



**TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY**

**Donna Ortiz
Agency Director**

Dr. Natalie Bolin, DSW, LCSW • Director • Behavioral Health Branch

November 20, 2024

COUNTY
ADDRESS
CITY, STATE, ZIP

Re: Letter of Agreement for Specialty Mental Health Services (SMHS) for out of county youth placed at a Short Term Residential Treatment Program (STRTP)

This letter serves as a one-time authorization between Tulare County Behavioral Health (TCBH) ("PAYER") and COUNTY ("PROVIDER"), to provide services for CLIENT NAME ("CLIENT"). Services under this agreement may be provided by the PROVIDER and/or a contracted provider who contracts directly with the PROVIDER.

Terms of Agreement

This agreement authorizes medically necessary Specialty Mental Health Services (SMHS). The terms of the agreement shall be from _____ to _____, not to exceed _____ under the rate terms for the authorized period. Recommendations for continued treatment and/or higher level of care treatment will be requested by the PROVIDER to TCBH for renewal and/or authorization.

Rate Terms

Services are to be provided by COUNTY :

- County Tax ID:
- Rate: TCBH will pay PROVIDER the Federal Financial Participation (FFP) match according to provider rates established by the Department of Health Care Services (DHCS) (attached).
- County NPI:
- Location:

If psychiatric services are to be provided by the County Mental Health Plan and not the STRTP, complete below section. If the STRTP provides their own psychiatric services, mark section below as "N/A".

- Tax ID:
- Rate:
- Provider NPI:
- Location:

Client Information

Name:

DOB:

Address:

Medi-Cal:

Phone:

Parent or Guardian Name:

STRTP Information

STRTP Name:

Address:

Phone:

Fax:

Email:

Claim Practices

PROVIDER shall submit claims via to TCBH Quality Improvement.

- Mailing Address: 5957 S Mooney Blvd, Visalia CA 93277
- HIPAA Compliant Fax: (559) 749-9802
- HIPAA Compliant Email to QIManagedCare@tularecounty.ca.gov

To provide timely payment of services, it is requested that services be billed to TCBH within 30 days of receipt of the corresponding 835 form from DHCS.

PROVIDER agrees in no event, to bill, charge, collect a deposit, no-show fee, or reimbursement from the CLIENT or have any recourse against a CLIENT, or person acting on CLIENT's behalf, for services provided pursuant to this Agreement. PROVIDER will not receive payment for CLIENT no show or denied claims. Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, federal and state billing and payment rules.

PROVIDER shall submit claims on attached spreadsheet and submit via mail or a HIPAA compliant fax or email. PROVIDER can verify the receipt and status of claim calling 559-624-7445.

Coordination of Care

PROVIDER will work with TCBH for coordination and continuity of care. If PROVIDER feels that CLIENT requires treatment in addition to authorized treatment described in this agreement, PROVIDER will notify TCBH of recommended treatment and additional service recommendations. TCBH will review the request and decide.

Authorization Renewal

If PROVIDER believes it is medically necessary for CLIENT to obtain services beyond those described or beyond the dates of service authorized in this Agreement, PROVIDER must obtain an additional authorization from TCBH to be eligible to receive reimbursement. It is encouraged that PROVIDER submit requests 30 days prior to end of authorization to avoid disruption in CLIENT treatment. PROVIDER will not receive payment for additional services outside of this authorization until authorization renewal is approved.

Utilization Review

PROVIDER agrees to cooperate with TCBH medical director, utilization review staff and other representatives of TCBH by timely and comprehensively responding to TCBH requests for review and validation of service delivery and to assure compliance with applicable state or federal laws, rules, and regulations and Medi-Cal documentation standards. All documentation should have the name of CLIENT, duration of session, CPT code, and location of service, along with any other documentation standard such as a wet signature or electronic signature of CLIENT. Payment can be denied if medical necessity is not established, or validation of service delivery is not present in documentation. PROVIDER is responsible for ongoing oversight and monitoring of the STRTP including ensuring STRTP staff are properly credentialed per Behavioral Health Information Notice (BHIN) 18-019.

Termination of Treatment

PROVIDER shall notify TCBH, prior to the discharge of CLIENT and shall allow designated TCBH staff to attend any discharge or treatment meetings regarding CLIENT served under this Agreement. It is encouraged that PROVIDER will collaborate with TCBH to ensure safe discharge.

Confidentiality

Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential.

Attachments

Provide DHCS SMHS Rates
AB1051 Invoice Spreadsheet

Tulare County Behavioral Health

Signature: _____

Name: _____

Title: Director, Behavioral Health

Date: _____

COUNTY

Signature: _____

Name: _____

Title: _____

Date: _____

NPI: _____