On Behalf of

San Bernardino County- Department of Behavioral Health

Concurrent Psychiatric Inpatient Utilization Review Provider Manual

PREPARED BY

Telligen®
HEALTHCARE INTELLIGENCE

1776 West Lakes Parkway
West Des Moines, IA 50266

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Introduction

Welcome to the Telligen, Inc. on behalf of San Bernardino County Department of Behavioral Health Concurrent Psychiatric Inpatient Utilization Review Provider Manual. This manual serves as a resource for providers delivering acute psychiatric inpatient services to Medi-Cal members and eligible indigent members within San Bernardino County.

San Bernardino County DBH contracts with Telligen to conduct concurrent utilization review and authorization services for psychiatric inpatient hospitalizations. Telligen's role is to ensure that inpatient services are medically necessary, clinically appropriate, and provided at the most appropriate level of care in accordance with applicable federal and state requirements, including California Department of Health Care Services (DHCS) Behavioral Health Information Notices (BHINs) and Medi-Cal regulations.

This manual outlines provider responsibilities, authorization requirements, medical necessity standards, documentation expectations, review processes, administrative day requirements, and appeal procedures. It is intended to support consistent communication between providers, DBH, and Telligen while promoting timely authorization decisions, continuity of care, and successful transitions to lower levels of care when clinically appropriate.

By partnering with providers throughout the review process, Telligen helps support quality behavioral health services, regulatory compliance, and effective utilization of resources for the members served by San Bernardino County.

For questions regarding utilization review processes, authorization requests, or this manual, providers may contact Telligen at **SBPsychReviews@Telligen.com** or **1-833-476-4850**.

Telligen is a trusted partner of U.S. government health agencies, state Medicaid agencies, self-fund employer and Taft-Hardy health plans, and managed care organizations, improving outcomes for millions of people nationwide through proven health management solutions and healthcare expertise.

Section 1: About Telligen

The purpose of Telligen's Utilization and Quality Management Program is to ensure that healthcare services provided to San Bernardino County members are medically necessary, of high quality, and delivered in compliance with applicable state and federal regulations, statutes, and policies.

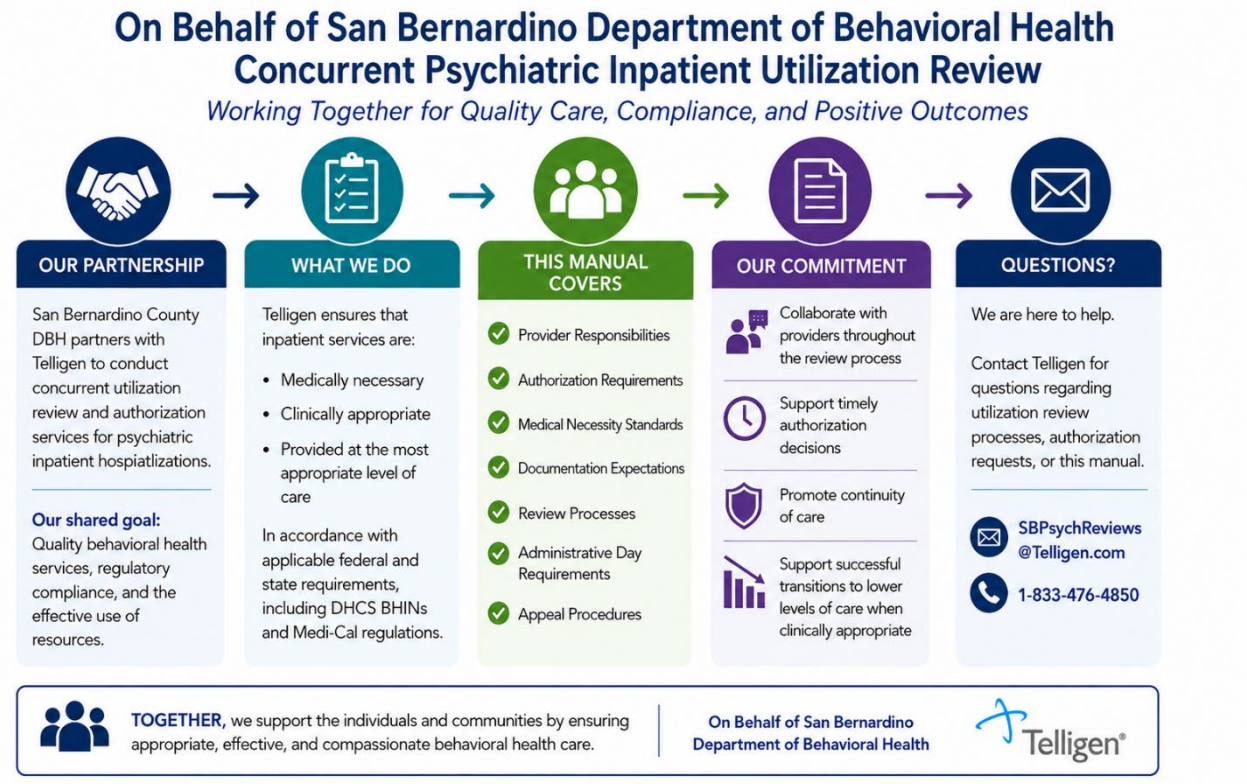


Figure 1

Corporate Background and Experience

As a Medicaid Utilization Management (UM) and Medicare Quality Improvement Organization (QIO) contractor for over 50 years, Telligen has developed contract specific UM plans for all elements of utilization review including admission, quality, invasive procedure, length of stay, outliers, coverage, discharge review and Diagnosis Related Group (DRG) validation. As a Utilization Review Accreditation Commission (URAC) accredited organization, we have corporate policies and procedures for Utilization Management that we will use as the foundation for the San Bernardino County Medi-Cal contract.

Utilization Management

Telligen's Utilization Management professionals evaluate appropriateness of services to ensure members receive the right care, in the right place, at the right time and in the right setting. We have programs covering inpatient, outpatient and specialty services using state-specific criteria and automated reviews processes across our state contracts.

Mission

Telligen is on a mission to transform lives and economies. Our employee-owners are committed to finding innovative solutions to make a difference in the lives of people and in the world of healthcare.

Vision

Telligen will be the company that fixes what ails the healthcare system in the United States.

Core Values

- Ownership
- Integrity

- Ingenuity
- Community

Section 2: Telligen's QIO Organization Chart

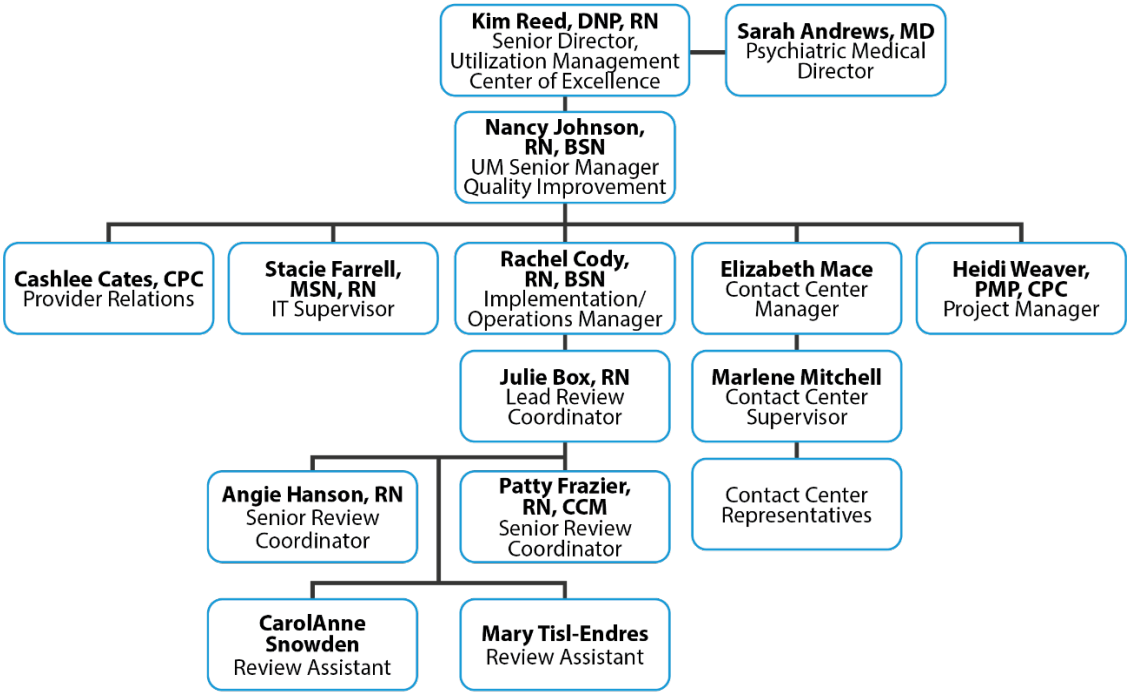


Figure 2

Team Positions for Concurrent Utilization Review Services

UM Position	Responsibilities	Qualifications
Senior Review Coordinator/Review Coordinator	• Performs concurrent, retrospective or continued stay utilization review based on contract, state, and URAC requirements. Screens individual cases according to specific criteria to determine if care is appropriate. • Refers cases that fail to meet criteria to peer review.	• An active Licensed Registered Nurse (RN), a licensed Master's Level Social Worker (LCSW, LMSW, LPC, LMFT) or a Psychologist licensed in the state of California or willing to obtain licensure upon hire. • 3+ years of Behavioral Health experience. • 3+ years post-degree clinical experience in direct patient care. • Strongly prefer (but not required), 2+ years of UM experience,

		performing medical necessity reviews against criteria such as MCG, ASAM, InterQual.
Review Assistant	• Interprets review guidelines to facilitate forward movement of the case review process including requests for clinical information, treatment plans, discharge dates and communicating the authorization for requested services. • Coordinates, distributes and tracks highly confidential medical information from	• High school diploma or equivalent; 2 years of experience working in a customer service or healthcare environment. • Demonstrated ability working with confidential information and in a deadline driven environment. • Excellent verbal and written communication skills and intermediate PC skills.

	multiple sources (fax, web, and phone). Interprets and adheres to URAC standards for assigned programs as well as federal and state requirements. • Ensure quality customer service by responding to phone inquiries from members, physicians, and providers. Prioritizes workload to meet program or regulatory time frames. • Provides verbal and written communications of review decisions to include administrative denials. Completes	• Positions working on specific contracts may require U.S. Citizenship. • Experience in a health care environment preferred. • Satisfactory completion of medical terminology course preferred. • Intermediate PC functions preferred.

	service/treatment screens for accurate transmission of outcome decision. • Provides general office support and performs miscellaneous duties as assigned.	
Provider Relations Representative	• Delivers training to providers and/or Qualitrac users. • Updates website information.	
Medical Director	• Conducts detailed peer reviews and peer-to-peer consultations. • Manages medical review activities to ensure adherence to healthcare regulations and standards.	

Acronyms

Acronym	Definition
BHIN	Behavioral Health Information Notice
BHP	Behavioral Health Plan
DBH	Department of Behavioral Health
DHCS	Department of Health Care Services
IMD	Institution for Mental Disease
LPHA	Licensed Practitioner of the Healing Arts
NOABD	Notice of Adverse Benefit Determination
PHF	Psychiatric Health Facility
SMHS	Specialty Mental Health Services
TAR	Treatment Authorization Request
UM	Utilization Management
UR	Utilization Review

Figure 4

Definitions

Acute Psychiatric Inpatient Services

Specialty Mental Health Services provided in a licensed hospital or psychiatric health facility for members who require 24-hour psychiatric assessment, treatment, monitoring, and intervention due to a mental health condition that cannot be safely managed at a lower level of care.

Administrative Day

A level of care used when a member no longer meets medical necessity criteria for acute psychiatric inpatient hospitalization but remains hospitalized while awaiting placement in an appropriate lower level of care.

Administrative Denial/Rejection

A denial of services based on reasons other than lack of medical necessity.

Appeal Request

A formal request submitted by a provider or member to reconsider a denied authorization or service determination.

Authorization

The determination that a requested service meets applicable medical necessity and coverage requirements and is approved for reimbursement.

Behavioral Health Information Notice (BHIN)

Communications issued by DHCS to provide guidance regarding Behavioral Health policies, procedures, and requirements.

Member

An individual receiving services under the Medi-Cal program or other covered Behavioral Health programs.

Care Coordination

The deliberate organization of member care activities and communication among providers and support systems to improve outcomes and continuity of care.

Clinical Peer Reviewer

A qualified licensed clinician designated by Telligen to review cases requiring additional clinical review and determination.

Clinical Review Criteria

Written criteria, guidelines, protocols, and decision-support tools used to determine medical necessity and appropriateness of services.

Concurrent Review

The evaluation of ongoing inpatient psychiatric services during a member's hospitalization to determine continued medical necessity.

Denial or non-certification

A determination that requested services do not meet medical necessity, appropriateness, effectiveness, or coverage requirements.

Discharge Planning

The process of preparing a member for a safe transition from inpatient care to an appropriate lower level of care.

Licensed Practitioner of the Healing Arts (LPHA)

A licensed professional authorized to provide Behavioral Health services within the scope of their professional license.

Medical Director

A licensed physician responsible for clinical oversight of utilization management, quality management, credentialing, and other clinical functions.

Behavioral Health Plan (BHP)

The county-operated mental health system is responsible for providing or arranging specialty mental health services for Medi-Cal members.

Medical Necessity

The determination that a service is reasonable, necessary, and appropriate to diagnose, prevent, or treat a mental health condition and meets applicable state and federal requirements.

Outcome Determination

The formal decision issued by Telligen regarding an authorization request, including approvals, modified approvals, administrative denials, or adverse determinations

Peer-to-Peer Review

A clinical discussion between a treating provider and a Telligen reviewing clinician regarding an authorization determination.

Provider

A physician, facility, hospital, psychiatric health facility, or other licensed healthcare professional or organization providing healthcare services.

Retrospective Review

A review conducted after services have been delivered to determine medical necessity, appropriateness, and compliance with coverage requirements.

Treatment Authorization Request (TAR)

The standardized authorization request used to obtain approval for covered inpatient psychiatric services.

Utilization Management (UM)

The process of evaluating medical necessity, appropriateness, efficiency, and quality of healthcare services through prospective, concurrent, and retrospective review.

Utilization Review (UR)

Activities performed to assess the necessity, appropriateness, and efficiency of healthcare services and compliance with regulatory requirements.

Section 3: Program Overview

Purpose

The San Bernardino County Department of Behavioral Health (DBH) contracts with Telligen to perform concurrent utilization review services for acute psychiatric inpatient hospitalizations provided to Medi-Cal members and eligible indigent individuals.
The purpose of the utilization review program is to ensure that members receive medically necessary, clinically appropriate services at the appropriate level of care while promoting quality outcomes, continuity of care, and compliance with state and federal requirements.



Figure 5

Program Goals

The Utilization Review program is designed to:

- Ensure services meet medical necessity requirements.
- Promote delivery of care at the least restrictive appropriate level of care.
- Support timely access to medically necessary treatment.
- Promote compliance with applicable Medi-Cal regulations.
- Ensure consistent application of authorization criteria.
- Support appropriate stewardship of Behavioral Health resources.

Scope of Review

Telligen conducts concurrent review activities for:

- Initial inpatient psychiatric hospitalization authorizations.
- Continued Stay Authorizations.
- Administrative Day Authorizations.
- Retrospective authorization reviews when applicable.
- Clinical consultations and peer reviews.
- Reconsiderations and Appeals.

Authority and Regulatory Requirements

The utilization review program operates in accordance with applicable federal and state laws, regulations, and guidance, including but not limited to:

- California Welfare and Institutions Code Section 14059.5
- California Code of Regulations, Title 9
- DHCS Behavioral Health Information Notice (BHIN) 22-017
- DHCS Behavioral Health Information Notice (BHIN) 26-001
- HIPAA Privacy and Security Rules
- Medi-Cal Specialty Mental Health Services requirements
- Applicable San Bernardino County DBH policies and procedures

Providers are responsible for complying with all applicable regulatory requirements governing inpatient psychiatric services.

Section 4: Telligen Review Process Overview

Review Screen Criteria: Telligen Multi-Tiered Review Process

Tier 1: Initial Review

Telligen Review Coordinators evaluate submitted clinical documentation to verify that authorization requests meet current guidelines. Coordinators evaluate the provider's notes and medical records against established criteria to determine if the requested care is appropriate.

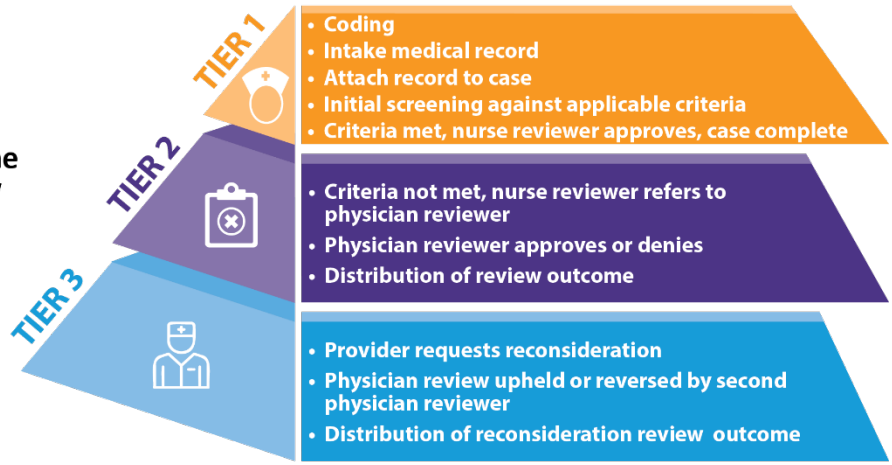
- **Requests for Additional Information:** If documentation is insufficient, a Request for Information (RFI) task is assigned to the provider. Providers have two calendar days to respond before an Administrative/ Technical Denial triggered by the Qualitrac Portal. Closed cases in Technical Denial status require a new Continued Stay Request for further authorization.
- **Resuming Review:** Once additional documentation or information is received, the review is completed within one business day. Telligen' team is available via phone or email to assist providers with documentation requirements.

Tier 2: Physician Review: If Tier 2 criteria are unmet, the nurse reviewer escalates the case to a physician for a final determination. Once approved or denied, the system attaches the outcome letter and emails the requestor to view it in the portal.

Tier 3: Reconsideration Review: In Tier 3, providers may request a reconsideration via peer-to-peer consultation or a first-level appeal. Once a physician renders a decision to overturn or uphold the denial, the system generates an outcome letter and emails the requestor to view it in the portal.

Figure 6

- **Initial nurse screening and review (Tier 1).**
- **Nurse reviewer sends the case to physician review (Tier 2).**
- **Following a physician reviewer denial, a provider requests a reconsideration or appeal review (Tier 3).**



Utilization Review Procedures

Telligen conducts Utilization Review activities to ensure that services provided to San Bernardino County members are medically necessary, appropriate, timely, and delivered at the appropriate level of care. Reviews are performed in accordance with applicable federal and state regulations, contractual requirements, and County policies.

Cases subject to Utilization Review are determined by the scope of the County's Utilization Management program and may include inpatient psychiatric admissions, continued stays, administrative days, and other services identified in the contract.

Medically Necessary

- Pursuant to Welfare and Institutions Code section 14184.402(a):
    - For members 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

- For members under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and better mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to better a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to better the mental health condition and are covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Review Methodology

Telligen Clinical Reviewers utilize the Qualitrac Utilization Management system to perform medical necessity reviews and document review determinations. Qualitrac incorporates evidence-based clinical criteria and review logic designed to support consistent and objective medical necessity determinations. The system assists reviewers in evaluating the appropriateness of the requested level of care, clinical indications for treatment, and the continued need for services.

Each request is assessed against the applicable clinical criteria, regulatory requirements, and supporting clinical documentation. When the submitted clinical information does not support the requested level of care or service, the case is referred for additional review in accordance with established utilization management procedures and physician review requirements.

Section 5: Medical Necessity Requirements for Inpatient Psychiatric Services

Telligen determines medical necessity for inpatient Specialty Mental Health Services (SMHS) in accordance with California Welfare and Institutions Code Section 14059.5

and applicable Department of Health Care Services Behavioral Health Information Notices (BHINs).

Initial Inpatient Psychiatric Admission

Inpatient psychiatric hospitalization is considered medically necessary when both of the following conditions are met:

1. The member cannot be safely treated at a lower level of care. A member who can be safely treated in a crisis residential treatment program for an acute psychiatric episode is considered to have met this requirement.
2. The member requires inpatient psychiatric services due to a diagnosed or suspected mental disorder and meets one or more of the following conditions:
    - Represents a current danger to self or others, or poses a risk of significant property destruction;
    - Is unable to provide for or utilize food, clothing, shelter, personal safety, or necessary medical care;
    - Presents a severe risk to physical health due to psychiatric symptoms;
    - Has experienced a recent and signification deterioration in functioning or
    - Requires inpatient hospitalization for psychiatric evaluation, medication management, or other treatment that can be reasonably be provided only in an inpatient setting.

Continued Stay Reviews

Continued inpatient psychiatric services are considered medically necessary when one or more of the following conditions exist:

1. The member continues to meet medical necessity criteria for inpatient psychiatric hospitalization.
2. The member experiences a serious adverse reaction to medications, procedures, or therapies that require continued inpatient monitoring and treatment.

3. New clinical findings or circumstances arise that independently establish medical necessity for inpatient psychiatric care.
4. The member requires ongoing medical evaluation or treatment that can only be safely and effectively provided in a hospital or psychiatric health facility.

Continued stay reviews are conducted in accordance with applicable concurrent review authorization requirements and guidance issued by the California Department of Health Care Services, including BHIN 22-017, BHIN 26-001, and any superseding guidance.

Section 6: Admission Notification and Initial Authorization Requests (Concurrent Request)

Required Documentation

Providers must submit all required documentation with each authorization request to support a timely utilization review. Complete submissions facilitate efficient processing and help prevent delays resulting from requests for additional information.

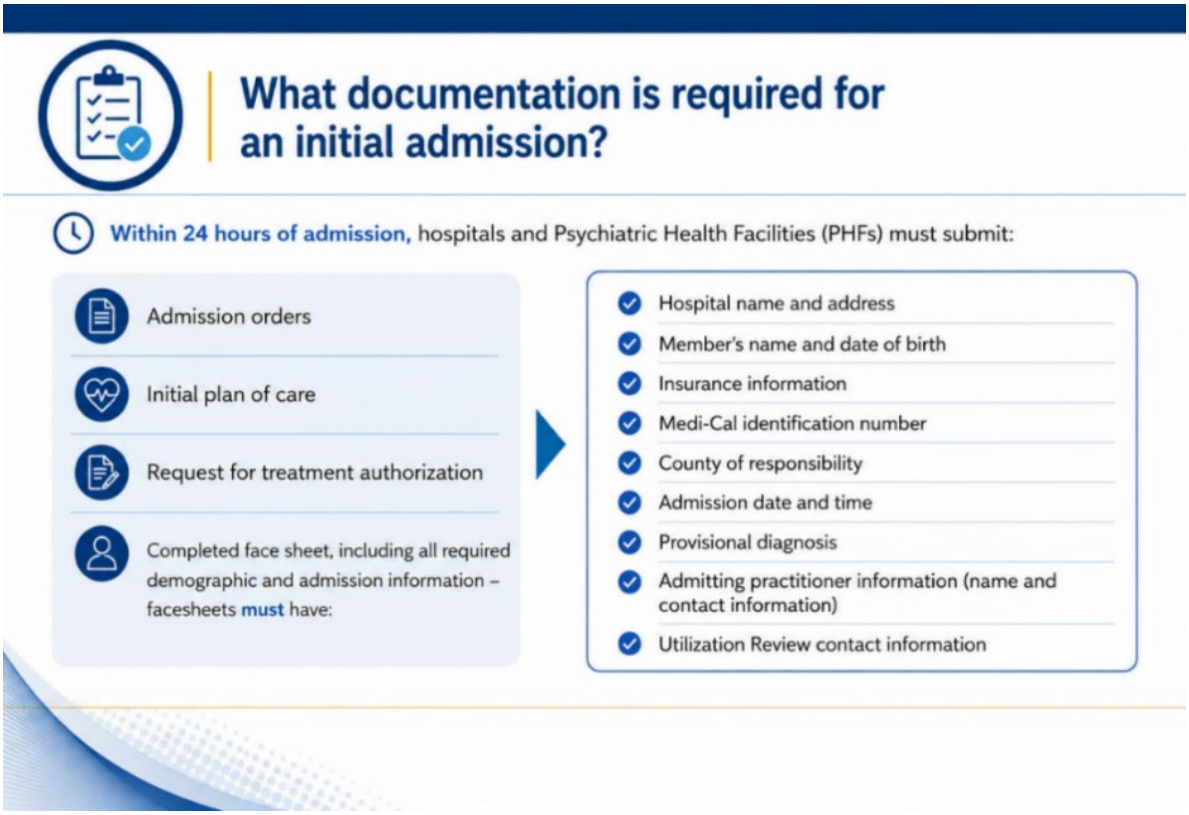


Figure 7

Initial Determination Timeframe

Telligen will issue an authorization determination as expeditiously as the member's condition requires and no later than **two calendar days** following receipt of all required information.

Continued Stay Authorization

Prior to expiration of the current authorization period, providers shall submit a continued stay authorization request. The following information represents examples of clinical documentation that may be submitted to support an initial or continued stay review. This list is intended as guidance and is not all- inclusive. Additional clinical information may be requested or considered necessary to evaluate medical necessity and the appropriateness of the requested level of care.

Examples of Clinical Information



Figure 8.

- Current diagnosis and presenting psychiatric condition.
- Current symptoms and behavioral observations.
- Suicide, homicide, and other risk assessment findings.
- Progress toward treatment goals and objectives.
- Medication changes, adherence, and treatment response.
- Nursing assessments and progress notes.
- Physician and psychiatric progress notes.
- Social work and care coordination documentation.
- Substance use history and current substance use concerns.
- Relevant medical history and current medical conditions.
- Treatment plan updates and modifications.
- Discharge planning activities and barriers to discharge.
- Requested number of continued stay days and clinical justification.

Determination Timeframe

Telligen will issue a continued stay determination within **one calendar day** of receipt of all necessary information.

Section 7: Administrative Day Authorizations

Administrative day services may be authorized when a member no longer requires acute inpatient psychiatric care but must remain hospitalized while awaiting placement at an appropriate lower level of care.

To request authorization for administrative days, the provider must submit an **Administrative Day Request Form** along with supporting documentation demonstrating that:

- Acute inpatient psychiatric criteria are no longer met; and
- Active and ongoing efforts are being made to secure an appropriate non-acute residential treatment placement.

Placement efforts must begin on the **first day** the member is placed on administrative day status. The following requirements apply:

- The provider must make at least **one contact per day** with a non-acute residential treatment facility until a total of **five contacts** has been completed within a **seven-consecutive-day period**, unless fewer than five appropriate non-acute residential treatment facilities are available as placement options for the member.
- All **five required contacts may be completed on the first day** of administrative day status. When all five contacts are completed on the first day, the remaining six days of the seven-day authorization period may be considered for authorization.
- Administrative days will **not be authorized** for days in which the required placement contact was not made before completion of the five required contacts within the seven-consecutive-day period.

Administrative day requests are evaluated against established administrative day criteria. Authorization is dependent upon the provider's documentation of ongoing, active efforts to secure an appropriate discharge setting for the member.

Documentation Requirements

Documentation supporting administrative day requests should include:

- Date of contact.
- Name of the facility or program contacted.
- Placement status or availability.
- Outcome of the contact or referral.
- Name and title of the staff member making the contact.

Placement Effort Requirements

Section 8: Retrospective Authorization Requests

Retrospective authorization requests may be reviewed under limited circumstances, including:

- Retroactive Medi-Cal eligibility determinations.
- Eligibility system inaccuracies.
- Pending coordination of benefits.
- Member failure to identify payer.

Supporting documentation must accompany all retrospective authorization requests.

Section 9: Treatment Authorization Request (TAR) Processing

Telligen processes Treatment Authorization Requests (TARs) in accordance with California Code of Regulations (CCR), Title 9, Section 1820.220 and applicable County requirements.

TAR Submission Requirements

Hospitals are responsible for submitting a completed Treatment Authorization Request (TAR Form 18-1) within **14 calendar days** of a member's discharge from an inpatient

psychiatric facility or at the **99-day mark** for members receiving continuous inpatient care.

The hospital is responsible for completing all required provider sections of the TAR, including Boxes 6 through 22B, prior to submission. Telligen will review the TAR for completeness and may return incomplete requests for correction or additional information.

TAR Review Process

Upon receipt of a completed TAR, a Telligen Clinical Reviewer will evaluate the request to determine whether the services meet applicable medical necessity and authorization requirements.

Review determinations may include:

- **Approved** – The requested services meet applicable authorization requirements.
- **Denied** – The requested services do not meet applicable authorization requirements.
- **Approved as Modified** – A portion of the requested services is authorized, or the authorization is modified based on the clinical review findings.

TAR Documentation Requirements

Following completion of the review, the Telligen Clinical Reviewer will complete the applicable TAR sections, including:

- **Box 22C** – Documentation of the clinical rationale and review determination.
- **Boxes 23–42** – Completion of required clinical review and authorization information.
- **Box 42A** – Documentation of the approved stay status (e.g., Acute or Administrative Day).
- **Box 42B** – Reviewer signature and authentication of the determination.
- **Box 44** – Date the TAR was completed and signed.

- **Box 45** – County code identifying the county of responsibility.

TAR Submission to DBH and The California Department of Healthcare Services (DHCS)

After the review has been completed and all required TAR fields have been finalized, Telligen will transmit the completed TAR to the County and to DHCS when appropriate. Completed TARs will be processed and forwarded within **five business days** of receipt of all information necessary to render a determination.

Section 10: Review Determinations

Telligen may issue one of the following determinations:

Determination	Description
Approval	Services are authorized as requested
Partial Denial	Services are authorized with modifications
Administrative or Technical Denial	Services are denied for reasons unrelated to medical necessity
Denial	Services are denied because medical necessity or coverage requirements have not been met.

Authorization Decisions & Notifications

Providers receive written notices for all authorization outcomes, which are available for download in the Qualitrac portal. Members automatically receive written notices for any adverse decisions (such as denials or modifications) according to regulatory and contractual guidelines.

Types of Denials

- **Technical Denials:** Triggered automatically if a Request for Information goes unanswered for two calendar days. To pursue authorization after a technical denial, you must submit a brand-new continued stay request.
- **Administrative Denials:** Stem from procedural oversights (like missing paperwork) rather than clinical criteria. Because these are non-clinical, peer-to-peer reviews and standard appeals do not apply; you must submit a fresh authorization request if services are still needed.

Peer to Peer Consultations and Appeals

Peer-to-Peer Consultations

If you disagree with an authorization outcome, you can request a Peer-to-Peer consultation with a Telligen physician reviewer. This is a collaborative dialogue to review the case's clinical context, discuss applied medical necessity standards, and evaluate any late-breaking medical information.

- **How to Request:** Email or call Telligen within **two business days** of the determination notice. A member of our team will schedule the phone consultation.
- **During the Process:** You may submit fresh clinical documentation before or during the call. If the new data fundamentally shifts the clinical picture, the reviewer may adjust the determination.
- **Important Rules:** Peer-to-peer reviews are strictly voluntary. They do not replace formal appeals, nor do they pause or extend standard appeal deadlines. If the original decision stands, providers will be briefed on subsequent appeal options.

First-Level Appeals

Providers can challenge an adverse determination by filing a first-level appeal via the Qualitrac portal within 60 calendar days of receiving the notice.

Your appeal should include a clear breakdown of why you are appealing. Original submission documents remain part of the case record and are available to the appeal reviewer. Providers should upload only additional clinical documentation supporting the appeal.

Independent clinical reviewers handle all first-level appeals. These reviewers possess the right clinical background and had zero involvement in the original decision.

Note: Non-DBH contracted facilities must bypass Telligen and submit first-level appeals directly to DHCS.

Second-Level Appeals

If you disagree with the outcome of a first-level appeal, escalate it according to your facility type:

- **DBH-Contracted Facilities:** Submit directly to the San Bernardino County Department of Behavioral Health (DBH)—do not route through Telligen. Connect with one of the contacts below:
  - **Sandra Razo:** Sandra.Razo@dbh.sbcounty.gov | (909) 386-8230
  - **Marisol Vera:** Marisol.Vera@dbh.sbcounty.gov | (909) 388-0886

- **Non-DBH Contracted Facilities:** Submit directly to DHCS, not Telligen.

Appeal Timeframes & Rules

- **Standard Appeals:** Resolved within **30 calendar days** of gathering all necessary review materials.
- **Expedited Appeals:** Reserved for urgent situations where a standard timeline threatens the member's life, health, or functional recovery (per 42 CFR § 1850.208 and DHCS BHIN 18-010E). These demand a decision within **three business days** (though a 14-day extension is permitted if extra documentation is urgently needed).

- **Outcome Delivery:** Providers view appeal decisions via the Qualitrac portal. Members receive adverse decision letters directly, per compliance standards.
- **Further Rights:** Additional legal or regulatory recourses may be available via DHCS and other state/federal channels.

Contact Telligen

The Telligen Contact Center representatives are available Monday through Friday 8:00 am to 5:00 pm Pacific time. Information may be submitted to Telligen by:

Contact Us:

Webpage/Portal: SBPsychReviews@Telligen.com

Toll Free Call Center: 1-833-476-4850

Senior Manager of Health Management: Nancy Johnson, RN, BSN (njohnson@telligen.com)

Manager, Health Management: Rachel Cody, RN, BSN (rcody@telligen.com)