Long Term Care (LTC) Handbook

Edition December 2025

optumsandiego.com

Funding for services is provided by the County of San Diego Health and Human Services Agency

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Introduction

Optum Public Sector San Diego, hereinafter referred to as “Optum,” contracts with Skilled Nursing Facilities (SNF) on behalf of the County of San Diego Behavioral Health Services (BHS). The services rendered in the County Funded SNFs are governed by the contract with Optum, the policies and procedures in this handbook, as well as the Federal, State, and local laws governing services rendered in SNFs. Providers are encouraged to review these documents closely.

This Long Term Care Handbook was developed to give facilities information about the Contracting, Authorization, Utilization Management, Billing, and Issues Resolution procedures for the County Funded network of SNFs. An electronic version of the handbook is available at optumsandiego.com > BHS Provider Resources > Long Term Care > Skilled Nursing Facilities.

The Role of Optum Public Sector San Diego

In its role as the Administrative Services Organization (ASO) for the County of San Diego’s publicly funded behavioral health system, Optum:

- Credentials and contracts with SNFs
- Authorizes County Funded SNF, SNF Patch, or NBU Patch, as part of Long Term Care (LTC) services
- Processes and pays claims for SNFs
- Conducts medical necessity and utilization management review for SNF Subacute services
- Operates a 24-hour Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care, including substance use disorder support services, referrals and information for mental health
- Through the ACL, facilitates access to clinically appropriate, culturally competent services for San Diego County residents in need of mental health and/or substance use disorder services 24/7

Optum Provider Line can be reached at (800) 798-2254. In addition, the website: optumsandiego.com provides links to this handbook and helpful documents regarding SNF services.

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Optum Contact Information		
Optum Claims • Billing questions	P: (800) 798-2254 Option 2 F: (877) 364-6945	E-mail for general claims information: psclaims@optum.com
Optum Public Sector San Diego Attn: Claims P.O. Box 601340 San Diego, CA 92160-1340	To submit: • County-funded SNF claims • Written inquiries regarding claims • Formal claims appeal with supporting documentation To return excess funds by check (Check must be made payable to "County of San Diego")	
Optum Utilization Management • Authorization for SNF services • Clinically related questions • General questions about County-funded SNFs or SNF Patch • Requests for authorization letters	P: (800) 798-2254 Option 3, then Option 5 F: (888) 687-2515 P: (800) 798-2254 Option 3, then Option 4 F: (888) 687-2515	Website: Long Term Care Optum San Diego
Optum Public Sector San Diego Attn: Utilization Management P.O. Box 601370 San Diego, CA 92160-1370		
Optum Provider Services • Contracting • Credentialing/Recredentialing • To update information	P: (800) 798-2254 Option 7 F: (877) 309-4862	E-mail: sdu_providerserviceshelp@optum.com
Optum Quality Improvement • Appeal questions • Administrative Day request questions	P: (619) 610-6736 F: (844) 897-5479	E-mail: sdqi@optum.com
Optum Quality Improvement Department P.O. Box 601370 San Diego, CA 92160-1370	To mail requests for: • Administrative Days Requests with supporting documentation • Appeal Requests with supporting documentation	
Important County of San Diego Contact Information		
Service Line Oversight Team	P: (619) 895-5558	E-mail: robert.gibson@sdcounty.ca.gov
Quality Improvement Department	P: (619) 563-2713	Website: Technical Resource Library San Diego County
County of San Diego Mental Health Plan Compliance Hotline	P: (866) 549-0004	E-mail: compliance.hhsa@sdcounty.ca.gov

Contracting, Credentialing and Recredentialing Process

Optum, on behalf of the County of San Diego Behavioral Health Services (BHS), is responsible for developing and maintaining a network of Skilled Nursing Facilities (SNF). All County Funded SNFs are required to contract with Optum, in order to receive reimbursement for services rendered to clients.

Contracting

The contracting process begins with the completion of a SNF Application, submission of credentialing documents (identified below), and review of the documents through the Optum Credentialing Committee. Optum Provider Services staff is available to discuss the application process and to assist facilities with completing the application.

The United Behavioral Health, Public Sector San Diego Skilled Nursing Facility Contract (operating under the brand of Optum) was developed in conjunction with County Behavioral Health Services (BHS) and contains:

- The Facility Contract with general terms applicable to contractors delivering county services
- Services and rates with revenue codes and reimbursement schedules
- This handbook is included by reference in the Skilled Nursing Facility Contract

All SNFs are required to follow the contracting, credentialing and recredentialing requirements. Please contact Optum San Diego Provider Line at (800) 798-2254, Option 7, with any questions pertaining to the contracting, credentialing or recredentialing process.

Credentialing

The Credentialing of SNF facilities is performed by a contracted Credentialing Verification Organization (CVO) for Optum Provider Services and includes documentation review and primary source verification. All SNFs are required to complete a Optum Credentialing and Recredentialing Application as part of the initial contracting process. The following documents are reviewed:

- Facility’s State license
- Business license (if applicable)
- Medicare/Medi-Cal certification
- Commercial general liability
- Professional liability insurance/professional errors and omission liability insurance
- Claims made insurance
- Workers’ Compensation
- Automobile insurance
- Sexual misconduct insurance
- Medicare/Medi-Cal Sanctions Report
- Copy of most recent State Agency Site Review or CMS Certification Approval Letter
- Malpractice history and complaints documented with the National Practitioner Data Bank (NPDB), Regional Medicare/Medi-Cal offices, and the State medical boards or other appropriate State agency
- Facility NPI number
- W9 and IRS Verification Letter

Recredentialing

Optum performs recredentialing of all SNF facilities. The recredentialing process occurs at a minimum of every thirty-six (36) months from the most recent credentialing or recredentialing date. Optum will send an Optum Facility Credentialing and Recredentialing Application directly to the SNF to complete and return to them. This recredentialing process enables Optum to verify that the SNF continues to meet the credentialing criteria required to contract with Optum.

The recredentialing process includes documentation review and primary source verification of documents reviewed during the original credentialing process.

Additional areas reviewed during the recredentialing process include:

- Facility data such as complaints and compliance with Principles of Care
- Compliance with contract obligations and the Optum authorization procedures

Facilities can help avoid delays at recredentialing time by updating credentials on an on-going basis. Facilities that delay updating documentation may not be able to obtain ongoing authorizations or claims reimbursement until all documentation is up to date. For instance, changes to a Tax ID or mailing addresses will adversely affect how quickly payment can be made. A facility may be required to furnish additional background information or to authorize a background investigation based upon new or additional information. Facilities that do not submit the required recredentialing documentation after outreach by Provider Services staff shall have their contracts terminated.

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CMS Star Rating Requirements

New Providers must have a current CMS three-star overall rating or higher at the time of consideration.

- If a provider's rating falls below three stars during the contract period, admissions will be paused, and the provider will have six months to bring the rating back up.
- A Corrective Action Notice (CAN) will be issued by County of San Diego, and the provider must submit a Corrective Action Plan (CAP) within thirty days of receiving the CAN.
- If the rating is not restored to three stars within six months, the contract may be subject to termination.

Current Providers operating under contract with a CMS rating below three stars will be given sixteen months to meet the threshold.

- After twelve months, if the provider has not achieved a three-star rating, admissions will be halted.
- A Corrective Action Notice (CAN) will be issued by County of San Diego, and the provider must submit a Corrective Action Plan (CAP) within thirty days of receiving the CAN.
- If, after sixteen months, the CMS rating still reflects below three stars, the contract may be subject to termination.

Disqualifying Conditions for New Providers

- Providers must not have any Immediate Jeopardy (IJ) deficiencies cited within the past three years.
- Providers must not be under active investigation by the Office of Inspector General (OIG), nor found guilty by the OIG within the past five years, unless there has been a verified ownership change since the time of the citation or finding.

Reentry After Termination

- A provider whose contract is terminated due to noncompliance may reapply after a minimum of twelve months, provided they meet all current inclusion criteria, including a three-star CMS rating and no disqualifying compliance history.

Additional Review Factors

- In addition to CMS ratings, the County reserves the right to review complaint volumes, substantiated deficiencies, and enforcement citations when determining contract eligibility and renewal.

Rating Source for Verification

- The provider's CMS star rating will be verified using the official CMS Care Compare website at the time of evaluation or contracting.

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Principles of Care

The following Principles of Care apply to all clients receiving services:

- **Care Should Promote the Client's Recovery:** Clients have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery. Clients also have the right to information that will inform decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.

- **Care Should Be Accessible:** Optimal clinical outcomes result when access to the most appropriate and available level of care is facilitated at admission and when transitioning between levels of care. A client's transition between levels of care should be timely and occur in a safe manner, and pertinent clinical information should be communicated to provider at the next level of care.

- **Care Should Be Appropriate:** Optimal clinical outcomes results when evidence-based treatment is provided in an available level of care, and the proposed care stems from the client's current condition. The level of care should be structured and intensive enough to safely and adequately treat a client's presenting problem and support recovery.

- Treatment planning should take into account significant variables such as the client's current clinical need, age and level of development, whether the proposed services are covered in the client's benefit plan, whether the proposed forms of treatment are evidence-based, whether the proposed services are available in or near the client's community, whether a less restrictive setting is available and whether community resources such as self-help and peer support groups, consumer-run services, and preventive health programs can augment treatment.

- **Care Should Be Effective:** There must be a reasonable expectation that evidence-based treatment delivered in the appropriate level of care will improve the client's presenting problems within a reasonable period of time. Improvement in this context is measured by weighing the effectiveness of treatment and the risk that the client's condition is likely to deteriorate or relapse if treatment in the current level of care were to be discontinued. Improvement must also be understood within a recovery framework where services support movement toward a full life in the community.

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SNF Guidelines for San Diego County Funding

Target population

1. Adults at least 18 years of age.

2. Clients with an adequately documented primary diagnosis of a serious, persistent, major mental disorder which requires treatment by licensed personnel in a secured mental health facility licensed as a Skilled Nursing Facility, in a 24-hour residential setting.

3. Is gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by Superior Court or signs a voluntary admission agreement.

    - For **Special Treatment Programs (STP)** level of care - Permanent, public or private LPS Conservatorship by Superior Court is required.

4. Cannot be safely managed in a less restrictive level of care. All other alternatives including Augmented Services Board and Care, traditional Board and Care, Full Service Partnership case management, and case management have been attempted or there is documentation that these alternatives are not able to meet the client's need.

5. Clients in an acute care psychiatric hospital requiring referral to a lower level of care, who are current residents of the State of California and have Medi-Cal eligibility for the County of San Diego and are not entitled to comparable services through other systems.

Client Services

Facility shall provide individualized services to clients such as:

1. Training to improve cognitive, behavioral, interpersonal coping skills.

2. Psychiatric symptom management.

3. Substance use recovery support focused on coping skills, relapse prevention skills and Medication Assisted Treatment (MAT) if appropriate.

4. Linkage to community-based organizations including, but not limited to, primary care clinics and complementary healing centers and organizations, faith-based congregations, cultural centers/organizations, and peer-directed programs such as Clubhouses.

Client services shall include the following:

1. Resolution or reduction of psychiatric symptoms or concerns.

2. Access to treatment and goals to stabilize psychiatric medication, including quarterly psychiatric visits with an MD/DO/PNP or PA trained in psychiatry.

3. Treatment of minor medical concerns as determined by a medical professional.

4. Education and support regarding activities of daily living, social skills, and dining.

5. Preparation for step-down to a lower level of care if clinically indicated.

6. Programming that may improve cognitive, behavioral, and interpersonal coping through groups, social events, and one on one staff support and interactions.

7. Access to recovery-based meetings to address both mental health and substance use disorders.

8. Access to transportation to and from medical appointments or court hearings.

9. Facility supervised outings.

Specific requirements for service delivery:

1. Engage the client in developing a Care Plan.

2. Designate case management and/or social work staffing trained in cultural competencies and mental health care.

3. Program and services shall be trauma-informed and allow services to be delivered in a way that will avoid inadvertent re-traumatization and will facilitate consumer participation in services.

4. Upon admission to the program, the client shall be informed of their client rights as well as the rules and regulations of the program.

5. Each client shall receive an orientation of the facility at time of admission, personal supplies, and as appropriate, instructions to medication times, mealtimes, phone numbers to phones, activity schedule, visiting hours, a map of the facility, writing supplies, etc.

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County of San Diego Oversight

SNF oversight shall be conducted by County of San Diego Behavioral Health Services (BHS) Service Line Oversight (SLO) Team for Long-tern Care (LTC). Such oversight shall include but not be limited to:

- Participation in site visits and systematic and regular review of clinical and operational practices
- Inspection of facilities
- Provision of Technical Assistance
- Review of all interactions with CDPH or other oversight agencies
- Review of records (including PHI)
- Monitoring tiered level-of-care assignments for accuracy and timeliness
- Reviewing administrative day utilization and bed hold practices
- Corrective Action Notices (if needed)
- Ceasing admission (when needed)
- Confirming proper discharge planning and documentation
- Validating program eligibility and care appropriateness
- Coordinating with Optum on performance concerns or required corrective actions

The SNF shall comply and respond timely to all requests related to service oversight from BHS SLO Team.

SNF shall comply with directives related to performance as outlined in the Optum Long-Term Care Handbook, Optum Contract and all relevant local, state and federal laws, regulations, policies and standards.

SLO Oversight Monitoring Outline

Item	Description	Month Due from SNF
Programmatic Desk Review	Review facility policies and procedures and verify compliance with requirements outline in LTC Handbook and SNF contract	January
Quarterly Desk Review (QSR) – Q2	Evaluate objectives outlined in the LTC Handbook	January
Administrative Desk Review	Confirm adherence to confidentiality standards, criminal background checks, and exclusion/debarment requirements	February
Quarterly Desk Review (QSR) – Q3	Evaluate objectives outlined in the LTC Handbook	April
Insurance Certificates	Validate active insurance coverage prior to the start of the fiscal year	June
Subcontract/Consultant Agreements	Review and confirm compliance of all program agreements	June
Quarterly Desk Review (QSR) – Q4	Evaluate objectives outlined in the LTC Handbook	July
Quarterly Desk Review (QSR) – Q1	Evaluate objectives outlined in the LTC Handbook	October
Deadline for Site Visits	Complete at least one on-site visit per fiscal year	December

Goals and Outcomes

SNF shall comply with all requests regarding local, state, and federal performance outcomes, including Minimum Data Set (MDS) data and participate in the outcomes measurement processes as requested.

SNF will provide state or federal survey data as soon as it is available to the SLO Team.

SNF's program shall have the following goals and objectives:

- To aid clients in reconstituting from the crisis that precipitated their acute hospitalization, to prevent further decompensation that could lead to acute hospitalization, to prevent placement in more restrictive longer-term settings.

- Clients at all levels of care shall demonstrate improved or best expected functional behavior, as measured by assessment, maintaining current functioning, or maximizing well-being and providing palliative interventions for residents with a prognosis of expected decline.

- To explore individual potential for improvement of quality of life, to significantly reduce recidivism to acute care facilities and prevent admission to other locked long-term care facilities or State hospitals.

- To develop alternative therapeutic interventions for the target population that will enable them to remain in the community for significantly longer periods of time if community placement is a viable option.

- Clients shall have the lowest necessary medication levels, as measured through medication usage, Gradual Dose Reductions when appropriate and clinical presentation.

- The SNF shall offer benefit to clients through a variety of rehabilitation services such as (but not limited to): individualized and group counseling; evidence-based substance use treatment; harm reduction strategies such as medication assisted treatment (MAT), including all oral medications that can be managed by the program internally for substance use disorders; access to educational and GED prep sessions as appropriate; wellness and recovery groups; art therapy; relapse prevention groups; nutritional counseling; life skills training; stress reduction; self-management skills; exercise group, social skills groups; DBT/CBT or other evidence-based therapies; peer support; vocational training and groups; personal motivation groups; pharmacology groups; monitoring and management related to self-harm/suicide, and anger management.

Outcome Objectives:

- Ninety percent (90%) of clients with a planned discharge from all levels of care will have improved their functioning as evidenced by their ability to function at a lower level of care and an improved Minimum Data Set (MDS) scores.

- At least ninety percent (90%) of residents admitted will complete six months of residency or be successfully placed at a lower level of care or a general SNF bed when appropriate.

- Fifteen percent (15%) or fewer clients with a planned discharge shall not be readmitted to an acute psychiatric facility or SNF within thirty days (30 days) of discharge from SNF or STP level of care. Discharge locations will be tracked and reported to SLO Team for monitoring activities.

Process Objectives:

- Discharge planning will start during the first 72 hours from time of admission with a projected timeframe for discharge established by a multidisciplinary team to avoid administrative days.

- Case management services will ensure that applications for Supplemental Security Income (SSI) or any other available financial benefits are initiated as part of the initial discharge planning process whenever eligibility is identified, and that such benefits are maintained in active status for individuals who already receive them.

- Medication regime/pharmacy audit shall be conducted at minimum once a month.

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Facility Requirements

Provider shall Comply with requirements as specified in the Long Term Care Handbook including but not limited to:

Cultural Competence

Cultural Competence is the ongoing process of recognizing how culture shapes our interactions—often in ways we may not consciously realize. It involves continuous growth in self-awareness, knowledge, skills, and advocacy, all within a broader social and systemic context. Understanding the complexity of personal identity and the intersection of lived experiences empowers providers within San Diego County Behavioral Health Services (SDCBHS) to deliver care that is culturally responsive and relevant.

Cultural and Linguistic Competence Standards

To comply with State and County mandates, providers must demonstrate cultural and linguistic competence across all organizational levels. This includes embedding inclusive practices into policies, procedures, and service delivery. Programs must ensure staff reflect and understand the diverse cultural backgrounds of the communities they serve, aligning services with the cultural dynamics of their specific region.

National Culturally and Linguistically Appropriate Services (CLAS) Standards

The CLAS Standards, developed by the U.S. Department of Health and Human Services Office of Minority Health, replace the Culturally Competent Clinical Practice Standards. These 15 standards guide healthcare organizations in delivering culturally and linguistically appropriate services across all levels of care. All contracts require programs to implement the CLAS Standards.

Standards Overview:

- Principal Standard:
  - Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

- Governance, Leadership, and Workforce:
  - Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
  - Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce responsive to the population served.
  - Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

- Communication and Language Assistance:
  - Offer language assistance at no cost to individuals with limited English proficiency or other communication needs.
  - Inform individuals of language assistance availability in their preferred language, both verbally and in writing.
  - Ensure competence of language assistance providers; avoid using untrained individuals or minors as interpreters.
  - Provide easy-to-understand materials and signage in commonly used languages.

- Engagement, Continuous Improvement, and Accountability:
  - Establish culturally and linguistically appropriate goals, policies, and accountability measures.
  - Conduct ongoing assessments and integrate CLAS measures into quality improvement activities.
  - Collect reliable demographic data to monitor CLAS impact on health equity and outcomes.
  - Assess community health assets and needs to inform service planning.
  - Partner with the community to ensure culturally appropriate policies and services.
  - Create culturally appropriate conflict and grievance resolution processes.
  - Communicate CLAS implementation progress to stakeholders and the public.

Cultural Competence Training Opportunities

- Trainings are available through contractors such as Community Research Foundation, New Alternatives, and Mental Health Systems, Inc. Other providers may participate on a fee basis.
- Contracted trainings are accessible via the BHS Workforce Education and Training Website: BHS Workforce Trainings
- Additional trainings are offered through the Academy of Professional Excellence (APEX) Academy for Professional Excellence via the Learning Management System (LMS): BHS Workforce Trainings
- The Cultural Competency Academy: Academy for Professional Excellence provides specialized training for BHS and contractors at no cost.

Cultural Competence Monitoring and Evaluation

- The BHS QA Unit and SLO Team monitor compliance with cultural competence standards outlined in the County's Cultural Competence Plan and State/Federal requirements.
- Monitoring is conducted through annual Contract Reviews and may involve medical record review.
- Use of designated tools is now a requirement for cultural competence compliance.

Program Level Requirements:

Cultural Competence Plan (CC Plan). CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library (TRL) website.

The CC Plan Component Guidelines are as follows:

- Current Status of Program
  - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
  - Identify how program administration prioritizes cultural competence in the delivery of services.
  - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
  - Goals accomplished regarding reducing health care disparities.
  - Identify barriers to quality improvement.

- Service Assessment Update and Data Analysis
    - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
    - Comparison of staff to diversity in community.
    - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
    - Use of interpreter services.
    - Service utilization by ethnicity, race, language usage, and cultural groups.
    - Client outcomes are meaningful to client's social ecological needs.
- Objectives
    - Goals for improvements.
    - Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
        - Trauma-informed principles and concepts integrated
        - Faith-based services

New contractors need to submit a CC Plan, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan.

Plans should be sent via email to BHS-HPA.HHSA@sdcounty.ca.gov.

Annual Program Evaluation – every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided three weeks to complete the survey. The survey can be completed in approximately one hour or less. The tool is available in the CC Handbook on TRL for reference.

In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

Biennial Staff Evaluation – every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services, by completing the Promoting Cultural Diversity Self-Assessment (PCDSA). The PCDSA supports the San Diego County Behavioral Health Services commitment to a culturally competent workforce and upholds the guidelines described in the Cultural Competence Plan and Handbook. The assessment's goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. The staff are provided two weeks to complete the survey. The tool is available in the Cultural Competence Handbook on TRL for reference 2020 PCDSA SystemwideReport.pdf

Annual Program Manager Evaluation – One of the Quality Assurance strategies in the County of San Diego Behavioral Health Services (BHS) Cultural Competence Plan is to survey all program managers annually to evaluate their perception of their programs' cultural and linguistic competence. Accordingly, all County and County-contracted programs are required to complete the Cultural and Linguistic Competence Policy Assessment (CLCPA). The goal of the CLCPA is to enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate

disparities. The tool is available in the Cultural Competence Handbook on the TRL for reference 2023 CLCPA Report_Final.pdf

A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of annual minimum four hours of training shall be maintained on the Quarterly Status Report.

- Please note that as of 05/12/25, per BHIN 25-019 Transgender, Gender Diverse, or Intersex Cultural Competency Training Program Requirements, all BHPs shall require staff who are in direct contact with members whether oral, written, or otherwise in the delivery of care or member services, including providers directly employed by the BHP (staff working in county owned and operated facilities), to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as TGI. This training may be developed in conjunction with existing cultural competency training.

- The following conditions also apply:

    - All new staff have one year to complete the 4 hours of cultural comp training.

    - Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement “a”.

    - Volunteers, Temporary Expert Professionals (TEP), Retire-Rehires, Certified Temporary Appointments, and Student Workers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

Consumer Preference – Language Requirements:

Services should be provided in the client’s preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client’s response must be documented. Service notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the member, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers. All County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the client’s language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on page 51 of the CC Handbook on TRL.

- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Suggestions surveys and discussion questions are available on pages 53, 57, and 59 of the CC Handbook on TRL.

National Voter Registration Act (NVRA) Compliance – Behavioral Health Programs

Under the NVRA of 1993, providers must offer voter registration materials during:

- Intake (excluding crisis situations)
- Renewal
- Address changes

Eligibility – TAY and Adult Programs

Services must be offered to clients who are:

- U.S. citizens
- California residents
- At least 18 years old by the next election
- Not on parole for a felony or legally deemed mentally incompetent to vote

Children's Programs

Voter registration must be offered to parents/guardians of clients under 18.

Language Requirements

Forms must be available in Spanish, Filipino, Vietnamese, and Chinese per County guidelines. Intake/admission packets must include:

- Voter Registration Form
- General and State Instructions
- DSS 16-64 Form
- For more information on locating voting resources in other languages please visit: Language Assistance

For additional language support, refer clients to the Secretary of State's toll-free number: 1-800-345-VOTE.

Assistance Standards

Clients must receive the same level of support for voter registration as for other service forms.

Training Requirement

Annual NVRA training is mandatory and available on the HHSA BHS website: Behavioral Health Services. Refer to Medi-Cal Eligibility Division Information Letter I 12-02: The Secretary of State's Changes to the California National Voter Registration Act (NVRA) Manual (2011 Revision) for details.

Non-Compliance

Failure to implement NVRA requirements may result in legal liability. For questions, contact the SLO Team your Contracting Officer Representative (COR).

False Claims Act

The False Claims Act (FCA) helps the government combat fraud in federal programs, purchases, and contracts. False Claims Unit | State of California (CFCA) applies to fraud involving state, city, county or other local government funds. All workforce members shall report any suspected inappropriate activity related to these Acts, which include acts, omissions or procedures that may violate the law or HHSA procedures. Some examples include:

- Billing for services not rendered or not medically necessary
- Billing separately for services that should be a single service
- Falsifying records or duplicate billing

County and County Contracted Programs are required to promptly report circumstances that may affect the member's eligibility such as the death of a member to the California Department of Health Care Services (DHCS). In addition to notifying the DHCS, the County or County Contracted Programs shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

Member deaths should be reported directly to the County of San Diego Health Information Management (HIM) Department email. The Program should ensure all documentation is entered within the EHR prior to emailing the department with the client's name, medical record number, and date of death. Please additionally reference OPOH Section G to determine if the member death also requires a Critical Incident Report (data) under certain circumstances.

The CFCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims. Programs and legal entities may not have any rule that prevents workforce members from reporting, nor may Programs or legal entities retaliate against a workforce member because of his or her involvement in a false claims action.

Any indication that any one of these activities is occurring should be reported immediately to the ACO at 619-338-2807, Compliance.HHSA@sdcounty.ca.gov, or to the HHSA Compliance hotline at (866) 549-0004. If any County or Contracted program needs training on the False Claims Act, reach out to the ACO at 619-338-2808 or email Compliance.HHSA@sdcounty.ca.gov.

In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done by phone, online form, email or by mail.

> Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations
> P.O. Box 997413 MS 2500
> Sacramento, CA 95899-7413
>
> 1-800-822-6222
>
> fraud@dhcs.ca.gov

All reporting shall include contacting your program COR immediately, as well as the BHS QA team at QIMatters.HHSA@sdcounty.ca.govto report any of these same concerns, or suspected incidents of fraud, waste, and/or abuse.

Mandated Reporting

All County and Contracted workforce members must comply with:

- Child Abuse Reporting Law (California Code, PEN 11164)
- Adult Abuse Reporting Law (California Code, WIC 15630)
- Reporting of Adult Abuse or Suspicion of a Crime (42 CFR 483.12(b)(c); F609-610) (for SNF providers)

For legal and ethical guidance, contact your agency's attorney, licensing board, or professional association.

Documentation Requirements

Programs must maintain medical records in compliance with Title 9, Chapter 11 and 42 CFR, and meet Behavioral Health Plan (BHP) standards outlined in the Uniform Clinical Record Manual (UCRM) and SDCBHS MIS User Manual, available via optumsandiego.com.

Documentation standards are based on:

- The State Agreement with DHCS
- Requirements from the BHP's Uniform Medical Record Committee (chaired by BHS QA Unit)

Training & Support Provided by BHS QA Unit:

- Annual BHS QA Forum: Annual Quality Assurance Forum for all System of Care (SOC) providers presented by the QA, PIT, and MIS units. Information is presented on system wide compliance with State, Federal and County BHP requirements. Areas for continuous quality improvement are identified and implemented for the System of Care.
- Quarterly In-Service Training: For new or reviewing clinical staff
- On-Site Trainings: Customized sessions upon request or BHS QA Unit identification

Client Rights

SNF shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code Sections 5325 et seq; Title 9 California Code of Regulations (CCR), Sections 862, 883, 884; Title 22 CCR, Sections 72453 and 72527; and 42 CFR Section 483.10.

Right to Monitor

County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of SNF in the delivery of services provided under this Contract. Full cooperation shall be given by the SNF in any auditing or monitoring conducted, according to this agreement.

SNF shall cooperate with County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by County. Should County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, County may audit, monitor, and/or request information from SNF to ensure compliance with laws, regulations, and requirements, as applicable.

SNF shall retain all records and documents originated or prepared pursuant to provider's performance under this Contract, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to provider's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.

SNF shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but not be limited to, monthly summary sheets, sign-in sheets, and other primary source

documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.

SNF shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.

SNF shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.

SNF shall agree to maintain and retain all appropriate service and financial records for a period of at least ten years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.

SNF shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

Provider shall receive referrals from the County's Administrative Services Organization (ASO) for the care levels the provider is contracted for as outlined below:

- Provider facility shall accommodate Special Treatment Program clients as outlined below:
    - Level 1 – Standard Beds = Client is not exhibiting needs beyond expected care at this level and requires minimal or no support beyond the SNF/STP setting and benefits from general programming.
    - Level 2 – Special Needs Beds = The Client requires some staff support in the SNF/STP setting and general programming, e.g., significant prompting for medications, ADL's, medical needs or hygiene. Document specific needs justifying level, e.g., frequency and type of prompting, nature of the medical needs, or hygiene issues and how assistance is provided.
    - Level 3 – Special Needs Plus = High risk behaviorally, medically or both. May require intervention by multiple disciplines and requires heightened monitoring such as Q15, Q30, line of sight or possibly 1:1. May require intervention and documentation by 2 or more disciplines as well as duration and type of enhanced monitoring, frequency and reason this is needed. This Level serves clients who exhibit high acuity – behavioral and/or medical, AWOL risk, increased psychology and specialty psychiatry interventions, and additional staffing/supervision.
- Provider facility shall accommodate Skilled Nursing Facility Patch clients as outlined below:

  Standard Care Rate
    - Adult Ambulatory Mental Health In-Patient Client/24-Hour Facility that includes:
        - Basic Care Services
        - Treatment Services
        - Case Management Services
- Provider facility shall accommodate Neurobehavioral clients as outlined below:
    - Neurobehavioral Disordered Mental Health In-Patient Client/24-Hour Facility that includes:
        - Basic Care Services

        - Treatment Services
        - Case Management Services
    - Private Room
        - High acuity presenting risk of harm to self or others in a shared room

Provider shall obtain SLO Team prior authorization for Admin Days utilization and Level 3 authorizations. When Admin Day is authorized for any clients no longer meeting criteria, but unable to step down to a lower level of care, the DHCS / Medi-Cal rate applies as full compensation for maintenance in the facility until an appropriate discharge location can be secured.

SNF shall submit a quarterly status report to the SLO Team as outlined by the SLO Team by the 20th of the following month on a format provided by the County SLO Team.

Provider shall comply with the County of San Diego Health and Human Services Agency (HHSA) research policies and procedures that require any research projects involving records, clients, staff, or locations of (or affiliated with) HHSA or its providers to be reviewed. For BHS, this requires review and approval by the BHS Research Committee. BHS approval shall be obtained prior to implementation and/or participation in a research study. Approval may also include a MOU between researchers and HHSA.

SNF providers will notify SLO Team of any significant interactions with State, federal or local regulatory agencies licensing visits/interactions and provide all licensing reports and plans of corrections and any other relevant information within 3 business days of receipt from the relevant agency. This includes, but is not limited to:

- Upcoming or completed DHCS/CDPH site visits.
- Licensing changes or renewals
- Any issues or concerns related to the facility's licensure status.
- Any Plan of Correction submitted by provider's organization to DHCS/CDPH

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Utilization Management and Authorizations

Optum Public Sector San Diego Utilization Management

Optum Utilization Management (UM) Long Term Care (LTC) team is responsible for providing initial and continued stay authorizations for clients that meet San Diego County Funded Long Term Care Criteria as established by the County, for various levels of care, including County Funded Skilled Nursing Facility (SNF), SNF Patch, and Neuro Behavioral Unit (NBU) Patch. The criteria for various LTC levels of care may be found at optumsandiego.com > BHS Provider Resources > Long Term Care. County funded Long Term Care referrals are accepted from Lanterman-Petris-Short (LPS) - Designated Acute Care Psychiatric Hospitals. Written clinical information provided by the SNF or hospital to Optum is reviewed by Optum Care Advocates and an Optum Medical Director to determine whether admission and/or continued stay criteria is met. Authorization requests are accepted from SNFs for existing residents when the client's San Diego Medi-Cal Managed Care Plan (MCP) has denied authorization due to their determination that the client's medical needs do not warrant SNF placement. Authorization requests are also accepted from SNFs for existing residents when the SNF believes that a San Diego Medi-Cal Managed Care Plan (MCP) client may meet the criteria for either SNF Patch or NBU Patch.

Please note: Funding for County Funded SNF, SNF Patch, or NBU Patch is intended to provide support for the client's serious and persistent mental illness. For SNF Patch and NBU Patch, the San Diego Medi-Cal Managed Care Plan is responsible for paying for the daily SNF bed rate. For County Funded SNF, the Managed Care Plan has denied SNF level of care, or the client has no medical needs requiring 24/7 skillable nursing care placement.

Initial Criteria and Referral to County Funded Skilled Nursing Facilities

How to Make a Referral to County Funded SNF, SNF Patch, SNF/STP or NBU Patch for a Client at an Acute Care Psychiatric Hospital

Please review the San Diego County Funded Long-Term Care Criteria at optumsandiego.com. Clients in an acute care psychiatric hospital who are current residents of the State of California and have Medi-Cal eligibility for the County of San Diego (and are not entitled to comparable services through other systems), may be referred for County SNF funding if the client has a primary mental health diagnosis that prohibits the client from being managed at a lower level of care, and the client meets all other criteria listed for the SNF level of care being requested.

Please follow these procedures when a client is being referred from an acute psychiatric hospital:

- Review the Admission Criteria for each SNF level of care and assess the client's appropriateness for referral and authorization through Optum. Verify the client has active San Diego Medi-Cal. Note the client's Medi-Cal Managed Care Plan (MCP) and contact the MCP plan before Optum if the primary reason for SNF placement is due to a skillable medical nursing need.

- If appropriate for referral to Optum, compile all required authorization request materials for a specific SNF level of care and submit to Optum LTC by fax to (888) 687-2515. A list of required documents necessary for authorization request is available at optumsandiego.com > BHS Provider Resources > Long Term Care > Referrals.

- For County Funded SNF referrals: If client meets County Funded SNF admission criteria, Optum will notify the referring hospital. A list of facilities contracted or credentialed with Optum to accept County Funded SNF referrals is available at optumsandiego.com > Referrals > Levels of Care > County Funded Skilled Nursing Facility. The hospital is responsible for finding placement in a SNF that is contracted with Optum. Once approval is given by Optum, the hospital may coordinate admission with the accepting facility.

- For SNF Patch and NBU Patch referrals: Once funding source is secured to pay the daily rate for the SNF bed, and if client meets all other criteria for SNF Patch or NBU Patch admission, Optum will notify the referring hospital and send the referral directly to the contracted Patch or NBU Patch facilities. Determinations from the contracted

facilities will be sent to Optum and the referring hospital. Once approval is received from both Optum and an accepting facility for Patch/NBU and arrangements have been made to bill the MCP for the SNF daily bed rate, the hospital may coordinate admission with the accepting facility. Please note that Patch or NBU Patch funding is meant to augment a previously secured SNF bed day payment source.

- Once the client admits to the SNF, the accepting facility will notify Optum in writing and an authorization will be generated.

- If the authorization request does not meet Optum/County SNF admission criteria, Optum will verbally notify the requestor and send a Letter of Determination (LOD) to the fax number provided on the Long Term Care Referral Screening Form. The reasons for denial and appeal information will be provided in the faxed LOD. The LOD will be addressed to the attending psychiatrist making the referral.

- If San Diego SNFs are interested in becoming credentialed and contracted with Optum, they may call our provider line at (800) 798-2254, option 7 for more information on that process.

How to Make a Referral to County Funded SNF, SNF Patch, SNF/STP or NBU Patch if the Client is a Current Resident in a SNF

If a client is a resident of a SNF and the client appears to meet criteria for SNF funding through the County of San Diego, please follow these steps:

- SNF Provider must be credentialed and contracted with Optum for County Funded Long Term Care; please call our provider line at (800) 798-2254, option 7 for more information on that process.

- Review the Admission Criteria for the appropriate SNF level of care here: optumsandiego.com to assess the client's appropriateness for referral and authorization through Optum. Verify the client has active San Diego County Medi-Cal.

- Contact the San Diego Medi-Cal Managed Care Plan before Optum if the primary reason for SNF placement is due to a skillable medical nursing need.

- The San Diego County Funded Long-Term Care Criteria at optumsandiego.com outlines requirements for referral such as: clients who are current residents of the State of California and have Medi-Cal eligibility for the County of San Diego, clients who are not entitled to comparable services through other systems, clients who have a primary mental health diagnosis that prohibits them from being managed at a lower level of care, and clients who meet all other criteria listed for the requested SNF level of care.

- If appropriate for referral, compile all required documentation for authorization request and submit to Optum LTC by fax to (888) 687-2515. A list of required documents is available at optumsandiego.com > BHS Provider Resources > Long Term Care > Referrals. To ensure Optum is able to make a timely and appropriate authorization decision, please submit complete and accurate referral packets.

- For County Funded SNF level of care, Optum may request a MCP denial be included with the authorization request.

- If the request is for Patch or NBU Patch funding, documentation must meet the San Diego County Funded Long-Term Care Criteria and demonstrate the client's need for additional support. Authorization request must include proposed interventions. Distributing psychiatric medication, in addition to medical medications, is not sufficient enough intervention and support to meet criteria for Patch level of care.

- When an individual meets the Admission Criteria for County Funded SNF, SNF Patch, SNF/STP or NBU Patch, Optum will verbally notify the SNF and upon admission will send a written authorization letter. When the

authorization request does not meet admission criteria, Optum will verbally notify the SNF and send a Letter of Determination (LOD) to the fax number provided by the SNF. The reasons for denial and appeal information will be provided in the faxed LOD. The LOD will be addressed to the attending psychiatrist making the referral.

Forms for Referral and Authorization Requests

The following Long Term Care Forms are available at optumsandiego.com > BHS Provider Resources > Long Term Care > Referrals > Referral Forms:

- County Funded Skilled Nursing, SNF Patch, SNF/STP and NBU Criteria
- County Funded SNF, SNF Patch, SNF/STP and NBU Referral Requirements
- County Funded SNF, SNF Patch, SNF/STP and NBU Referral Process
- Mini-Cog™Exam
- Case Manager Recommendation
- Representative Payee Form
- Long Term Care Referral Screening Form
- Long Term Care Referral Screening Form Tip Sheet

The following Long Term Care Forms are available at optumsandiego.com > BHS Provider Resources > Long Term Care > Long Term Care Facilities > ALL:

- Admission Form
- Bed Hold Return
- LTC Administrative Days Request
- LTC Appeal Form

The following Long Term Care Forms are available at optumsandiego.com > BHS Provider Resources > Long Term Care > Long Term Care Facilities > Skilled Nursing Facilities:

- SNF Bed Hold Request
- SNF Patch-NBU Referral Determination
- Skilled Nursing Facilities Concurrent Review Template
- Skilled Nursing Facility Discharge Notification

Initial Authorization for County Funded Skilled Nursing Facilities

Optum Utilization Management (UM) is responsible for providing an initial authorization for clients who meet San Diego County Funded Long-Term Care Criteria for County Funded SNF, SNF Patch, SNF/STP or NBU Patch. After Optum approves a client for admission to one of these levels of care, (see Initial Referral to County Funded Skilled Nursing Facilities section), the admitting SNF is responsible for informing Optum in writing of the date of admission to the County Funded SNF, SNF Patch, SNF/STP or NBU Patch. This is the date that the SNF facility is requesting County funded payment to begin. Please follow these steps:

- The admitting facility shall complete the Admission Form, indicating level of care previously approved by Optum and send to Optum LTC by fax to (888) 687-2515.
- An initial 90-day authorization will be issued, and an authorization letter will be sent to the SNF facility.
- Additional authorizations follow the Continued Stay Authorization for County Funded Skilled Nursing Facilities process outlined in this handbook.

Continued Stay Criteria for County Funded Skilled Nursing Facilities

Concurrent reviews are used to request additional authorization from Optum and shall be submitted prior to the end date of the current authorization time period. Concurrent reviews for continued authorization are due two (2) weeks prior to the expiration of the previous authorization. Subsequent concurrent reviews will be at a frequency based on clinical presentation, no less than thirty (30) days and no more than one hundred and eighty (180) days from the last review, and are dependent on clinical documentation, level of impairment, and progress towards discharge plan.

Provider delay in submitting a concurrent authorization request to Optum UM LTC department, may delay claims payment. Incomplete submission or failure to submit an authorization request, may result in non-payment for the stay in the Long Term Care facility if authorization request is retroactively reviewed and the request is deemed to not meet criteria. Incomplete submissions are not authorized and without authorization, services may not be reimbursed.

To be approved, the authorization request must meet the following criteria for continued stay in a County Funded SNF, SNF Patch, SNF/STP or NBU Patch:

1. The client continues to meet the admission criteria for the current level of care.

2. The client continues to present with symptoms and/or history that demonstrate a significant likelihood of deterioration in functioning/relapse if transitioned to a less intense level of care.

3. The treatment being provided is appropriate and of sufficient intensity to address the client's condition and support the client's movement toward recovery.

4. The treatment plan is accompanied by ongoing documentation that the client's symptoms are being addressed by active interventions. The interventions focus on specific, realistic, achievable treatment and recovery goals that are appropriate to the client's strengths, problems, and situation; and designed to prevent relapse and measure progress toward discharge.

5. Measurable and realistic progress has occurred or there is clear compelling evidence that continued treatment at the current level of care is required to prevent acute deterioration or exacerbation that would then require a higher level of care.

6. The client requires the current level of care in order to move toward recovery.

7. If clinically indicated, there is an appropriate discharge plan to a less restrictive level of care that considers the client's recovery goals and preferences and allows for treatment gains to be maintained/enhanced. Any applicable barriers to potential discharge shall be explored and appropriately addressed.

8. For County Funded SNF, Optum may request with the continued stay authorization request, documentation showing that the responsible Medi-Cal Managed Care Plan re-evaluated client, as clinically indicated or as appropriate, and determined that the client does not meet the Managed Care Plan's SNF Level of Care criteria.

9. The primary focus of treatment for the level of care funded through the County of San Diego, is not a physical health condition that requires skilled nursing care.

And the authorization request must meet at least one of the following clinical criteria:

   a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk of being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.

   b. A lower level of care in which the client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF level of care is unavailable, insufficient, or inadequate.

- Exceptions to criteria may be made by an Optum Medical Director after consultation with San Diego County's Medical Director and applicable County Contracting Officer's Representative.

Continued Stay Authorization for County Funded Skilled Nursing Facilities

Please follow these procedures when requesting a continued stay authorization by submitting a concurrent review prior to the end date of the current authorization time period:

- The SNF is required to request continued stay authorization at least fourteen (14) business days prior to the end of the current authorization. The end date of the current authorization is included on the most recent authorization letter sent to the SNF.

- Review the Continued Stay Criteria for County Funded Skilled Nursing Facilities section for County Funded SNF, SNF Patch, SNF/STP or NBU Patch to assess the patient's appropriateness for continued stay through Optum. Confirm that the client has active San Diego Medi-Cal funding.

If client appears appropriate for continued stay, complete the Skilled Nursing Facilities Concurrent Review Template located at optumsandiego.com and submit to Optum LTC by fax to (888) 687-2515.

- Optum will review the documentation and make an authorization determination within fourteen (14) calendar days of receiving complete information.

- Optum will authorize between thirty (30) days and one hundred and eighty (180) days for continued stay if criteria is met. An authorization letter, with the last day authorized, will be sent to the facility.

- If the authorization request does not meet Optum/County Continued Stay Criteria, Optum will issue a Continued Stay Notice. The Continued Stay Notice will include reasons for denial and how to appeal the denial. The notice will be addressed to the attending psychiatrist treating the client. Optum will verbally notify the SNF and send a Letter of Determination (LOD) to the fax number provided by the SNF.

Bed Hold Days for County Funded SNF, SNF Patch, or NBU Clients

When a client is admitted to a hospital for acute care (either for a psychiatric or physical health reason) the skilled nursing facility shall afford the patient a bed hold of seven (7) days, which may be exercised by the patient or the patient's representative (22 CCR 72520). If Absent without Leave (AWOL) from the SNF, and the SNF anticipates re-admitting the client and is willing to hold the bed for that client, the SNF may consider use of a bed hold. If the SNF does not anticipate re-admitting the AWOL client, the SNF submits a Skilled Nursing Facility Discharge Notification found at optumsandiego.com > Long Term Care Facilities > Skilled Nursing Facilities. Please note: County Funded SNF is the only level of care eligible for reimbursement for the bed hold rate through Optum. Since the Medi-Cal Managed Care Plan (MCP) is the primary payor for the SNF bed day rate for both SNF Patch and NBU Patch, the MCP should be paying for the bed hold day for those clients. For all SNF clients, please notify Optum of the bed hold so that Optum may support the SNF provider and also coordinate with any other community stakeholders as needed.

Optum will approve a bed hold of up to seven (7) days for hospital admission or AWOL. Please note: The only reasons for requesting a bed hold are admission to an acute care hospital or AWOL when the SNF is willing to readmit the client.

Please follow these procedures when requesting or notifying Optum of a bed hold:

- SNF facility notifies Optum Utilization Management in writing when a client becomes AWOL or is admitted to a hospital. Complete the SNF Bed Hold Request Form available at optumsandiego.com and fax the SNF Bed Hold Request Form to Optum LTC at (888) 687-2515. Include details of what led up to the bed hold and the location of the client if hospitalized.

- Optum will review the request and approve a bed hold of up to seven (7) days for a hospital admission or when a client is AWOL.

- If a client is hospitalized and additional time is needed, an extension may be requested by notifying the Optum Medical Director and Optum Long Term Care team and approval may be sought from the County of San Diego. For extension requests, attach the original SNF Bed Hold Request Form and provide updates including where the

client is, treatment being provided, and anticipated return date. If approved, updates shall be provided in 7-day increments.

- If a client returns to the SNF prior to the end of the bed hold, the SNF shall notify Optum of the date the client is re-admitted to the SNF by completing the Bed Hold Return Form available at optumsandiego.com > Long Term Care Facilities > ALL and faxing the form to Optum LTC at (888) 687-2515. This notification is required at the time of the client's re-admission to the SNF.

- If a client does not return to the SNF by the end of the bed hold, the SNF facility is expected to discharge the client (as of the day after the bed hold ends).

- The nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the 7-day bed hold period, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident— (i) Requires the services provided by the facility; and (ii) Is eligible for Medicaid nursing facility services. (42 CFR 483.12(8)(b)(3) Please follow the Discharge from County Funded SNF, SNF Patch, or NBU Patch procedure provided in this handbook.

- For County Funded SNF bed holds: A bed hold authorization will be entered.

- For SNF Patch or NBU Patch bed holds: There will be a gap in the Optum authorization during the bed hold, as no services were provided to the client by the facility during the dates of the bed hold. The Medi-Cal Managed Care Plan (MCP) is the primary payor for the SNF bed day rate for both SNF Patch and NBU Patch; please contact the MCP if applicable for any bed hold day payment.

Discharge from County Funded SNF, SNF Patch, or NBU Patch

The SNF is required to inform Optum in writing at the time of a client's discharge from the SNF if a Patch or County funded Client. This is done by fully completing the Skilled Nursing Facility Discharge Form available at optumsandiego.com > Long Term Care Facilities > Skilled Nursing Facilities and faxing to Optum at (888) 687-2515. Please note: The day of discharge is not a billable day. The SNF is also required to coordinate the discharge with the client's case manager, conservator, legal representative, and/or family as appropriate. The SNF is expected to follow all required State and federal regulations related to discharge.

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Appealing Clinical Determinations

There may be instances when a facility disagrees with a clinical determination made by Optum. In such cases, the facility is encouraged to communicate any concerns or issues regarding clinical decisions directly to Optum. Optum is committed to reviewing and responding to all concerns in an objective and timely manner.

Right to Appeal

Facilities have the right to appeal any denied or modified request for payment authorization. An appeal may be initiated when the attending psychiatrist, conservator, or client disagrees with the determination outlined in the Letter of Determination or the Notice That Criteria for Continued Stay is Not Met.

To initiate an appeal, the facility must submit a written request within seven (7) calendar days of receiving the determination notice.

Appeal Submission Requirements

The appeal must include the following:

- A completed appeal request form (included with the determination letter or notice from Optum)
- Documentation explaining how the client meets the Continued Stay Criteria for County-Funded Skilled Nursing Facility (SNF) services
- Clinical records supporting the existence of medical necessity, if applicable
- A summary outlining the reasons why the services should be authorized

Submission Methods

Submit the appeal form and supporting documentation via one of the following methods:

Mail:
Optum, Quality Improvement
PO Box 601370
San Diego, CA 92160-1370

Fax:
(844) 897-5479

Secure Email:
SDQI@optum.com

Review Process

Once received, Optum will forward the appeal and all supporting documentation to the County of San Diego for review. The County will evaluate the request and issue a determination. Optum will then send the County's determination letter to the requesting facility.

The appeal process typically takes approximately fourteen (14) calendar days from the date Optum receives the appeal.

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Requesting Administrative Days

County-funded Skilled Nursing Facilities (SNFs) that admit clients primarily for psychiatric care may request administrative days when appropriate. Administrative days may be requested when:

- The facility receives a Notice That Criteria for Continued Stay is Not Met, and
- The client meets criteria for a lower level of care, but
- There are placement challenges prior to the end of the current authorization period

Administrative days provide additional time to secure appropriate placement for the client.

How to Submit a Request for Administrative Days

To request administrative days, follow these steps:

1. Complete the Designated Request Form
   The facility or County Case Management Program Manager must submit a written request using the designated form included with the Notice That Criteria for Continued Stay is Not Met.

2. Include Supporting Documentation
   Attach any relevant documentation that supports the need for administrative days.

3. Submit at Least Two (2) Weeks in Advance
   Submit the request no later than two (2) weeks prior to the end of the current authorization period.

4. Send the Request to Optum
   Submit the completed form and supporting documents via one of the following methods:

   Mail:
   Optum, Quality Improvement
   PO Box 601370
   San Diego, CA 92160-1370

   Fax:
   (844) 897-5479

   Secure Email:
   SDQI@optum.com

Review and Determination

- Optum will forward the request and documentation to the County of San Diego for review.
- The County will evaluate the request and render a determination.
- The facility will receive a written outcome from Optum within fourteen (14) calendar days of submission.

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Claims and Billing

Optum, on behalf of the County of San Diego, is responsible for the reimbursement of claims for County Funded Skilled Nursing Facilities (SNF). Please follow the billing procedures described in this section.

Verification of Medi-Cal Eligibility

SNF providers are required to verify Medi-Cal eligibility for each month of service. The state eligibility system is updated on the 1st of each month. Verifying eligibility provides critical information including:

- Medi-Cal coverage type (Aid Code)
- County of Residence (37 to bill San Diego Medi-Cal)
- Other insurance coverage
- Ineligible Aide Code

It is the responsibility of the facility rendering services to verify eligibility by calling the Automated Eligibility Verification System (AEVS) at (800) 456-AEVS (2387) or using the website: medi-cal.ca.gov. Facilities must have a valid PIN/User ID to access AEVS and may call (800) 541-5555 for assistance obtaining a temporary PIN.

Debarment and Exclusions Requirement and Monthly Attestation Letter

SNFs contracted with Optum, on behalf of the County of San Diego Behavioral Health Services, shall not employ anyone listed as an ineligible person by the Office of the Inspector General (OIG). An "Ineligible Person" is an employee who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment, or ineligibility. SNFs are required to confirm on a monthly basis, that employees are not listed as ineligible by checking the following website: exclusions.oig.hhs.gov.

In addition to checking the OIG, SNFs may not employ anyone identified as an “Ineligible Person” by the California Department of Health Services (CDHS) in providing care or services through this contract. Any employee(s) of the SNF who is determined to be an “Ineligible Person” cannot care for or be involved with clients whose services are paid for by the County of San Diego. An "Ineligible Person" in this scenario is an individual who has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. SNFs are required to verify on a monthly basis, the eligibility of staff working with County of San Diego clients by checking the following website: medi-cal.ca.gov (search under "Medi-Cal Suspended and Ineligible List").

By the last day of each month, the SNF is required to submit a signed attestation that none of its employees are listed as an “Ineligible Person” on the OIG and the Medi-Cal websites listed above. After confirming the eligibility of employees, the SNF is required to sign the Debarment and Exclusion Attestation Form and fax it to Optum Provider Services at (877) 309 - 4862. Optum Claims staff is able to adjudicate claims very quickly; however, claims payment will be held until the signed Debarment and Exclusion Attestation Form is received by Optum Provider Services. The required Debarment and Exclusion Attestation Form is provided with the contract.

Submitting Claims for County Funded Skilled Nursing Facilities

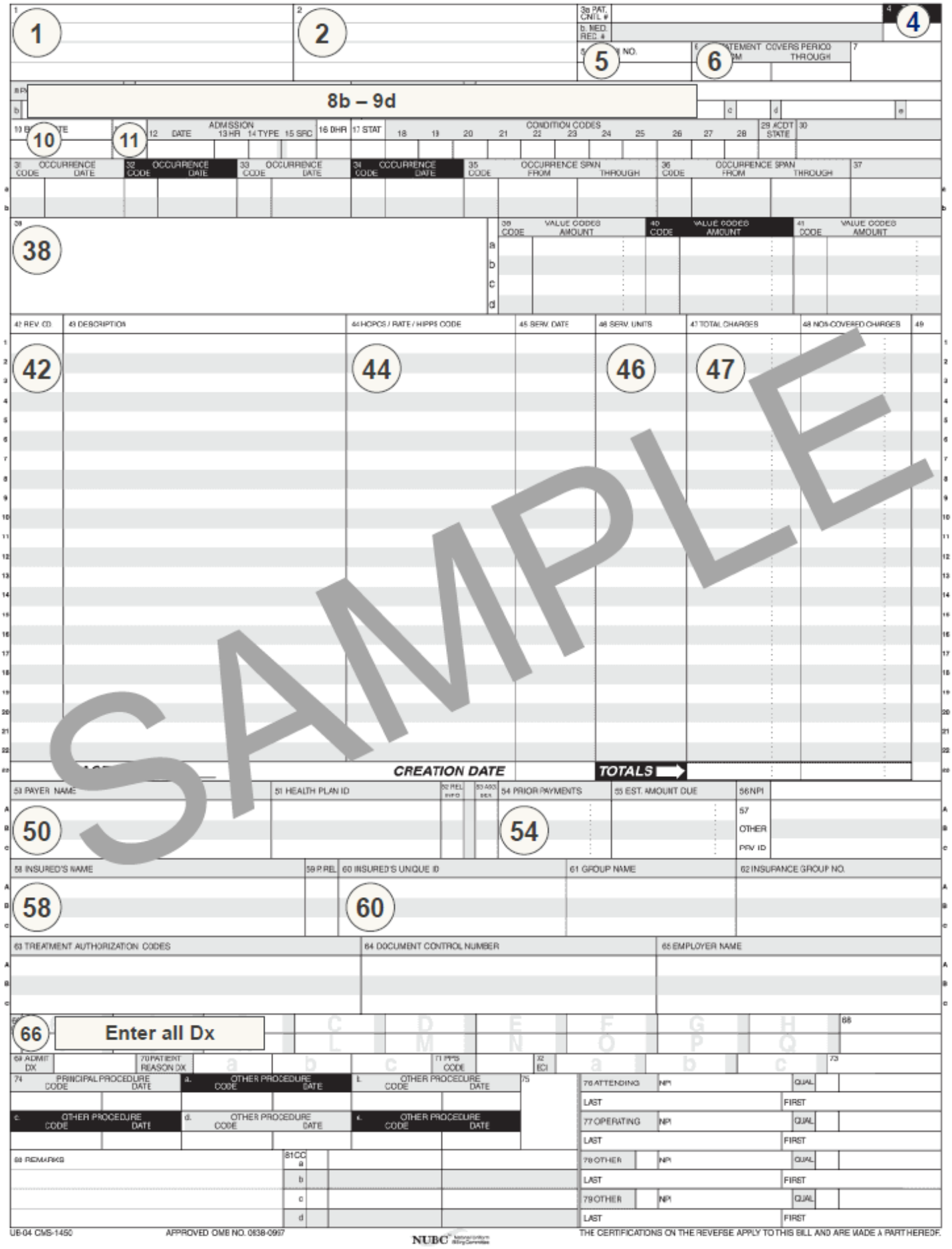
Claims submission procedure:

1. All claims must be submitted within 120 days from the month of service.
2. All claims must be submitted using an original UB-04 form.
3. The following data elements must be included on the UB-04 form. Claims submitted without these data elements will be denied.

Box #	Field Name	Instructions
1	Facility Information	Enter the facility name, address, telephone and county, zip code.
2	Pay-to Name and Address	Enter the Pay-to Name and address of provider submitting the bill.
4	Type of Bill	Enter the type of bill for the purposes of third-party processing of the claim such as inpatient of outpatient.
5	Federal Tax Number	Enter the Tax Identification Number (TIN) or the Employer Identification Number (EIN). This number is assigned by the federal government for tax reporting purposes.
6	Statement Covers Period	Enter the beginning and end dates of service for the period reflected on the claim MMDDYY.
8b	Patient Name	Enter the patient's last name, middle initial, and first name.
9a	Patient Address	Enter the patient's street address, or P.O. Box or RFD, city, state, ZIP code.
9b	City Address	Enter the patient's city.
9c	State	Enter the patient's State code.
9d	ZIP Code	Enter the patient's ZIP code.
10	Patient Birth Date	Enter the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Patient Sex	Enter the sex of the client. Enter M for male or F for female.
38	Responsible Party Information	Enter the name and address of the person responsible for the bill.
42	Revenue Code	Enter the applicable numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/ancillary service as outlined in the SNF contract Exhibit B rate schedule.
44	HCPCS/ Rate/ HIPPS Code	Enter the appropriate HCPCS codes for ancillary service, the accommodation rate for bills for inpatient services, or SNF HIPPS (Health Insurance Prospective Payment Systems) rate codes for specific patient groups that are the basis for payment under a prospective payment system.
46	Service Units	Enter the number of inpatient SNF days are reported.
47	Total Charges	Enter the total charges covered and non-covered related to the current billing period.
50	Client Contribution	Enter "Client Contribution" if payments are received from the client or from a third party on the client's behalf for services billable to County of San Diego.
54	Amount of Client Contribution	Report total payments received from the client or from a third party on the client's behalf for services billable to County of San Diego for the applicable billing period.
58	Insured's Name	Enter the name (last, first name, middle initial) of the individual who carries the insurance benefits. This must match the name of the insured's BIC Number.
60	Insured's Unique ID	Enter the unique number that Medi-Cal assigns the client to insure the individual Medi-Cal Benefits Identification Card (BIC).
66	Diagnosis Code	Enter the ICD-10 CM code. All diagnosis billed based on UB-04 must be entered.

Facilities are required to mail County of San Diego Funded SNF claims to the following address:

Optum Public Sector San Diego/ SNF
P.O. Box 601340
San Diego, CA 92160-1340



Reporting Client Contributions

Client contributions include any payments received from the client or from a third party on the client's behalf for services billable to the County of San Diego. These contributions must be reported on the claim form for the applicable billing period. Optum will deduct reported contributions from the claim payment on behalf of the County of San Diego. Failure to report contributions may result in payment adjustments or recoupments.

Claims Processing Procedures

All claims must be submitted within 120 days from the month of service. Clean claims will be processed within thirty (30) days from the receipt of the claim. Processing means paid or denied. All payments will be made based on the approved fee schedule in effect at the time service is delivered.

Overpayment

Overpayments may be offset against future claims payments. In such cases, the facility will be notified of the action and given thirty (30) days to appeal. Appeals should be submitted as described in the Appealing Clinical Determinations section of this handbook.

If a facility chooses to return excess funds by check, the check must be made payable to "County of San Diego" and mailed to Optum Public Sector San Diego/ Claims Department for processing at the address below:

Optum Public Sector San Diego/ SNF Claims/Refunds
Attn: Claims Manager
P.O. Box 601340
San Diego, CA 92160-1340

How to Submit Billing Inquiries

Facilities may submit specific questions regarding claims to Optum by phone or fax.

Facilities may call (800) 798-2254, Option 2 for all claims related inquiries. Facilities may also submit questions by fax to (619) 641-6975. Written inquiries may be sent to:

Optum Public Sector San Diego/ SNF Claims Services
P.O. Box 601340
San Diego, CA 92160-1340

Claims Problem Resolution and Appeals

In the event of a denied claim, a facility may appeal the decision by contacting the Claims Provider Service Representative at (800) 798-2254, Option 2. The Senior Claims Examiner will contact the SNF to resolve the appeal informally. The SNF provider may be asked to submit written documentation justifying the request to overturn the denial. Should the outcome of the informal problem resolution process result in a decision that the facility feels is not satisfactory, the facility may submit a formal claims appeal, in writing, with supporting documentation to:

Optum Public Sector San Diego Attn: Claims Provider Services
P.O. Box 601340
San Diego, CA 92160-1340

Acknowledgment of written appeals will be mailed to the facility within two (2) business days of receipt. Supporting documentation must include the client's name, Medi-Cal BIC Number, date(s) of service and authorization number with supporting documentation available. A written response will be sent to the facility within thirty (30) days of receipt of the claims appeal.

Ethical, Legal and Billing Issues Hotline

The County of San Diego has created a hotline to report concerns about a variety of ethical, legal, and billing issues. The confidential hotline is toll-free and available 24-hours per day, seven (7) days per week. Callers may remain anonymous if they wish. Providers are encouraged to contact the hotline with any concerns regarding misconduct, fraud, or abuse. The number of the County of San Diego's Mental Health Plan Compliance Hotline is (866) 549-0004.

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Critical Incident Reporting (CIR)

Critical Incident Reporting (CIR) Overview

SNF providers are required to report incidents that pose potential risk or exposure to clients, staff, or the community. These incidents are categorized as either Critical or Non-Critical:

Reporting Requirements

- Critical Incidents: Must be reported to the BHS Quality Assurance (QA) Unit within twenty-four (24) hours of awareness. Submit CIR Form via secure email to qimatters.hhsa@sdcounty.ca.gov or fax to 619-236-1953.
- Non-Critical Incidents: Submit via the online NON-CRITICAL INCIDENT REPORT (NON-CIR), which routes directly to the program's Contracting Officer Representative (COR) and is reviewed by BHS QA Unit.

Who Must Report

All providers are required to report critical incidents involving:

- Clients in active treatment
- Clients discharged within the past thirty (30) days

Providers are also responsible for notifying appropriate external authorities when necessary.

Definition of Critical Incident

A Critical Incident involves serious health, safety, or risk concerns, including but not limited to:

- Client Deaths: Pending, Natural, Overdose, Suicide, Homicide
- Suicide Attempts
- Non-Fatal Overdoses
- Medication Errors causing severe harm
- Staff Misconduct: Abuse, exploitation, boundary violations
- Client Assaults resulting in hospitalization
- Critical Injuries related to MH/SUD symptoms
- Adverse Media/Social Media Events

Deaths due to natural causes off-site do not require a CIR but must be logged for BHS QA Unit review. On-site natural deaths do require a CIR.

Supplemental Requirements

- Overdose Incidents: Clients must be offered a referral to Medication Assisted Treatment (MAT).
- BHS QA Review: BHS QA Unit will investigate, monitor trends, and may request corrective action plans.
- Resources: CIR form and MAT provider directory are available at optumsandiego.com under the Incident Reporting tab.

Critical Incident Reporting Procedures

1. All providers/facilities must report critical incidents involving beneficiaries in active treatment or discharged within the past **thirty (30) days**.

2. Submit Critical Incident Reports to BHS QA Unit within **twenty-four (24) hours** of incident notification.

3. Per SB 425, healthcare entities must report allegations of sexual misconduct by providers to the appropriate licensing board within **fifteen (15) days**.

4. Tarasoff incidents are classified as Non-Critical and submitted via the online form. ROF is only required if systemic or treatment issues are identified.

5. Do not file CIRs within the beneficiary's medical record. Maintain in a separate, secure, confidential file.

6. Completed suicides or alleged beneficiary homicides require BHS QA Unit chart review and a Root Cause Analysis (RCA) within **thirty (30) days**.

Clinical Case Reviews

- Directed by the BHS Clinical Director, reviews focus on completed suicides, homicides, and complex clinical issues to identify systemic trends and improve quality of care.

- Programs must comply with medical record requests for case conferences.

- Stakeholders (e.g., BHS Director, CORs, BHS QA staff) may request reviews at any time. Coordinate requests through the BHS QA Unit via QIMatters.hhsa@sdcounty.ca.gov .

General Administration Policies and Procedures

Root Cause Analysis (RCA) Worksheet Usage:

San Diego County contracted programs may use the Critical Incident RCA Worksheet or an alternative process approved by their Legal Entity (LE). Programs opting for an alternative must ensure it incorporates best practices for analyzing findings. Technical assistance is available via QIMatters.hhsa@sdcounty.ca.gov. RCA training is offered quarterly.

Critical Incident Reporting on Weekends and Holidays:

Legal Entity behavioral health programs must report Critical Incidents to the BHS QA Unit and designated County staff on weekends and holidays. This requirement does not apply to Non-Critical Incidents.

Reporting Procedure:

1. Notify BHS QI Matters as soon as possible upon awareness of the incident.

2. Each LE must designate 1–3 senior staff as contacts for weekend/holiday reporting. These contacts will report incidents to County Designated Staff via phone or voicemail.

3. Program staff must report incidents only to their LE designated staff, not directly to County staff.

4. Reporting hours are 8:00am–8:00pm. Incidents outside these hours should be reported the next day during reporting hours.

5. Weekend coverage includes Saturday and Sunday; holiday coverage includes designated County holidays.

6. County Designated Staff (in priority order):

    a. Adult SOC Assistant Deputy Director – A/OA Providers

b. CYF SOC Assistant Deputy Director – CYF Providers

c. BHS Director (third backup)

Non-Critical Incident Reporting

Non-Critical Incidents must be reported via an online submission form to the COR/Program Manager and BHS QA within twenty-four (24) hours of incident awareness. These incidents indicate potential risk but do not meet the criteria for Critical Incidents. Previously classified as 'Unusual Occurrences' or 'Serious Incident Report Level 2'.

Non-Critical Incidents are reported via and online submission form that can be found NON-CRITICAL INCIDENT REPORT (NON-CIR) and on optumsandiego.com > SMHS & DMC-ODS Health Plans Page > “Incident Reporting” tab

Please review the Non-Critical Incident Reporting FAQ and Tip Sheet posted on Optum for additional information for submission of Non-Critical Incidents and completion of the form.

Do not include Protected Health Information (PHI) in the submission. If PHI is shared, a Privacy Incident Report (PIR) must be completed.

Examples of Non-Critical Incidents:

- AWOL
- Staff contract/policy violations
- Medication loss/theft
- Physical restraints (prone/supine)
- Tarasoff reporting
- Non-critical onsite injuries
- Adverse police/PERT involvement
- Property destruction
- Other adverse deviations

Key Considerations:

1. All providers/facilities must report incidents involving beneficiaries in active treatment or discharged within thirty (30) days.
2. Submit the online form within twenty-four (24) hours via the optumsandiego.com > SMHS & DMC-ODS Health Plans > Incident Reporting tab.
3. Complete the form fully and accurately.
4. Do not include PHI (e.g., names, EHR numbers).
5. Ensure correct COR email spelling; incorrect submissions will not be accepted.
6. Refer to the Non-Critical Incident Reporting FAQ and Tip Sheet for guidance.
7. BHS QA or COR may request a Report of Findings (ROF) for any Non-Critical Incident.
8. Incidents involving police/PERT (e.g., arrests, restraints) require an N-CIR report.
9. Physical restraints are reported only during program hours (CYF mental health beneficiaries only).
10. Non-Critical injuries require medical treatment beyond first aid and occur onsite.

11. Epidemics, infectious disease outbreaks, and poisoning are reported under 'Other'.

Safety and Security Notifications

Appropriate agencies must be notified of Non-Critical Incidents within their specified timelines and formats.

Regulatory Reporting Obligations:

Provider/Facility shall comply with all applicable federal, state, and local laws and regulations regarding the reporting of Critical Incidents to relevant governmental, licensing, and oversight bodies, including but not limited to the California Department of Public Health, Department of Social Services, Department of Developmental Services, and applicable Regional Centers.

Provision of Reports:

To the extent permitted by applicable law, Provider/Facility shall provide Optum/County with copies of any incident reports submitted to governmental or licensing authorities in connection with a Critical Incident. Such reports shall be transmitted securely and in accordance with applicable privacy laws, including HIPAA, and Optum's/County's data protection protocols.

Cooperation with Quality Assurance Activities:

Provider/Facility shall cooperate with Optum/County in any follow-up inquiries related to a Critical Incident. This includes, but is not limited to, providing additional documentation, participating in Root Cause Analyses (RCA), developing and implementing Corrective Action Plans (CAP), and engaging in other quality assurance activities reasonably requested by Optum.

Confidentiality and Use of Information:

All information provided to Optum/County pursuant to this Agreement shall be treated as confidential and used solely for the purposes of quality assurance, compliance monitoring, and Beneficiary safety. Optum/County shall maintain such information in accordance with applicable privacy laws and contractual obligations.

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Complaints about Administrative and Contract Issues

Complaints about Optum administrative procedures, referral authorizations, forms, response, or lack of response by an Optum employee, as well as other general questions and concerns about policies and procedures, can be discussed with any Optum staff person with whom the provider comes in contact. Optum documents the content of the complaint and is obligated to come to a resolution within thirty (30) days of receiving the complaint. The participation of providers in this process is viewed as a reflection of the providers' genuine commitment to improve the quality of care and service.

Providers are protected from any form of retaliation because of filing a complaint. Optum tracks and trends the data gathered from complaints and appeals and uses this information to focus quality improvement initiatives.

Providers may present complaints, issues, or concerns to Optum by contacting the Provider Line at (800) 798-2254, Option 7, or by calling the County Mental Health Plan QI Department at (619) 563-2713.

Optum

optum.com