agent of Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 C.F.R. § 455.101.

Criminal Background Checks

Contractor must require providers (employees and contracted) to consent to criminal background checks including livescans pursuant to 42 C.F.R. 455.434(a). Upon DHCS' determination that Contractor or a person with a five percent (5%) or more direct or indirect ownership interest in Contractor meets DHCS' criteria for criminal background checks as a high risk to the Medicaid program, Contractor's providers (employees and contracted) must submit livescans pursuant to 42 C.F.R. 455.434(b)(1).

Exhibit C is three pages

Exhibit E

TEHAMA COUNTY Behavioral Health Member Handbook

Specialty Mental Health Services and Drug Medi-Cal

Tehama County Health Services Agency
Mental Health and Substance Use Recovery Division
P.O. Box 400
1860 Walnut Street
Red Bluff, CA 96080
Phone: (530) 527-5631
TCHSA Access Line 1-800-240-3208 is available 24 hours a day, 7 days a week.

Effective Date: January 1, 2026[1]

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English
ATTENTION: If you need help in your language call 1-800-240-3208 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-240-3208 (TTY: 711). These services are free of charge.

العربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-240-3208 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-240-3208 (TTY: 711). هذه الخدمات مجانية.

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-240-3208 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-240-3208 (TTY: 711): Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-240-3208 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-240-3208 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

繁體中文 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 1-800-240-3208 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-240-3208 (TTY: 711)。这些服务都是免费的。

فارسی (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-240-3208 (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-240-3208 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

[1] The handbook must be offered at the time the member first accesses services.

हिंदी (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-240-3208 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-240-3208 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Hmoob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-240-3208 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-240-3208 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)
注意日本語での対応が必要な場合は 1-800-240-3208 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-240-3208 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-240-3208 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-240-3208 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-240-3208 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ
1-800-240-3208 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-240-3208 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-240-3208 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-240-3208 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-240-3208 (TTY: 711).
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-240-3208 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-240-3208 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-240-3208 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-240-3208 (TTY: 711). Estos servicios son gratuitos.

Tagalog (Filipino)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-240-3208 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-240-3208 (TTY: 711). Libre ang mga serbisyong ito.

ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-240-3208 (TTY: 711) น
อกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-240-3208 (TTY: 711) **ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้**

Українська (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-240-3208 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-240-3208 (TTY: 711). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-240-3208 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-240-3208 (TTY: 711). Các dịch vụ này đều miễn phí.

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Other languages

If you need help in your language call 1-800-240-3208 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-240-3208 (TTY: 711). These services are free of charge.

Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

Interpreter Services

The county provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. The county can also provide auxiliary aids and services to a family

member, friend, or anyone else with whom it is appropriate to communicate with on your behalf. Interpreter, linguistic and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

COUNTY CONTACT INFORMATION

We are here to help. The following county contact information will help you get the services you need.

Telephone Number: (530) 527-5631
County 24/7 Access Line: (800) 240-3208
County behavioral health website hyperlink:
https://www.tehamacohealthservices.net/administration/about-us/behavioral-health/
County Provider Directory hyperlink:
https://www.tehamacohealthservices.net/behavioral-health-provider-directory/
Tehama County Patient Access Application Programming Interfaces (APIs) are still under development at this time. When they are completed and ready to be accessed, an update will be made to this handbook.

Who Do I Contact If I'm Having Suicidal Thoughts?

If you or someone you know is in crisis, please call the 988 Suicide and Crisis Lifeline at **988** or the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**. Chat is available at https://988lifeline.org/.
To access your local programs, please call the 24/7 Access Line or county telephone number listed above.

PURPOSE OF THIS HANDBOOK

Why is it important to read this handbook?

Your county has a mental health plan that offers mental health services known as "specialty mental health services". Additionally, your Drug Medi-Cal county provides services for alcohol or drug use, known as "substance use disorder services". Together these services are known as "behavioral health services", and it is important that you have information about these services so that you can get the care you need. This handbook explains your benefits and how to get care. It will also answer many of your questions.

You will learn:

- How to receive behavioral health services through your county.
- What benefits you can access.
- What to do if you have a question or problem.
- Your rights and responsibilities as a member of your county.
- If there is additional information about your county, which may be indicated at the end of this handbook.

If you do not read this handbook now, you should hold on to it so you can read it later. This book is meant to be used along with the book you got when you signed up for your Medi-Cal benefits. If you have any questions about your Medi-Cal benefits, call the county using the phone number on the front of this book.

Where Can I Go for More Information About Medi-Cal?

Visit the Department of Health Care Services website at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Beneficiaries.aspx for more information about Medi-Cal.

BEHAVIORAL HEALTH SERVICES INFORMATION

How to Tell if You or Someone You Know Needs Help?

Many people go through hard times in life and may experience mental health or substance use conditions. The most important thing to remember is that help is available. If you or your family member are qualified for Medi-Cal and need behavioral health services, you should call the county's 24/7 Access Line or the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook. Your managed care plan can also help you contact your county if they believe you or a family member need behavioral health services that the managed care plan does not cover. Your county will help you find a provider for the services you may need.

The list below can help you decide if you or a family member needs help. If more than one sign is present or happens for a long time, it may be a sign of a more serious problem that requires professional help. Here are some common signs you might need help with a mental health condition or substance use condition:

Thoughts and Feelings

- Strong mood changes, possibly with no reason, such as:
    - Too much worry, anxiety, or fear
    - Too sad or low
    - Too good, on top of the world
    - Moody or angry for too long
- Thinking about suicide
- Focusing only on getting and using alcohol or drugs
- Problems with focus, memory or logical thought and speech that are hard to explain
- Problems with hearing, seeing, or sensing things that are hard to explain or that most people say don't exist

Physical

- Many physical problems, possibly without obvious causes, such as:
    - Headaches
    - Stomach aches
    - Sleeping too much or too little
    - Eating too much or too little
    - Unable to speak clearly
- Decline in looks or strong concern with looks, such as:
    - Sudden weight loss or gain
    - Red eyes and unusually large pupils
    - Odd smells on breath, body, or clothing

Behavioral

- Having consequences from your behavior because of changes to your mental health or using alcohol or drugs, such as:
    - Having issues at work or school
    - Problems in relationships with other people, family, or friends
    - Forgetting your commitments
    - Not able to carry out usual daily activities
- Avoiding friends, family, or social activities
- Having secretive behavior or secret need for money
- Becoming involved with the legal system because of changes to your mental health or using alcohol or drugs

Members Under the Age of 21

How Do I Know When a Child or Person Under the Age of 21 Needs Help?

You may contact your county or managed care plan for a screening and assessment for your child or teenager if you think they are showing signs of a behavioral health condition. If your child or teenager qualifies for Medi-Cal and the screening or assessment shows that behavioral health services are needed, then the county will arrange for your child or teenager to receive behavioral health services. Your managed

care plan can also help you contact your county if they believe your child or teenager needs behavioral health services that the managed care plan does not cover. There are also services available for parents who feel stressed by being a parent.

Minors 12 years of age or older, may not need parental consent to receive outpatient mental health treatment or counseling if the attending professional person believes the minor is mature enough to participate in the behavioral health services. Minors 12 years of age or older, may not need parental consent to receive medical care and counseling to treat a substance use disorder related problem. Parental or guardian involvement is required unless the attending professional person determines that their involvement would be inappropriate after consulting with the minor.

The list below can help you decide if your child or teenager needs help. If more than one sign is present or persists for a long time, it may be that your child or teenager has a more serious problem that requires professional help. Here are some signs to look out for:

- A lot of trouble paying attention or staying still, putting them in physical danger or causing school problems
- Strong worries or fears that get in the way of daily activities
- Sudden huge fear without reason, sometimes with racing heart rate or fast breathing
- Feels very sad or stays away from others for two or more weeks, causing problems with daily activities
- Strong mood swings that cause problems in relationships
- Big changes in behavior
- Not eating, throwing up, or using medicine to cause weight loss
- Repeated use of alcohol or drugs
- Severe, out-of-control behavior that can hurt self or others
- Serious plans or tries to harm or kill self
- Repeated fights, use of a weapon, or serious plan to hurt others

ACCESSING BEHAVIORAL HEALTH SERVICES

How Do I Get Behavioral Health Services?

If you think you need behavioral health services such as mental health services and/or substance use disorder services, you can call your county's 24/7 Access Line or the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook. Once you contact the county, you will receive a screening and be scheduled for an appointment for an assessment.

You can also request behavioral health services from your managed care plan if you are a member. If the managed care plan determines that you meet the access criteria for behavioral health services, the managed care plan will help you to get an assessment to receive behavioral health services through your county. Ultimately, there is no wrong door for getting behavioral health services. You may even be able to receive behavioral health services through your managed care plan in addition to behavioral health services through your county. You can access these services through your behavioral health provider if your provider determines that the services are clinically appropriate for you and as long as those services are coordinated and not duplicative.

In addition, keep the following in mind:

- You may be referred to your county for behavioral health services by another person or organization, including your general practitioner/doctor, school, a family member, guardian, your managed care plan, or other county agencies. Usually, your doctor or the managed care plan will need your consent or the permission of the parent or caregiver of a child, to make the referral directly to the county, unless there is an emergency.
- Your county may not deny a request to do an initial assessment to determine whether you meet the criteria for receiving behavioral health services.
- Behavioral health services can be provided by the county or other providers the county contracts with (such as clinics, treatment centers, community-based organizations, or individual providers).

Where Can I Get Behavioral Health Services?

You can get behavioral health services in the county where you live, and outside of your county if necessary. Each county has behavioral health services for children, youth, adults, and older adults. If you are under 21 years of age, you are eligible for additional coverage and benefits under Early and Periodic Screening, Diagnostic, and Treatment. See the “Early and Periodic Screening, Diagnostic, and Treatment” section of this handbook for more information.

Your county will help you find a provider who can get you the care you need. For mental health services, the county must refer you to the closest provider to your home, or within time or distance standards who will meet your needs.

When Can I Get Behavioral Health Services?

Your county has to meet appointment time standards when scheduling a service for you. For mental health services, the county must offer you an appointment:

- Within 10 business days of your non-urgent request to start services with the mental health plan;
- Within 48 hours if you request services for an urgent condition that does not require prior authorization;
- Within 96 hours of an urgent condition that does require prior authorization;
- Within 15 business days of your non-urgent request for an appointment with a psychiatrist; and,
- Within 10 business days from the prior appointment for nonurgent follow up appointments for ongoing conditions.

For substance use disorder services, the Drug Medi-Cal county must offer you an appointment:

- Within 10 business days of your non-urgent request to start services with a substance use disorder provider for outpatient and intensive outpatient services;
- Within 48 hours if you request services for an urgent condition that does not require prior authorization;

- Within 96 hours of an urgent condition that does require prior authorization;
- Within 3 business days of your request for Narcotic Treatment Program services;
- A follow-up non-urgent appointment within 10 days if you're undergoing a course of treatment for an ongoing substance use disorder, except for certain cases identified by your treating provider.

However, these times may be longer if your provider has determined that a longer waiting time is medically appropriate and not harmful to your health. If you have been told you have been placed on a waitlist and feel the length of time is harmful to your health, contact your mental health plan's 24/7 Access Line or the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook. You have the right to file a grievance if you do not receive timely care. For more information about filing a grievance, see "The Grievance Process" section of this handbook.

What Are Emergency Services?

Emergency services are services for members experiencing an unexpected medical condition, including a psychiatric emergency medical condition. An emergency medical condition has symptoms so severe (possibly including severe pain) that an average person could reasonably expect the following might happen at any moment:

- The health of the individual (or the health of an unborn child) could be in serious trouble
- Causes serious harm to the way your body works
- Causes serious damage to any body organ or part

A psychiatric emergency medical condition occurs when an average person thinks that someone:

- Is a current danger to themselves or another person because of a mental health condition or suspected mental health condition.
- Is immediately unable to provide for their needs, such as; food, clothing, shelter, personal safety, or access necessary medical care because of a mental health

condition or suspected mental health condition and/or severe substance use disorder.

Emergency services are covered 24 hours a day, seven days a week for Medi-Cal members. Prior authorization is not required for emergency services. The Medi-Cal program will cover emergency conditions, whether the condition is due to a physical health or mental health condition (thoughts, feelings, behaviors which are a source of distress and/or dysfunction in relation to oneself or others). If you are enrolled in Medi-Cal, you will not receive a bill to pay for going to the emergency room, even if it turns out to not be an emergency. If you think you are having an emergency, call **911** or go to any hospital or other setting for help.

Who Decides Which Services I Will Receive?

You, your provider, and the county are all involved in deciding what services you need to receive. A behavioral health professional will talk with you and will help determine what kind of services are needed.

You do not need to know if you have a behavioral health diagnosis or a specific behavioral health condition to ask for help. You will be able to receive some services while your provider completes an assessment.

If you are under the age of 21, you may also be able to access behavioral health services if you have a behavioral health condition due to trauma, involvement in the child welfare system, juvenile justice involvement, or homelessness. Additionally, if you are under age 21, the county must provide medically necessary services to help your behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered medically necessary.

Some mental health services may require prior authorization from the county. Services that require prior authorization include Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster

Care. Call your county's 24/7 Access Line using the telephone number on the cover of this handbook to request additional information.

The county's authorization process for mental health services must follow specific timelines.

- For a standard prior mental health authorization, the county must decide based on your provider's request as quickly as your condition requires, but not to exceed five (5) business days from when the county receives the request.
    - For example, if following the standard timeframe could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, your mental health plan must rush an authorization decision and provide notice based on a timeframe related to your health condition that is no later than 72 hours after receipt of the service request. Your county may extend the time for up to 14 additional calendar days after the county receives the request if you or your provider request the extension or the county provides justification for why the extension is in your best interest.

If the county does not make a decision within the listed timelines or denies, delays, reduces, or terminates the services requested, the county must send you a Notice of Adverse Benefit Determination telling you that the services are denied, delayed, reduced or terminated, inform you that you may file an appeal, and give you information on how to file an appeal.

You may ask the county for more information about its authorization processes.

If you don't agree with the county's decision on an authorization process, you may file an appeal. For more information, see the "Problem Resolution" section of this handbook.

What Is Medical Necessity?

Services you receive must be medically necessary and clinically appropriate to address your condition. For members 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect your life, prevent significant illness or disability, or improve severe pain.

For members under the age of 21, a service is considered medically necessary if it corrects, sustains, supports, improves, or makes more tolerable a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment services.

How Do I Get Other Mental Health Services That Are Not Covered by the County?

If you are enrolled in a managed care plan, you have access to the following outpatient mental health services through your managed care plan:

- Mental health evaluation and treatment, including individual, group and family therapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring prescription drugs.
- Psychiatric consultation.

To get one of the above services, call your managed care plan directly. If you are not in a managed care plan, you may be able to get these services from individual providers and clinics that accept Medi-Cal. The county may be able to help you find a provider or clinic.

Any pharmacy that accepts Medi-Cal can fill prescriptions to treat a mental health condition. Please note that most prescription medication dispensed by a pharmacy, called Medi-Cal Rx, is covered under the Fee-For-Service Medi-Cal program, not your managed care plan.

What Other Substance Use Disorder Services Are Available from Managed Care Plans or the Medi-Cal "Fee for Service" Program?

Managed care plans must provide covered substance use disorder services in primary care settings and tobacco, alcohol, and illegal drug screening. They must also cover substance use disorder services for pregnant members and alcohol and drug use screening, assessment, brief interventions, and referral to the appropriate treatment setting for members ages 11 and older. Managed care plans must provide or arrange services for Medication Assisted Treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings. Managed care plans must also provide emergency services necessary to stabilize the member, including voluntary inpatient detoxification.

How Do I Get Other Medi-Cal Services (Primary Care/Medi-Cal)?

If you are in a managed care plan, the plan is responsible for finding a provider for you. If you are not enrolled in a managed care plan and have "regular" Medi-Cal, also called Fee-For-Service Medi-Cal, then you can go to any provider that accepts Medi-Cal. You must tell your provider that you have Medi-Cal before you begin getting services. Otherwise, you may be billed for those services. You may use a provider outside your managed care plan for family planning services.

Why Might I Need Psychiatric Inpatient Hospital Services?

You may be admitted to a hospital if you have a mental health condition or signs of a mental health condition that can't be safely treated at a lower level of care, and because of the mental health condition or symptoms of mental health condition, you:

- Represent a danger to yourself, others, or property.
- Are unable to care for yourself with food, clothing, shelter, personal safety, or necessary medical care.
- Present a severe risk to your physical health.
- Have a recent, significant deterioration in the ability to function as a result of a mental health condition.
- Need psychiatric evaluation, medication treatment, or other treatment that can only be provided in the hospital.

SELECTING A PROVIDER

How Do I Find a Provider For The Behavioral Health Services I Need?

Your county is required to post a current provider directory online. You can find the provider directory link in the County Contact section of this handbook. The directory contains information about where providers are located, the services they provide, and other information to help you access care, including information about the cultural and language services that are available from the providers.

If you have questions about current providers or would like an updated provider directory, visit your county's website or use the telephone number located on the cover of this handbook. You can get a list of providers in writing or by mail if you ask for one.

Note: The county may put some limits on your choice of providers for behavioral health services. When you first start receiving behavioral health services you can request that your county provide you with an initial choice of at least two providers. Your county must also allow you to change providers. If you ask to change providers, the county must allow you to choose between at least two providers when possible and that there are enough providers close to you to make sure that you can get covered mental health services if you need them. Your county is responsible for ensuring that you have timely access to mental health services.

Sometimes the county's contracted providers choose to no longer provide behavioral health services because they may no longer contract with the county or no longer accept Medi-Cal. When this happens, the county must make a good faith effort to give written notice to each person who was receiving behavioral health services from the provider. You are required to get a notice 30 calendar days prior to the effective date of the termination or 15 calendar days after the county knows the provider will stop working. When this happens, your county must allow you to continue receiving services from the provider who left the county, if you and the provider agree. This is called "continuity of care" and is explained below.

Note: American Indian and Alaska Native individuals who are eligible for Medi-Cal and reside in Drug Medi-Cal counties, can also receive Drug Medi-Cal services through Indian Health Care Providers.

Can I Continue To Receive Specialty Mental Health Services From My Current Provider?

If you are already receiving mental health services from a managed care plan, you may continue to receive care from that provider even if you receive mental health services from your county, as long as the services are coordinated between the providers and the services are not the same.

In addition, if you are already receiving mental health services from another county, managed care plan, or an individual Medi-Cal provider, you may request "continuity of care" so that you can stay with your current provider, for up to 12 months. You may wish to request continuity of care if you need to stay with your current provider to continue your ongoing treatment or because it would cause serious harm to your mental health condition to change to a new provider. Your continuity of care request may be granted if the following is true:

- You have an ongoing relationship with the provider you are requesting and have seen that provider in the last 12 months;
- You need to stay with your current provider to continue ongoing treatment to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.
- The provider is qualified and meets Medi-Cal requirements;
- The provider agrees to the county's requirements for contracting with the mental health plan and payment for services; and
- The provider shares relevant documentation with the county regarding your need for the services.

YOUR RIGHT TO ACCESS YOUR MENTAL HEALTH MEDICAL RECORDS AND PROVIDER DIRECTORY INFORMATION USING SMART DEVICES

You can access your mental health records and/or find a provider using an application downloaded on a computer, smart tablet, or mobile device. Your county may have information available on their website for you to consider before choosing an application to get your information in this way. For more information on the availability of your access, contact your county by referring to the “County Contact Information” section within this handbook.

SCOPE OF SERVICES

If you meet the criteria for accessing behavioral health services, the following services are available to you based on your need. Your provider will work with you to decide which services will work best for you.

Specialty Mental Health Services

Mental Health Services

- Mental health services are individual, group, or family-based treatment services that help people with mental health conditions to develop coping skills for daily living. These services also include work that the provider does to help make the services better for the person receiving care. These kinds of things include assessments to see if you need the service and if the service is working; treatment planning to decide the goals of your mental health treatment and the specific services that will be provided; and "collateral", which means working with family members and important people in your life (if you give permission) to help you improve or maintain your daily living abilities.
- Mental health services can be provided in a clinic or provider's office, your home or other community setting, over the phone, or by telehealth (which includes both audio-only and video interactions). The county and provider will work with you to determine the frequency of your services/appointments.

Medication Support Services

- These services include prescribing, administering, dispensing, and monitoring of psychiatric medicines. Your provider can also provide education on the medication. These services can be provided in a clinic, the doctor's office, your home, a community setting, over the phone, or by telehealth (which includes both audio-only and video interactions).

Targeted Case Management

- This service helps members get medical, educational, social, prevocational, vocational, rehabilitative, or other community services when these services may be hard for people with a mental health condition to get on their own. Targeted case management includes, but is not limited to:
    - Plan development;
    - Communication, coordination, and referral;
    - Monitoring service delivery to ensure the person's access to service and the service delivery system; and
    - Monitoring the person's progress.

Crisis Intervention Services

- This service is available to address an urgent condition that needs immediate attention. The goal of crisis intervention is to help people in the community so that they won't need to go to the hospital. Crisis intervention can last up to eight hours and can be provided in a clinic or provider's office, or in your home or other community setting. These services can also be done over the phone or by telehealth.

Crisis Stabilization Services

- This service is available to address an urgent condition that needs immediate attention. Crisis stabilization lasts less than 24 hours and must be provided at a licensed 24-hour health care facility, at a hospital-based outpatient program, or at a provider site certified to provide these services.

Adult Residential Treatment Services

- These services provide mental health treatment to those with a mental health condition living in licensed residential facilities. They help build skills for people and provide residential treatment services for people with a mental health condition. These services are available 24 hours a day, seven days a week. Medi-Cal does not cover the room and board cost for staying at these facilities.

Crisis Residential Treatment Services

- These services provide mental health treatment and skill building for people who have a serious mental or emotional crisis. This is not for people who need psychiatric care in a hospital. Services are available at licensed facilities for 24 hours a day, seven days a week. Medi-Cal does not cover the room and board cost for these facilities.

Day Treatment Intensive Services

- This is a structured program of mental health treatment provided to a group of people who might otherwise need to be in the hospital or another 24-hour care facility. The program lasts three hours a day. It includes therapy, psychotherapy and skill-building activities.

Day Rehabilitation

- This program is meant to help people with a mental health condition learn and develop coping and life skills to better manage their symptoms. This program lasts at least three hours per day. It includes therapy and skill-building activities.

Psychiatric Inpatient Hospital Services

- These are services provided in a licensed psychiatric hospital. A licensed mental health professional decides if a person needs intensive around-the-clock treatment for their mental health condition. If the professional decides the member needs around-the-clock treatment, the member must stay in the hospital 24 hours a day.

Psychiatric Health Facility Services

- These services are offered at a licensed psychiatric health facility specializing in 24-hour rehabilitative treatment of serious mental health conditions. Psychiatric health facilities must have an agreement with a nearby hospital or clinic to meet the physical health care needs of the people in the facility. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury

that would require treatment beyond what ordinarily could be treated on an outpatient basis.

Therapeutic Behavioral Services

Therapeutic Behavioral Services are intensive short-term outpatient treatment interventions for members up to age 21. These services are designed specifically for each member. Members receiving these services have serious emotional disturbances, are experiencing a stressful change or life crisis, and need additional short-term, specific support services.

These services are a type of specialty mental health service available through the county if you have serious emotional problems. To get Therapeutic Behavioral Services, you must receive a mental health service, be under the age of 21, and have full-scope Medi-Cal.

- If you are living at home, a Therapeutic Behavioral Services staff person can work one-to-one with you to decrease severe behavior problems to try to keep you from needing to go to a higher level of care, such as a group home for children and young people under the age of 21 with very serious emotional problems.
- If you are living in an out-of-home placement, a Therapeutic Behavioral Services staff person can work with you so you may be able to move back home or to a family-based setting, such as a foster home.

Therapeutic Behavioral Services will help you and your family, caregiver, or guardian learn new ways of addressing problem behavior and increasing the kinds of behavior that will allow you to be successful. You, the Therapeutic Behavioral Services staff person, and your family, caregiver, or guardian will work together as a team to address problematic behaviors for a short period until you no longer need the services. You will have a Therapeutic Behavioral Services plan that will say what you, your family, caregiver, or guardian, and the Therapeutic Behavioral Services staff person will do while receiving these services. The Therapeutic Behavioral Services plan will also

include when and where services will occur. The Therapeutic Behavioral Services staff person can work with you in most places where you are likely to need help. This includes your home, foster home, school, day treatment program, and other areas in the community.

Intensive Care Coordination

This is a targeted case management service that facilitates the assessment, care planning for, and coordination of services to beneficiaries under age 21. This service is for those that are qualified for the full-scope of Medi-Cal services and who are referred to the service on basis of medical necessity. This service is provided through the principles of the Integrated Core Practice Model. It includes the establishment of the Child and Family Team to help make sure there is a healthy communicative relationship among a child, their family, and involved child-serving systems.

The Child and Family Team includes professional support (for example: care coordinator, providers, and case managers from child-serving agencies), natural support (for example: family members, neighbors, friends, and clergy), and other people who work together to make and carry out the client plan. This team supports and ensures children and families reach their goals.

This service also has a coordinator that:

- Makes sure that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, client-driven, culturally and language appropriate manner.
- Makes sure that services and support are based on needs of child.
- Makes a way to have everyone work together for the child, family, providers, etc.
- Supports parent/caregiver in helping meet child’s needs.
- Helps establish the Child and Family Team and provides ongoing support.
- Makes sure the child is cared for by other child-serving systems when needed.

Intensive Home-Based Services

- These services are designed specifically for each member. It includes strength-based interventions to improve mental health conditions that may interfere with the child/youth's functioning. These services aim to help the child/youth build necessary skills to function better at home and in the community and improve their family's ability to help them do so.
- Intensive Home-Based Services are provided under the Integrated Core Practice Model by the Child and Family Team. It uses the family's overall service plan. These services are provided to members under the age of 21 who are eligible for full-scope Medi-Cal services. A referral based on medical necessity is needed to receive these services.

Therapeutic Foster Care

- The Therapeutic Foster Care service model provides short-term, intensive, and trauma-informed specialty mental health services for children up to the age of 21 who have complex emotional and behavioral needs. These services are designed specifically for each member. In Therapeutic Foster Care, children are placed with trained, supervised, and supported Therapeutic Foster Care parents.

Parent-Child Interaction Therapy (PCIT)

- PCIT is a program that helps children ages 2-7 who have difficult behaviors and helps their parents or caregivers learn new ways to handle them. These behaviors might include getting angry or not following rules.
- Through PCIT, a parent or caregiver wears a headset while playing with their child in a special playroom. A therapist watches from another room or on video and gives advice to the parent or caregiver through the headset. The therapist helps the parent or caregiver learn how to encourage healthy behavior and improve their relationship with their child.

Functional Family Therapy (FFT)

- FFT is a short and focused counseling program for families and youth ages 11-18 who have difficult behaviors or trouble dealing with their emotions. This could include breaking rules, fighting, or using drugs.
- FFT works with a youth's family and sometimes other members of the youth's support system like teachers or doctors to help reduce the youth's unhealthy behavior.

Multisystemic Therapy (MST)

- MST is a family-based program for youth ages 12-17 who show serious difficulty with behavior. MST is often used for youth who have had trouble with the law, might be at risk of becoming involved with the law, or at risk of becoming removed from their home because of their behavior.
- MST involves family and community supports in therapy to help youth work on behaviors such as breaking the law or using drugs. MST also helps parents learn skills to help them handle these behaviors at home, with their peers, or in other community settings.
- Through MST, parents and caregivers can learn how to handle challenges with their kids or teenagers. They will also learn to better deal with issues at home, with friends, or in their neighborhood. The program respects different cultures and focuses on helping families in their own homes and communities. It also works with schools, the police, and the courts.
- How often families meet with the program can change. Some families might just need short check-ins, while others might meet for two hours every day or every week. This help usually lasts for 3 to 5 months.

Justice-Involved Reentry

- Providing health services to justice-involved members up to 90 days prior to their incarceration release. The types of services available include reentry case management, behavioral health clinical consultation services, peer supports, behavioral health counseling, therapy, patient education, medication services,

post-release and discharge planning, laboratory and radiology services, medication information, and support services. To receive these services, individuals must be a Medi-Cal or CHIP member, and:

  - If under the age of 21in custody at a Youth Correctional Facility.
  - If an adult, be in custody and meet one of the health care needs of the program.

- Contact your county using the telephone number on the cover of this handbook for more information on this service.

Medi-Cal Peer Support Services (varies by county)

- Medi-Cal Peer Support Services promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. These services can be provided to you or your designated significant support person(s) and can be received at the same time as you receive other mental health or Drug Medi-Cal county services. The Peer Support Specialist in Medi-Cal Peer Support Services is an individual who has lived experience with behavioral health or substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the county, and who provides these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.
- Medi-Cal Peer Support Services include individual and group coaching, educational skill-building groups, resource navigation, engagement services to encourage you to participate in behavioral health treatment, and therapeutic activities such as promoting self-advocacy.
- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of which county they live in.
- Providing Medi-Cal Peer Support Services is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Mobile Crisis Services

- Mobile Crisis Services are available if you are having a mental health crisis.
- Mobile Crisis Services are provided by health providers at the location where you are experiencing a crisis, including at your home, work, school, or other community locations, excluding a hospital or other facility setting. Mobile Crisis Services are available 24 hours a day, 7 days a week, and 365 days a year.
- Mobile Crisis Services include rapid response, individual assessment, and community-based stabilization. If you need further care, the mobile crisis providers will also provide warm handoffs or referrals to other services.

Assertive Community Treatment (ACT) (varies by county)

- ACT is a service that helps people with serious mental health needs. People who need ACT have typically been to the hospital, visited the emergency room, stayed in treatment centers and/or had trouble with the law. They might also have been homeless or not able to get help from regular clinics.
- ACT tailors services to each person and their own needs. The goal is to help people feel better and learn how to live in their community. A team of different experts works together to provide all kinds of support and treatment. This team helps people with their mental health, teaches them important life skills, coordinates their care, and offers support in the community. The overall aim is to help each person recover from their behavioral health condition and live a better life within their community.
- Providing ACT is optional for participating counties. Refer to the “Additional Information About Your County” section located at the end of this handbook to find out if your county provides this service.

Forensic Assertive Community Treatment (FACT) (varies by county)

- FACT is a service that helps people with serious mental health needs who have also had trouble with the law. It works just like the ACT program, but with some extra features to help people who are at high risk or have been previously involved with the criminal justice system.

- The FACT team is made up of experts who have special training to understand the needs of people who have had trouble with the law. They provide the same types of support and treatment as ACT, like helping with behavioral health, teaching life skills, coordinating care, and offering community support.
- The goal is to help each person feel better, stay out of trouble, and live a healthier life in their community.
- Providing FACT is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Coordinated Specialty Care (CSC) for First Episode Psychosis

- CSC is a service that helps people who are experiencing psychosis for the first time. There are many symptoms of psychosis, including seeing or hearing things that other people do not see or hear. CSC provides quick and combined support during the early stages of psychosis, which helps prevent hospital stays, emergency room visits, time in treatment centers, trouble with the law, substance use, and homelessness.
- CSC focuses on each person and their own needs. A team of different experts works together to provide all kinds of help. They assist with mental health treatment, teach important life skills, coordinate care, and offer support in the community. The goal is to help people feel better, manage their symptoms, and live well in their community.
- Providing CSC for FEP is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Clubhouse Services (varies by county)

- Clubhouses are special places that help people recover from behavioral health conditions. They focus on people's strengths and create a supportive community.
- In a Clubhouse, people can find jobs, make friends, learn new things, and develop skills to improve their health and well-being. People also work alongside

Clubhouse staff to contribute to shared Clubhouse needs, like making lunch for other Clubhouse members. The goal is to help everyone be members of a community, encourage others to achieve their goals, and improve their overall quality of life.

- Providing Clubhouse Services is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Enhanced Community Health Worker (CHW) Services (varies by county)

- CHWs are health workers who have special training and are trusted members of their communities.
- The goal of Enhanced CHW Services is to help stop diseases, disabilities, and other health problems before they get worse. Enhanced CHW services include all the same parts and rules as regular CHW preventive services, but they are tailored for people who need extra behavioral health support. The goal is to give extra support to keep these members healthy and well.
- Some of these services include: health education and training, including control and prevention of chronic or infectious disease; behavioral, perinatal, and oral health conditions; and injury prevention; health promotion and coaching, including goal setting and creating action plans to address disease prevention and management.
- Providing Enhanced CHW Services is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Supported Employment (varies by county)

- The Individual Placement and Support (IPS) model of Supported Employment is a service that helps people with serious behavioral health needs find and keep competitive jobs in their community.
- By participating in IPS Supported Employment, people can get better job outcomes and support their recovery from their behavioral health condition.

- This program also helps improve independence, a sense of belonging, and overall health and well-being.
- Providing Supported Employment is optional for participating counties. Refer to the “Additional Information About Your County” section located at the end of this handbook to find out if your county provides this service.

In-Reach Services (varies by county)

- Community Transition In-Reach Services help people who are in a psychiatric hospital or facility for a long time or are at risk of staying there for a long time. The program works with you, your family, the hospital or facility, and other support people to help you move back into the community. The goal is to help you avoid long stays in the psychiatric hospital or other care centers.

Substance Use Disorder Services

What are Drug Medi-Cal County Services?

Drug Medi-Cal County services are for people who have a substance use condition, meaning they may be misusing alcohol or other drugs, or people who may be at risk of developing a substance use condition that a pediatrician or general practitioner may not be able to treat. These services also include work that the provider does to help make the services better for the person receiving care. These kinds of things include assessments to see if you need the service and if the service is working.

Drug Medi-Cal services can be provided in a clinic or provider’s office, or your home or other community setting, over the phone, or by telehealth (which includes both audio-only and video interactions). The county and provider will work with you to determine the frequency of your services/appointments.

***American Society of Addiction Medicine (ASAM*)**

The county or provider will use the American Society of Addiction Medicine tool to find the appropriate level of care. These types of services are described as “levels of care,” and are defined below.

Screening, Assessment, Brief Intervention, and Referral to Treatment (American Society of Addiction Medicine Level 0.5)

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) is not a Drug Medi-Cal benefit. It is a benefit in Medi-Cal Fee-for-Service and Medi-Cal managed care delivery system for members that are aged 11 years and older. Managed care plans must provide covered substance use disorder services, including this service for members ages 11 years and older.

Early Intervention Services

Early intervention services are a covered Drug Medi-Cal service for members under age 21. Any member under age 21 who is screened and determined to be at risk of developing a substance use disorder may receive any service covered under the outpatient level of service as early intervention services. A substance use disorder diagnosis is not required for early intervention services for members under age 21.

Early Periodic Screening, Diagnosis, and Treatment

Members under age 21 can get the services described earlier in this handbook as well as additional Medi-Cal services through a benefit called Early and Periodic Screening, Diagnostic, and Treatment.

To be able to get Early and Periodic Screening, Diagnostic, and Treatment services, a member must be under age 21 and have full-scope Medi-Cal. This benefit covers services that are medically necessary to correct or help physical and behavioral health conditions. Services that sustain, support, improve, or make a condition more tolerable are considered to help the condition and are covered as Early and Periodic Screening, Diagnostic, and Treatment services. The access criteria for members under 21 are different and more flexible than the access criteria for adults accessing Drug Medi-Cal

services, to meet the Early and Periodic Screening, Diagnostic, and Treatment requirement and the intent for prevention and early intervention of substance use disorder conditions.

If you have questions about these services, please call your Drug Medi-Cal county or visit the DHCS Early and Periodic Screening, Diagnostic, and Treatment webpage.

Outpatient Treatment Services (American Society of Addiction Medicine Level 1)

- Counseling services are provided to members up to nine hours a week for adults and less than six hours a week for members under age 21 when medically necessary. You might get more hours based on your needs. Services can be provided by someone licensed, like a counselor, in person, by telephone, or by telehealth.
- Outpatient Services include assessment, individual counseling, group counseling, patient education, medication services, Medication Assisted Treatment for opioid use disorders, and substance use disorder crisis intervention services.

Intensive Outpatient Services (American Society of Addiction Medicine Level 2.1)

- Intensive Outpatient Services are given to members a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for members under age 21 when medically necessary. Services may exceed the maximum based on individual medical necessity. Services are mostly counseling and education about addiction-related issues. Services can be provided by a licensed professional or a certified counselor in a structured setting. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.
- Intensive Outpatient Services include the same things as Outpatient Services. More hours of service is the main difference.

Perinatal Residential Substance Use Disorder Treatment Services

- Providing non-medical rehabilitative substance use disorder treatment services for pregnant and postpartum women. The types of services offered include assessments, counseling, education, and medication assistance.
- For information about these services call the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook.

Narcotic Treatment Program

- Narcotic Treatment Programs are programs outside of a hospital that provide medications to treat substance use disorders, when ordered by a doctor as medically necessary. Narcotic Treatment Programs are required to give medications to members, including methadone, buprenorphine, naloxone, and disulfiram.
- A member must be offered, at a minimum, 50 minutes of counseling sessions per calendar month. These counseling services can be provided in person, by telehealth, or by telephone. Narcotic Treatment Services include assessment, individual counseling, group counseling, patient education, medical psychotherapy, medication services, care management Medication Assisted Treatment for opioid use disorders, and substance use disorder crisis intervention services.

Medication Assisted Treatment

- Medication Assisted Treatment is available in clinical and non-clinical settings. Medication Assisted Treatment includes all FDA-approved medications and biological products to treat opioid use disorders. Members have a right to be offered Medication Assisted Treatment on-site or through a referral outside of the facility. A list of approved medications include:
    - Acamprosate Calcium
    - Buprenorphine Hydrochloride
    - Buprenorphine Extended-Release Injectable (Sublocade)
    - Buprenorphine/Naloxone Hydrochloride
    - Naloxone Hydrochloride

    - Naltrexone (oral)
    - Naltrexone Microsphere Injectable Suspension (Vivitrol)
    - Lofexidine Hydrochloride (Lucemyra)
    - Disulfiram (Antabuse)
    - Methadone (delivered only by Narcotic Treatment Programs)
- Medication Assisted Treatment may be provided with the following services: assessment, individual counseling, group counseling, patient education, medical psychotherapy, medication services, substance use disorder crisis intervention services, and prescribing and monitoring of Medication Assisted Treatment. Medication Assisted Treatment may be provided as part of all Drug Medi-Cal services, including Outpatient Treatment Services, Intensive Outpatient Services, and Residential Treatment, for example.
- Members may access Medication Assisted Treatment outside of the Drug Medi-Cal county as well. For instance, Medication Assisted Treatment, such as buprenorphine, can be prescribed by some prescribers in primary care settings that work with your managed care plan and can be dispensed or administered at a pharmacy.

Justice-Involved Reentry

- Providing health services to justice-involved members up to 90 days prior to their incarceration release. The types of services available include reentry case management, behavioral health clinical consultation services, peer supports, behavioral health counseling, therapy, patient education, medication services, post-release and discharge planning, laboratory and radiology services, medication information, and support services. To receive these services, individuals must be a Medi-Cal or CHIP member, and:
    - If under the age of 21 in custody at a Youth Correctional Facility.
    - If an adult, be in custody and meet one of the health care needs of the program.
- Contact your county using the telephone number on the cover of this handbook for more information on this service.

Medi-Cal Peer Support Services (varies by county)

- Medi-Cal Peer Support Services promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. These services can be provided to you or your designated significant support person(s) and can be received at the same time as you receive other mental health or Drug Medi-Cal county services. The Peer Support Specialist in Medi-Cal Peer Support Services is an individual who has lived experience with behavioral health or substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the counties, and who provides these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.
- Medi-Cal Peer Support Services include individual and group coaching, educational skill-building groups, resource navigation, engagement services to encourage you to participate in behavioral health treatment, and therapeutic activities such as promoting self-advocacy.
- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of which county they live in.
- Providing Medi-Cal Peer Support Services is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Mobile Crisis Services

- Mobile Crisis Services are available if you are having a substance use crisis.
- Mobile Crisis Services are provided by health providers at the location where you are experiencing a crisis, including at your home, work, school, or other community locations, excluding a hospital or other facility setting. Mobile Crisis Services are available 24 hours a day, 7 days a week, and 365 days a year.

- Mobile Crisis Services include rapid response, individual assessment, and community-based stabilization. If you need further care, the mobile crisis providers will also provide warm handoffs or referrals to other services.

Enhanced Community Health Worker (CHW) Services (varies by county)

- CHWs are health workers who have special training and are trusted members of their communities.
- The goal of Enhanced CHW Services is to help stop diseases, disabilities, and other health problems before they get worse. Enhanced CHW Services include all the same parts and rules as regular CHW preventive services, but they are tailored for people who need extra behavioral health support. The goal is to give extra support to keep these members healthy and well.
- Some of these services include: health education and training, including control and prevention of chronic or infectious disease; behavioral, perinatal, and oral health conditions; and injury prevention; health promotion and coaching, including goal setting and creating action plans to address disease prevention and management.
- Providing Enhanced CHW Services is optional for participating counties. Refer to the “Additional Information About Your County” section located at the end of this handbook to find out if your county provides this service.

Supported Employment (varies by county)

- The Individual Placement and Support (IPS) model of Supported Employment is a service that helps people with serious behavioral health needs find and keep competitive jobs in their community.
- By participating in IPS Supported Employment, people can get better job outcomes and support their recovery from their behavioral health condition.
- This program also helps improve independence, a sense of belonging, and overall health and well-being.
- Providing Supported Employment is optional for participating counties. Refer to the “Additional Information About Your County” section located at the end of this

handbook to find out if your county provides this service.

AVAILABLE SERVICES BY TELEPHONE OR TELEHEALTH

In-person, face-to-face contact between you and your provider is not always required for you to be able to receive behavioral health services. Depending on your services, you might be able to receive your services through telephone or telehealth. Your provider should explain to you about using telephone or telehealth and make sure you agree before beginning services via telephone or telehealth. Even if you agree to receive your services through telehealth or telephone, you can choose later to receive your services in-person or face-to-face. Some types of behavioral health services cannot be provided only through telehealth or telephone because they require you to be at a specific place for the service, such as residential treatment services or hospital services.

THE PROBLEM RESOLUTION PROCESS: TO FILE A GRIEVANCE, APPEAL, OR REQUEST A STATE FAIR HEARING

What If I Don't Get the Services I Want From My County?

Your county must have a way for you to work out any problems related to the services you want or are receiving. This is called the problem-resolution process and it could involve the following:

- The Grievance Process: A verbal or written expression of unhappiness about anything regarding your specialty mental health services, substance use disorder services, a provider, or the county. Refer to the Grievance Process section in this handbook for more information.
- The Appeal Process: An appeal is when you don't agree with the county's decision to change your services (e.g., denial, termination, or reduction to services) or to not cover them. Refer to the Appeal Process section in this handbook for more information.
- The State Fair Hearing Process: A State Fair Hearing is a meeting with an administrative law judge from the California Department of Social Services (CDSS) if the county denies your appeal. Refer to the State Fair Hearing section in this handbook for more information.

Filing a grievance, appeal, or requesting a State Fair Hearing will not count against you and will not impact the services you are receiving. Filing a grievance or appeal helps to get you the services you need and to solve any problems you have with your behavioral health services. Grievances and appeals also help the county by giving them the information they can use to improve services. Your county will notify you, providers, and parents/guardians of the outcome once your grievance or appeal is complete. The State Fair Hearing Office will notify you and the provider of the outcome once the State Fair Hearing is complete.

Note: Learn more about each problem resolution process below.

Can I Get Help With Filing an Appeal, Grievance, or State Fair Hearing?

Your county will help explain these processes to you and must help you file a grievance, an appeal, or to request a State Fair Hearing. The county can also help you decide if you qualify for what's called an "expedited appeal" process, which means it will be reviewed more quickly because your health, mental health, and/or stability are at risk. You may also authorize another person to act on your behalf, including your provider or advocate.

If you would like help, contact your county using the telephone number listed on the cover of this handbook. Your county must give you reasonable assistance in completing forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

If You Need Further Assistance

Contact the Department of Health Care Services, Office of the Ombudsman:

- Phone: # **1-888-452-8609**, Monday through Friday, 8 a.m. to 5 p.m. (excluding holidays).

OR

- E-mail: MMCDOmbudsmanOffice@dhcs.ca.gov. **Please note**: E-mail messages are not considered confidential (please do not include personal information in the e-mail message).

You may also get free legal help at your local legal aid office or other groups. To ask about your State Fair Hearing rights, you can contact the California Department of Social Services Public Inquiry and Response Unit at this phone number: **1-800-952-5253** (for TTY, call **1-800-952-8349**).

Grievances

What Is a Grievance?

A grievance is any expression of dissatisfaction you have with your behavioral health services that is not covered by the appeal or State Fair Hearing process. This includes concerns about the quality of your care, how you are treated by staff and providers, and disagreements about decisions regarding your care.

Examples of grievances:

- If you feel that a provider has been rude to you or has not respected your rights.
- If the county needs more time to make a decision about approving a service your provider has requested for you, and you disagree with this extension.
- If you are not satisfied with the quality of care you are receiving or the way your treatment plan is being communicated to you.

What Is the Grievance Process?

The grievance process will:

- Involve simple steps to file your grievance orally or in writing.
- Not cause you to lose your rights or services or be held against your provider.
- Allow you to approve another person to act on your behalf. This could be a provider or an advocate. If you agree to have another person act on your behalf, you may be asked to sign an authorization form, which gives your county permission to release information to that person.
- Make sure the approved person deciding on the grievance is qualified to make decisions and has not been a part of any previous level of review or decision-making.
- Determine the duties of your county, provider, and yourself.
- Make sure the results of the grievance are provided within the required timeline.

When Can I File a Grievance?

You can file a grievance at any time if you are unhappy with the care you have received or have another concern regarding your county.

How Can I File a Grievance?

You may call your county's 24/7 toll-free Access Line at any time or call the Drug Medi-Cal county phone number within the hours of operation to receive assistance with a grievance. Oral or written grievances can be filed. Oral grievances do not have to be followed up in writing. If you file your grievance in writing, please note the following: Your county supplies self-addressed envelopes at all provider sites. If you do not have a self-addressed envelope, mail your written grievances to the address provided on the front of this handbook.

How Do I Know If the County Received My Grievance?

Your county is required to provide you with a written letter to let you know your grievance has been received within five calendar days of receipt. A grievance received over the phone or in person, that you agree is resolved by the end of the next business day, is exempt and you may not get a letter.

When Will My Grievance Be Decided?

A decision about your grievance must be made by your county within 30 calendar days from the date your grievance was filed.

How Do I Know If the County Has Made a Decision About My Grievance?

When a decision has been made about your grievance, the county will:

- Send you or your approved person a written notice of the decision;
- Send you or your approved person a Notice of Adverse Benefit Determination advising you of your right to request a State Fair Hearing if the county does not notify you of the grievance decision on time;
- Advise you of your right to request a State Fair Hearing.

You may not get a written notice of the decision if your grievance was filed by phone or in person and you agree your issue has been resolved by the end of the next business day from the date of filing.

Note: Your county is required to provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires. You may call the county for more information if you do not receive a Notice of Adverse Benefit Determination.

Is There a Deadline to File a Grievance?

No, you may file a grievance at any time. Do not hesitate to bring issues to the county's attention. The county will always work with you to find a solution to address your concerns.

Appeals

You may file an appeal when you do not agree with the county's decision for the behavioral health services you are currently receiving or would like to receive. You may request a review of the county's decision by using:

- The Standard Appeal Process.

OR

- The Expedited Appeal Process.

Note: The two types of appeals are similar; however, there are specific requirements to qualify for an expedited appeal (see below for the requirements).

The county shall assist you in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying you of the location of the form on their website or providing you with the form upon your request. The county shall also advise and assist you in requesting continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations.

What Does the Standard Appeal Process Do?

The Standard Appeal Process will:

- Allow you to file an appeal orally or in writing.
- Make sure filing an appeal will not cause you to lose your rights or services or be held against your provider in any way.
- Allow you to authorize another person (including a provider or advocate) to act on your behalf. Please note: If you authorize another person to act on your behalf, the county might ask you to sign a form authorizing the county to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe. Please note: This is 10 days from the date your Notice of Adverse Benefit Determination was mailed or personally given to you.
- Make sure you do not pay for continued services while the appeal is pending and if the final decision of the appeal is in favor of the county's adverse benefit determination.
- Make sure the decision-makers for your appeal are qualified and not involved in any previous level of review or decision-making.
- Allow you or your approved person to review your case file, including medical records and other relevant documents.
- Allow you to have a reasonable opportunity to present evidence, testimony, and arguments in person or in writing.
- Allow you, your approved person, or the legal representative of a deceased member's estate to be included as parties to the appeal.
- Give you written confirmation from your county that your appeal is under review.
- Inform you of your right to request a State Fair Hearing, following the completion of the appeal process.

When Can I File an Appeal?

You can file an appeal with your county when:

- The county or the contracted provider determines that you do not meet the access criteria for behavioral health services.

- Your healthcare provider recommends a behavioral health service for you and requests approval from your county, but the county denies the request or alters the type or frequency of service.
- Your provider requests approval from the county, but the county requires more information and does not complete the approval process on time.
- Your county does not provide services based on its predetermined timelines.
- You feel that the county is not meeting your needs on time.
- Your grievance, appeal, or expedited appeal was not resolved in time.
- You and your provider disagree on the necessary behavioral health services.

How Can I File an Appeal?

- You may file an appeal via one of the following three methods:
    - Call your county's toll-free phone number or Drug Medi-Cal county's phone number within the hours of operation listed on the cover of this handbook. After calling, you will have to file a subsequent written appeal as well; or
    - Mail your appeal (The county will provide self-addressed envelopes at all provider sites for you to mail in your appeal). Note: If you do not have a self-addressed envelope, you may mail your appeal directly to the address in the front of this handbook; or
    - Submit your appeal by e-mail or fax. Please refer to the 'County Contact Information' section of this handbook to find the appropriate method (e.g., email, fax) for submitting your appeal.

How Do I Know If My Appeal Has Been Decided?

You or your approved person will receive written notification from your county of the decision on your appeal. The notification will include the following information:

- The results of the appeal resolution process.
- The date the appeal decision was made.
- If the appeal is not resolved in your favor, the notice will provide information regarding your right to a State Fair Hearing and how to request a State Fair

Hearing.

Is There a Deadline to File an Appeal?

You must file an appeal within 60 calendar days of the date on the Notice of Adverse Benefit Determination. There are no deadlines for filing an appeal when you do not get a Notice of Adverse Benefit Determination, so you may file this type of appeal at any time.

When Will a Decision Be Made About My Appeal?

The county must decide on your appeal within 30 calendar days of receiving your request.

What If I Can't Wait 30 Days for My Appeal Decision?

If the appeal meets the criteria for the expedited appeal process, it may be completed more quickly.

What Is an Expedited Appeal?

An expedited appeal follows a similar process to the standard appeal but is quicker. Here is additional information regarding expedited appeals:

- You must show that waiting for a standard appeal could make your behavioral health condition worse.
- The expedited appeal process follows different deadlines than the standard appeal.
- The county has 72 hours to review expedited appeals.
- You can make a verbal request for an expedited appeal.
- You do not have to put your expedited appeal request in writing.

When Can I File an Expedited Appeal?

If waiting up to 30 days for a standard appeal decision will jeopardize your life, health, or ability to attain, maintain or regain maximum function, you may request an expedited resolution of an appeal.

Additional Information Regarding Expedited Appeals:

- If your appeal meets the requirements for an expedited appeal, the county will resolve it within 72 hours of receiving it.
- If the county determines that your appeal does not meet the criteria for an expedited appeal, they are required to provide you with timely verbal notification and will provide you with written notice within two calendar days, explaining the reason for their decision. Your appeal will then follow the standard appeal timeframes outlined earlier in this section.
- If you disagree with the county's decision that your appeal does not meet the criteria for expedited appeal, you may file a grievance.
- After your county resolves your request for an expedited appeal, you and all affected parties will be notified both orally and in writing.

State Fair Hearings

What Is A State Fair Hearing?

A State Fair Hearing is an independent review conducted by an administrative law judge from the California Department of Social Services (CDSS) to ensure you receive the behavioral health services that you are entitled to under the Medi-Cal program.
Please visit the California Department of Social Services website https://www.cdss.ca.gov/hearing-requests for additional resources.

What Are My State Fair Hearing Rights?

You have the right to:

- Request a hearing before an administrative law judge, also known as a State Fair Hearing, to address your case.
- Learn how to request a State Fair Hearing.
- Learn about the regulations that dictate how representation works during the State Fair Hearing.
- Request to have your benefits continue during the State Fair Hearing process if you request for a State Fair Hearing within the required timeframes.

- Not pay for continued services while the State Fair Hearing is pending and if the final decision is in favor of the county's adverse benefit determination.

When Can I File for a State Fair Hearing?

You can file for a State Fair Hearing if:

- You filed an appeal and received an appeal resolution letter telling you that your county denied your appeal request.
- Your grievance, appeal, or expedited appeal wasn't resolved in time.

How Do I Request a State Fair Hearing?

You can request a State Fair Hearing:

- Online: at the Department of Social Services Appeals Case Management website: https://acms.dss.ca.gov/acms/login.request.do
- In Writing: Submit your request to the county welfare department at the address shown on the Notice of Adverse Benefit Determination, or mail it to:
  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430
- By Fax: 916-651-5210 or 916-651-2789

You can also request a State Fair Hearing or an expedited State Fair Hearing:

- By Phone:
  - *State Hearings Division*, toll-free, at **1-800-743-8525** or **1- 855-795-0634**.
  - *Public Inquiry and Response*, toll-free, at **1- 800-952-5253** or TDD at **1-800-952-8349**.

Is There a Deadline to Ask for a State Fair Hearing?

You have 120 days from the date of the county's written appeal decision notice to request a State Fair Hearing. If you didn't receive a Notice of Adverse Benefit Determination, you may file for a State Fair Hearing at any time.

Can I Continue Services While I'm Waiting for a State Fair Hearing Decision?

Yes, if you are currently receiving authorized services and wish to continue receiving the services while you wait for the State Fair Hearing decision, you must request a State Fair Hearing within 10 days from the date the appeal decision notice was postmarked or delivered to you. Alternatively, you can request the hearing before the date your county says that services will be stopped or reduced.

Note:

- When requesting a State Fair Hearing, you must indicate that you wish to continue receiving services during the State Fair Hearing process.
- If you request to continue receiving services and the final decision of the State Fair Hearing confirms the reduction or discontinuation of the service you are receiving, you are not responsible for paying the cost of services provided while the State Fair Hearing was pending.

When Will a Decision Be Made About My State Fair Hearing Decision?

After requesting a State Fair Hearing, it may take up to 90 days to receive a decision.

Can I Get a State Fair Hearing More Quickly?

If you think waiting that long will be harmful to your health, you might be able to get an answer within three working days. You can request for an Expedited State Fair Hearing by either writing a letter yourself or asking your general practitioner or mental health professional to write a letter for you. The letter must include the following information:

1. Explain in detail how waiting up to 90 days for your case to be decided can seriously harm your life, health, or ability to attain, maintain, or regain maximum function.
2. Ask for an "expedited hearing" and provide the letter with your request for a hearing.

The State Hearings Division of the Department of Social Services will review your request for an expedited State Fair Hearing and determine if it meets the criteria. If your

request is approved, a hearing will be scheduled, and a decision will be made within three working days from the date the State Hearings Division receives your request.

ADVANCE DIRECTIVE

What is an Advance Directive?

You have the right to an advance directive. An advance directive is a written document about your health care that is recognized under California law. You may sometimes hear an advance directive described as a living will or durable power of attorney. It includes information about how you would like health care provided or says what decisions you would like to be made, if or when you are unable to speak for yourself. This may include such things as the right to accept or refuse medical treatment, surgery, or make other health care choices. In California, an advance directive consists of two parts:

- Your appointment of an agent (a person) making decisions about your health care; and
- Your individual health care instructions.

Your county is required to have an advance directive program in place. Your county is required to provide written information on the advance directive policies and explain the state law if asked for the information. If you would like to request the information, you should call the telephone number on the cover of this handbook for more information.

You may get a form for an advance directive from your county or online. In California, you have the right to provide advance directive instructions to all of your healthcare providers. You also have the right to change or cancel your advance directive at any time.

If you have a question about California law regarding advance directive requirements, you may send a letter to:

California Department of Justice
Attn: Public Inquiry Unit
P. O. Box 944255
Sacramento, CA 94244-2550

RIGHTS AND RESPONSIBILITIES

County Responsibilities

What is my County Responsible for?

Your county is responsible for the following:

- Figuring out if you meet the criteria to access behavioral health services from the county or its provider network.
- Providing a screening or an assessment to determine whether you need behavioral health services.
- Providing a toll-free phone number that is answered 24 hours a day, seven days a week, that can tell you how to get mental health services. The telephone number is listed on the cover of this handbook.
- Making sure there are sufficient mental health providers nearby so that you can access the services covered by your county when necessary.
- Informing and educating you about services available from your county.
- Providing services in your language at no cost to you, and if needed, providing an interpreter for you free of charge.
- Providing you with written information about what is available to you in other languages or alternative forms like Braille or large-size print. Refer to the "Additional Information About Your County" section located at the end of this handbook for more information.
- Informing you about any significant changes in the information mentioned in this handbook at least 30 days before the changes take effect. A change is considered significant when there is an increase or decrease in the quantity or types of services offered, if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits you receive from the county.
- Making sure to connect your healthcare with any other plans or systems that may be necessary to help transition your care smoothly. This includes ensuring that any referrals for specialists or other providers are properly followed up on and

that the new provider is willing to take care of you. (This responsibility is specific to mental health services only)

- Making sure you can keep seeing your current healthcare provider, even if they are not in your network, for a certain amount of time. This is important if switching providers would harm your health or raise the chance of needing to go to the hospital. (This responsibility is specific to mental health services only)

Is Transportation Available?

If you struggle to attend your medical or behavioral health appointments, the Medi-Cal program helps in arranging transportation for you. Transportation must be provided for Medi-Cal members who are unable to provide transportation on their own and who have a medical necessity to receive Medi-Cal covered services. There are two types of transportation for appointments:

- Non-Medical: transportation by private or public vehicle for people who do not have another way to get to their appointment.
- Non-Emergency Medical: transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation.

Transportation is available for trips to the pharmacy or to pick up needed medical supplies, prosthetics, orthotics, and other equipment.

If you have Medi-Cal but are not enrolled in a managed care plan, and you need non-medical transportation to a health-related service, you can contact the non-medical transportation provider directly or your provider for assistance. When you contact the transportation company, they will ask for information about your appointment date and time.

If you need non-emergency medical transportation, your provider can prescribe non-emergency medical transportation and put you in touch with a transportation provider to coordinate your ride to and from your appointment(s).

For more information and assistance regarding transportation, contact your managed care plan.

Member Rights

What Are My Rights as a Recipient of Medi-Cal Behavioral Health Services?

As a Medi-Cal member, you have the right to receive medically necessary behavioral health services from your county. When accessing behavioral health services, you have the right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Get clear and understandable explanations of available treatment options.
- Participate in decisions related to your behavioral health care. This includes the right to refuse any treatment that you do not wish to receive.
- Get this handbook to learn about county services, county obligations, and your rights.
- Ask for a copy of your medical records and request changes, if necessary.
- Be free from any form of restraint or seclusion that is imposed as a means of coercion, discipline, convenience, or retaliation.
- Receive timely access to care 24/7 for emergency, urgent, or crisis conditions when medically necessary.
- Upon request, receive written materials in alternative formats such as Braille, large-size print, and audio format in a timely manner.
- Receive behavioral health services from the county that follows its state contract for availability, capacity, coordination, coverage, and authorization of care. The county is required to:
    - Employ or have written contracts with enough providers to make sure that all Medi-Cal eligible members who qualify for behavioral health services can receive them in a timely manner.
    - Cover medically necessary services for you in a timely manner. In addition, the mental health plan must cover medically necessary services out-of-network for you in a timely manner, if the mental health plan does

not have an employee or contract provider who can deliver the services. **Note:** The county must make sure you do not pay anything extra for seeing an out-of-network provider. See below for more information:

- *Medically necessary behavioral health services* for individuals 21 years of age or older are services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Medically necessary behavioral health services for individuals under 21 years of age are services that sustain, support, improve, or make more tolerable a behavioral health condition.
- *Out-of-network provider* is a provider who is not on the county's list of providers.

  - Upon your request, provide a second opinion from a qualified health care professional within or outside of the network at no extra cost.
  - Make sure providers are trained to deliver the behavioral health services that the providers agree to cover.
  - Make sure that the county's covered behavioral health services are enough in amount, length of time, and scope to meet the needs of Medi-Cal-eligible members. This includes making sure that the county's method for approving payment for services is based on medical necessity and that the access criteria is fairly used.
  - Make sure that its providers conduct thorough assessments and collaborate with you to establish treatment goals.
  - Coordinate the services it provides with services being provided to you through a managed care plan or with your primary care provider, if necessary. (This requirement is specific to mental health services only)
  - Participate in the state's efforts to provide culturally competent services to all, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

- Express your rights without harmful changes to your treatment.
- Receive treatment and services in accordance with your rights described in this

handbook and with all applicable federal and state laws such as:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
- The Rehabilitation Act of 1973.
- Title IX of the Education Amendments of 1972 (regarding education programs and activities).
- Titles II and III of the Americans with Disabilities Act.
- Section 1557 of the Patient Protection and Affordable Care Act.

- You may have additional rights under state laws regarding behavioral health treatment. To contact your county's Patients' Rights Advocate, please contact your county by using the telephone number listed on the cover of the handbook.

Adverse Benefit Determinations

What Rights Do I Have if the County Denies the Services I Want or Think I Need?

If your county denies, limits, reduces, delays, or ends a service you think you need, you have the right to a written notice from the county. This notice is called a "Notice of Adverse Benefit Determination". You also have a right to disagree with the decision by asking for an appeal. The sections below inform you of the Notice of Adverse Benefit Determination and what to do if you disagree with the county's decision.

What Is an Adverse Benefit Determination?

An Adverse Benefit Determination is defined by any of the following actions taken by the county:

- The denial or limited authorization of a requested service. This includes determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;

- The failure to provide services in a timely manner;
- The failure to act within the required timeframes for standard resolution of grievances and appeals. Required timeframes are as follows:
    - If you file a grievance with the county and the county does not get back to you with a written decision on your grievance within 30 days.
    - If you file an appeal with the county and the county does not get back to you with a written decision on your appeal within 30 days.
    - If you filed an expedited appeal and did not receive a response within 72 hours.
- The denial of a member's request to dispute financial liability.

What Is a Notice of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination is a written letter that your county will send you if it decides to deny, limit, reduce, delay, or end services you and your provider believe you should get. The notice will explain the process the county used to make the decision and include a description of the criteria or guidelines that were used to determine whether the service is medically necessary.

This includes denial of:

- A payment for a service.
- Claims for services that are not covered.
- Claims for services that are not medically necessary.
- Claims for services from the wrong delivery system.
- A request to dispute financial liability.

Note: A Notice of Adverse Benefit Determination is also used to tell you if your grievance, appeal, or expedited appeal was not resolved in time, or if you did not get services within the county's timeline standards for providing services.

Timing of the Notice

The county must mail the notice:

- To the member at least 10 days before the date of action for termination, suspension, or reduction of a previously authorized behavioral health service.
- To the member within two business days of the decision for denial of payment or decisions resulting in denial, delay, or modification of all or part of the requested behavioral health services.

Will I Always Get A Notice Of Adverse Benefit Determination When I Don't Get The Services I Want?

Yes, you should receive a Notice of Adverse Benefit Determination. If you do not receive a notice, you may file an appeal with the county or if you have completed the appeal process, you can request a State Fair Hearing. When you contact your county, indicate you experienced an adverse benefit determination but did not receive a notice. Information on how to file an appeal or request a State Fair Hearing is included in this handbook and should also be available in your provider's office.

What Will the Notice of Adverse Benefit Determination Tell Me?

The Notice of Adverse Benefit Determination will tell you:

- What your county did that affects you and your ability to get services.
- The date the decision will take effect and the reason for the decision.
- If the reason for the denial is that the service is not medically necessary, the notice will include a clear explanation of why the county made this decision. This explanation will include the specific clinical reasons why the service is not considered medically necessary for you.
- The state or federal rules the decision was based on.
- Your rights to file an appeal if you do not agree with the county's decision.
- How to receive copies of the documents, records, and other information related to the county's decision.
- How to file an appeal with the county.
- How to request a State Fair Hearing if you are not satisfied with the county's decision on your appeal.
- How to request an expedited appeal or an expedited State Fair Hearing.

- How to get help filing an appeal or requesting a State Fair Hearing.
- How long you have to file an appeal or request a State Fair Hearing.
- Your right to continue to receive services while you wait for an appeal or State Fair Hearing decision, how to request continuation of these services, and whether the costs of these services will be covered by Medi-Cal.
- When you have to file your appeal or State Fair Hearing request by if you want the services to continue.

What Should I Do When I Get a Notice of Adverse Benefit Determination?

When you get a Notice of Adverse Benefit Determination, you should read all the information in the notice carefully. If you don't understand the notice, your county can help you. You may also ask another person to help you.

You can request a continuation of the service that has been discontinued when you submit an appeal or request for a State Fair Hearing. You must request the continuation of services no later than 10 calendar days after the date the Notice of Adverse Benefit Determination was post-marked or delivered to you, or before the effective date of the change.

Can I Keep Getting My Services While I Wait for an Appeal Decision?

Yes, you might be able to keep getting your services while you wait for a decision. This means you can keep seeing your provider and getting the care you need.

What Do I Have to Do to Keep Getting My Services?

You must meet the following conditions:

- You ask to keep getting the service within 10 calendar days of the county sending the Notice of Adverse Benefit Determination or before the date the county said the service would stop, whichever date is later.
- You filed an appeal within 60 calendar days of the date on the Notice of Adverse Benefit Determination.

- The appeal is about stopping, reducing, or suspending a service you were already getting.
- Your provider agreed that you need the service.
- The time period the county already approved for the service has not ended yet.

What If the County Decides I Do Not Need the Service After the Appeal?

You will not be required to pay for the services you received while the appeal was pending.

Member Responsibilities

What are my responsibilities as a Medi-Cal member?

It is important that you understand how the county services work so you can get the care you need. It is also important to:

- Attend your treatment as scheduled. You will have the best result if you work with your provider to develop goals for your treatment and follow those goals. If you do need to miss an appointment, call your provider at least 24 hours in advance, and reschedule for another day and time.
- Always carry your Medi-Cal Benefits Identification Card (BIC) and a photo ID when you attend treatment.
- Let your provider know if you need an oral interpreter before your appointment.
- Tell your provider all your medical concerns. The more complete information that you share about your needs, the more successful your treatment will be.
- Make sure to ask your provider any questions that you have. It is very important you completely understand the information that you receive during treatment.
- Follow through on the planned action steps you and your provider have agreed upon.
- Contact the county if you have any questions about your services or if you have any problems with your provider that you are unable to resolve.
- Tell your provider and the county if you have any changes to your personal information. This includes your address, phone number, and any other medical

information that may affect your ability to participate in treatment.

- Treat the staff who provide your treatment with respect and courtesy.
- If you suspect fraud or wrongdoing, report it:
    - The Department of Health Care Services asks that anyone suspecting Medi-Cal fraud, waste, or abuse to call the DHCS Medi-Cal Fraud Hotline at **1-800-822-6222**. If you feel this is an emergency, please call **911** for immediate assistance. The call is free, and the caller may remain anonymous.
    - You may also report suspected fraud or abuse by e-mail to fraud@dhcs.ca.gov or use the online form at http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

Do I Have To Pay For Medi-Cal?

Most people in Medi-Cal do not have to pay anything for medical or behavioral health services. In some cases, you may have to pay for medical and/or behavioral health services based on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for medical or behavioral health services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or behavioral health services. The amount that you pay is called your 'share of cost'. Once you have paid your 'share of cost,' Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don't have medical expenses, you don't have to pay anything.
- You may have to pay a 'co-payment' for any treatment under Medi-Cal. This means you pay an out-of-pocket amount each time you get a medical service or go to a hospital emergency room for your regular services.
- Your provider will tell you if you need to make a co-payment.

NONDISCRIMINATION NOTICE

Discrimination is against the law. TCHSA follows State and Federal civil rights laws. TCHSA does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

TCHSA provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio or accessible electronic formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact TCHSA-BH by calling 1-800-240-3208. Or, if you cannot hear or speak well, please call TTY: 711. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

HOW TO FILE A GRIEVANCE

If you believe that TCHSA has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Quality Assurance Manager. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact TCHSA Quality Assurance Manager between 8:00 AM and 5:00 PM by calling *(530) 527-8491.* Or, if you cannot hear or speak well, please call *TTY: 711*.
- In writing: Fill out a complaint form or write a letter and send it to:

  Quality Assurance Manager, PO Box 400, Red Bluff, CA 96080.
- In person: Visit your doctor's office or TCHSA *Facility* and say you want to file a grievance.

- Electronically: Visit TCHSA website at:

  https://www.tehamacohealthservices.net/administration/quality-assurance/

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.

- In writing: Fill out a complaint form or send a letter to:

  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at:
  https://www.dhcs.ca.gov/discrimination-grievance-procedures

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

NOTICE OF PRIVACY PRACTICES

A statement describing the county's policies and procedures for preserving the confidentiality of medical records is available and will be given to you upon request.

If you are of the age and capacity to consent to behavioral health services, you are not required to get any other member's authorization to get behavioral health services or to submit a claim for behavioral health services.

You can ask your county to send communications about behavioral health services to another mailing address, email address, or telephone number that you choose. This is called a "request for confidential communications." If you consent to care, the county will not give information on your behavioral health services to anyone else without your written permission. If you do not give a mailing address, email address, or telephone number, the county will send communications in your name to the address or telephone number on file.

The county will honor your requests to get confidential communications in the form and format you asked for. Or they will make sure your communications are easy to put in the form and format you asked for. The county will send them to another location of your choice. Your request for confidential communications lasts until you cancel it or submit a new request for confidential communications.

Pursuant to Civil Code section 56.107(b) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a member (or his/her personal representative) may request alternate confidential communications by completing a Request to Receive Alternate Confidential Communications of Medical Information form. This form is available at all Tehama County Health Services Agency (TCHSA) sites. The completed form can be turned in at any TCHSA site, or it can be mailed to:

Tehama County Health Services Agency, Medical Information Request
P.O. Box 400
Red Bluff, CA 96080

TCHSA will verify the identity of the individual making the request. TCHSA's policy as described in TCHSA Policy and Procedure 8-02-3006, Alternate Confidential Communications, is to act on the request (i.e., agree to the request or, if possible, discuss with the member the reason(s) for denying the request) as soon as reasonably possible after receipt of the request.

A statement of the county's policies and procedures for protecting your medical information (called a "Notice of Privacy Practices") is included below:

A current printed version of the TCHSA Notice of Privacy Practices may be requested from any TCHSA site, or an online version of may be found at the following website: https://www.tehamacohealthservices.net/our-administration/compliance/privacy-practices-fraud/

The state Department of Healthcare Services (DHCS) also has a Notice of Privacy Practices, which may be viewed at the following website: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf.

WORDS TO KNOW

988 Suicide and Crisis Lifeline: A phone number that provides free, confidential support for people experiencing a mental health crisis, including suicidal thoughts. It is available 24/7 to connect callers with trained counselors who can offer help and support.

Administrative law judge: A judge who hears and decides cases involving adverse benefit determinations.

American Society of Addiction Medicine (ASAM): A professional medical society representing doctors and other healthcare professionals who specialize in addiction treatment. This organization created the ASAM Criteria, which is the national set of criteria for addiction treatment.

Appeal resolution: The process of resolving a disagreement you have with a decision made by the county about coverage of a requested service. In simpler terms: It is how you get a second look at a decision you do not agree with.

Application Programming Interfaces (APIs): APIs are like messengers that allow different software programs to "talk" to each other and share information.

Assessment: A service activity designed to evaluate the current status of mental, emotional, or behavioral health.

Authorization: Giving permission or approval.

Authorized representative: Someone legally allowed to act on behalf of another person.

Behavioral Health: Refers to our emotional, psychological, and social well-being. In simpler terms: It is about how we think, feel, and interact with others.

Benefits: Health care services and drugs covered under this health plan.

Benefits Identification Card (BIC): An ID card to verify your Medi-Cal health insurance.

Care Coordination Services (Coordination of Care): Helps people navigate the healthcare system.

Caregiver: Someone who provides care and support to another person who needs help.

Case manager: Registered nurses or social workers who can help a member understand major health problems and arrange care with the member's providers.

Case management: It is a service to assist members in accessing needed medical, educational, social, rehabilitative, or other community services. In other words, it helps people get the care and support they need.

CHIP (Children's Health Insurance Program): A government program that helps families get health insurance for their children if they cannot afford it.

Civil Rights Coordinator: Ensures that an organization (like a school, company, or government agency) complies with laws that protect people from discrimination.

Client-driven: Something that is focused on the needs and preferences of the client.

Community-based organizations: Groups of people who work together to improve their community.

Community-based adult services (CBAS): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver training and support, nutrition services, transportation, and other services for members who qualify.

Community-based stabilization: Helps people experiencing a mental health crisis get support within their own community instead of going to a hospital.

Continuation of service: See continuity of care.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from their existing out-of-network provider for up to 12 months if the provider and county agree.

Copayment (co-pay): A payment a member makes, generally at the time of service, in addition to the insurer's payment.

Covered Services: Medi-Cal services for which the county is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form).

Culturally competent services: Providing services that are respectful of and responsive to a person's culture, language, and beliefs.

Designated significant support person(s): Person(s) who the member or the provider thinks are important to the success of treatment. This can include parents or legal guardians of a minor, anyone living in the same household, and other relatives of the member.

DHCS: The California Department of Health Care Services. This is the State office that oversees the Medi-Cal program.

Discrimination: The unfair or unequal treatment of someone based on their race, gender, religion, sexual orientation, disability, or other characteristics.

Early and periodic screening, diagnostic, and treatment (EPSDT): Go to “Medi-Cal for Kids and Teens.”

Family-based treatment services: Provides support and treatment to children and their families to address mental health challenges within the home environment.

Family planning services: Services to prevent or delay pregnancy. Services are provided to members of childbearing age to enable them to determine the number and spacing of children.

Fee-for-Service (FFS) Medi-Cal: Payment model in which Behavioral Health providers are paid for each individual service they provide patient, rather than a per-patient monthly or annual fee. Medi-Cal Rx is covered under this program.

Financial liability: Being responsible for paying a debt or cost.

Foster home: A household that provides 24-hour substitute care for children who are separated from their parents or guardians.

Fraud: An intentional act to deceive or misrepresent made by a person with knowledge that the deception or misrepresentation could result in some unauthorized benefit to themselves or someone else.

Full-scope Medi-Cal: Free or low-cost health care for people in California that provides more than just emergency health care. It provides medical, dental, mental health, family planning, and vision (eye) care. It also covers treatment for alcohol and drug use, medicine your doctor orders, and more.

Grievance: A member's verbal or written expression of dissatisfaction about a service covered by Medi-Cal, a managed care plan, a county, or a Medi-Cal provider. A grievance is the same as a complaint.

Guardian: A person legally responsible for the care and well-being of another person, usually a child or someone who cannot care for themselves.

Hospital: A place where a member gets inpatient and outpatient care from doctors and nurses.

Hospitalization: Admission to a hospital for treatment as an inpatient.

Indian Health Care Providers (IHCP): A health care program operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Health Program, Tribal Organization or Urban Indian Organization (UIO) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603).

Initial Assessment: An evaluation of the member to determine the need for mental health services or substance use disorder treatment.

Inpatient Detoxification: A voluntary medical acute care service for detoxification for members with severe medical complications associated with withdrawals.

Integrated Core Practice Model: A guide that outlines the values, standards, and practices for working with children, youth, and families in California.

Licensed mental health professional: Any provider who is licensed in accordance with applicable State of California law such as the following: licensed physician, licensed psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurse, licensed psychiatric technician.

Licensed psychiatric hospital: A mental health treatment facility that is licensed to provide 24-hour inpatient care for mentally disordered, incompetent, or a danger to themselves or others.

Licensed residential facility: Facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol or other drug (AOD) misuse or abuse.

Managed care plan: A Medi-Cal health plan that uses only certain doctors, specialists, clinics, pharmacies, and hospitals for Medi-Cal recipients enrolled in that plan.

Medi-Cal: California's version of the federal Medicaid program. Medi-Cal offers free and low-cost health coverage to eligible people who live in California.

Medi-Cal for Kids and Teens: A benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early. They must get treatment to take care of or help the conditions that might be found in the check-ups. This benefit is also known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under federal law.

Medi-Cal Peer Support Specialist: An individual who has lived experience with behavioral health or substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the county, and who provides services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.

Medi-Cal Rx: A pharmacy benefit service that is part of FFS Medi-Cal and known as "Medi-Cal Rx" that provides pharmacy benefits and services, including prescription drugs and some medical supplies to all Medi-Cal members.

Medically necessary (or medical necessity): For members 21 years of age or older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For members under 21 years of age, a service is medically necessary if it is to correct or ameliorate a mental illness or condition discovered by a screening service.

Medication Assisted Treatment (MAT): The use of FDA approved medication in combination with counseling or behavioral therapies to provide a "whole-patient" approach to the treatment of substance use disorder.

Member: An individual who is enrolled in the Medi-Cal program.

Mental health crisis: When someone is experiencing a situation where their behaviors or symptoms put themselves or others at risk and require immediate attention.

Mental health plan: Each county has a mental health plan that is responsible for providing or arranging specialty mental health services to Medi-Cal members in their county.

Network: A group of doctors, clinics, hospitals, and other providers contracted with the county to provide care.

Non-emergency medical transportation: Transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by a member's provider and when picking up prescriptions and medical supplies.

Office of the Ombudsman: Helps solve problems from a neutral standpoint to make sure that members receive all medically necessary and covered services for which plans are contractually responsible.

Out-of-home placement: A temporary or permanent removal of a child from their home to a safer environment like with a foster family or in a group home.

Out-of-network provider: A provider who is not part of the county's contracted network.

Out-of-pocket: A personal cost to a member to receive covered services. This includes premiums, copays, or any additional costs for covered services.

Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purpose of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies, and supplements

Participating provider (or participating doctor): A doctor, hospital, or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with the county to offer covered services to members at the time a member gets care.

Plan development: A service activity that consists of development of client plans, approval of client plans, and/or monitoring of a member's progress.

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter ("OTC") drugs that do not require a prescription.

Primary care: Also known as "routine care". These are medically necessary services and preventative care, well-child visits, or care such as routine follow-up care. The goal of these services is to prevent health problems.

Primary care provider (PCP): The licensed provider a member has for most of their health care. The PCP helps the member get the care they need. A PCP can be a:

- General practitioner

- Internist
- Pediatrician
- Family practitioner
- OB/GYN
- Indian Health Care Provider (IHCP)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): The process by which a member or their provider must request approval from the county for certain services to ensure the county will cover them. A referral is not an approval. A prior authorization is the same as pre-approval.

Problem resolution: The process that allows a member to resolve a problem or concern about any issue related to the county's responsibilities, including the delivery of services.

Provider Directory: A list of providers in the county's network.

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to cause an immediate danger to the member or others or the member is immediately unable to provide for or use food, shelter, or clothing due to the mental disorder.

Psychological testing: A test that helps understand someone's thoughts, feelings, and behaviors.

Referral: When a member's PCP says the member can get care from another provider. Some covered care services require a referral and pre-approval (prior authorization).

Rehabilitative and habilitative therapy services and devices: Services and devices to help members with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

Residential shelter services: Provides temporary housing and support to people who are homeless or experiencing a housing crisis.

Screening: A quick check conducted to determine the most appropriate services.

Share of cost: The amount of money a member must pay toward their medical expenses before Medi-Cal will pay for services.

Serious emotional disturbances (problems): Refers to a significant mental, behavioral, or emotional disorder in children and adolescents that interferes with their ability to function at home, school, or in the community.

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, a member will need a referral from their PCP to go to a specialist.

Specialty mental health services (SMHS): Services for members who have mental health services needs that are higher than a mild to moderate level of impairment.

Strength-based: Looking at what someone can do, instead of just focusing on their problems.

Substance use disorder services: Services that help people who are struggling with addiction to drugs or alcohol.

Telehealth: A way of delivering health care services through information and communication technologies to facilitate a patient's health care.

Trauma: A deep emotional and psychological distress that results from experiencing or witnessing a terrifying event.

Trauma-informed specialty mental health services: These services recognize that many people struggling with mental health issues have experienced trauma, and they provide care that is sensitive to and supportive of those who have been traumatized.

Treatment Plan: A plan to address a member's needs and monitor progress to restore the member's best possible functional level.

TTY/TDD: Devices that assist people who are deaf, hard of hearing, or have a speech impairment to make and receive phone calls. TTY stands for "Teletypewriter". TDD stands for "Telecommunications Device for the Deaf".

Vocational services: Services that help people find and keep jobs.

Waitlist: A list of people who are waiting for something that is not currently available, but may be in the future.

Warm handoff: A smooth transfer of care from one provider to another.

ADDITIONAL INFORMATIOM ABOUT TEHAMA COUNTY

Additional County-Specific Information

These services, new in 2026, are being provided by TCHSA.

- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

These services are **not** being offered by TCHSA. Members will be notified when services become available in Tehama County.

- Assertive Community Treatment (ACT)
- Forensic Assertive Community Treatment (FACT)
- Clubhouse Services
- Enhanced Community Health Worker (CHW) Services
- Supported Employment
- In-Reach Services

TCHSA can provide you with forms or other written information in your preferred language, or in alternative forms like Braille, 20-point font large-size print, audio recordings or accessible electronic format, at no charge to you. Ask your provider or call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free. Due to translation, processing and/or printing time, it may take up to 5 business days before you receive the forms or materials.

The county provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. The county can also provide auxiliary aids and services to a family member, friend, or anyone else with whom it is appropriate to communicate with on your behalf. Interpreter, linguistic and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

Exhibit E

INVOICE

Program: **MHSA FSP Services Non-Billable** Invoice No: #

For the period: _____ through _____

Contractor: Remi Vista, Inc.

Address: PO BOX 494100 (393 Marina Circle) Redding, CA 96049-4100

FSP Non-mental health sercies and supports (Cal. Code Regs. Tit. 9, § 3620):

A. FOOD -DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL FOOD COSTS	$0.00

B. CLOTHING - DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL CLOTHING COSTS	$0.00

C. HOUSING - DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL HOUSING COSTS	$0.00

D. HEALTH CARE TREATMENT - DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL HEALTH CARE TREATMENT COSTS	$0.00

E. CO-OCCURING TREATMENT - DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL CO-OCCURING TREATMENT COSTS	$0.00

F. RESPITE - DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL RESPITE COSTS	$0.00

E. OTHER PRE-APPROVED - DESCRIPTION	MEETS ISSP GOAL	PT ID#	AMOUNT
	Y/N		
	Y/N		
		TOTAL OTHER COSTS	$0.00

MONTHLY NON-BILLABLE FSP SERVICES	**$0.00**