alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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Specialty Mental Health Services (SMHS)

Frequently Asked Questions (FAQs)

ACBH Quality Assurance Department

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Note: Please anticipate multiple revisions to this document throughout the 2022 calendar year and beyond as Cal-AIM changes continue to impact guidelines and providers continue to submit questions. ACBH is publishing this document as of April 2022 with the best and most current information we have. We encourage our community partners to utilize the QATA mailbox, qata@acgov.org, and the Brown Bag meetings to submit questions in an effort to help this document evolve and meet the needs of providers.

For CalAIM specific FAQs, please see document titled “CalAIM Frequently Asked Questions”

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Informing Materials, Consents, and Beneficiary Rights

Are providers required to utilize the Informing Materials developed by ACBH?

All ACBH beneficiaries must receive ACBH's Informing Materials/Consent to Treat Package and have a signed signature page/checklist in the medical record. Providers have some discretion around including additional informing material documents as long as it does not confuse or contradict the ACBH information.

For reference, the Informing Materials Packets in all threshold languages can be found here: BHCS Providers Website (acbhcs.org)

What Scope of Practice must staff have to present, explain, and answer questions regarding the ACBH required Informing Materials Packet?

Any staff that is deemed qualified by the agency as having the training, knowledge, and experience to accurately present, explain, and answer questions regarding the Informing Materials Packet may do so for the following elements of the packet: Freedom of Choice; Explanation of the Provider Referral List, the Guide to Medi-Cal Mental Health Services & the BHP Member Handbook; Advance Directive Information; Beneficiary Problem Resolution Information; Maintaining a Welcoming & Safe Place (not a required informing material). The Progress Note must document this discussion and be signed by the staff person.

Only staff whose Scope of Practice includes conducting Mental Health Assessments may present, explain, and answer questions regarding the following Informing Materials Packet elements: Consent for Services; Confidentiality & Privacy Statement (Duty to Report); The Notice of Privacy Practices (HIPAA/HITECH). This is limited to Licensed, Waivered, or Registered providers or 2nd Year Graduate Trainees. Given the potential for the discussion of these documents to elicit sensitive clinical information, it must be held in a confidential setting. The Progress Note must document the discussion and be signed by staff with appropriate credentials.

The MHP Contract with CA DHCS, Exhibit A, Attachment 3, Item No. 4 states that a beneficiary may "request and receive a copy of his or her medical records, and request that they be amended or corrected." Can providers override such a request if it is not in the best clinical interest of the client?

This beneficiary right incorporates parts of the HIPAA Privacy Rule. The exact language of Title 42, CFR, Section 438.100(b)(2)(vi) states: "If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, [the beneficiary has the right to] request and receive a copy

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of his or her medical records, and request that they be amended or corrected, as specified in CFR Secs. 164.524 and 164.526."

MHPs are subject to the HIPAA Privacy Rule, as such they must grant beneficiaries this right, unless one of the below exceptions applies.

Title 45, CFR Section 164.524 describes an individual's rights and exceptions to accessing their records. This section (164.524(a)(3)(i)) addresses situations in which accessing the information would not be in the best interest of the beneficiary.

> "(i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person; (ii) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or (iii) The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person."

Note: In April 2003, the HIPAA Privacy Rule became effective, and such began the requirement of MHPs to grant these rights to beneficiaries.

The full text of Title 45, CFR, Section 164.524 can be accessed here:
http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/45cfr164.524.pdf

Title 45, CFR, Section 164.526 describes the amendment process for changing medical records, and the exceptions. The full text of Title 45, CFR, Section 164.526 can be accessed here:
http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/45cfr164.526.pdf

Release of Information

If PHI is released without authorization from the client, will this result in recoupment?

This will not result in recoupment. However, this would be considered a HIPAA breach and would need to be reported. This would also increase liability risk for the provider.

Is a Release of Information (ROI) needed for an emergency contact?

A signed ROI form is recommended even in emergency situations; however, if one cannot be obtained and there is an urgent care coordination need, it can be bypassed when in the best interest of client. Please note that the guidance around discussing PHI without consent states to use discretion and limit the exchange of information to only what is necessary. The Code of

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Federal Regulations outlines exceptions to the ROI requirements for mental health treatment as summarized in the answer for the next question.

Under what circumstances can a provider disclose PHI to a family member, relative, close friend, or another person identified by the individual without an ROI?

A provider may disclose PHI to a family member, relative, close friend, or other person identified by the Mental Health (not SUD) client as responsible for their care without an ROI when all the following circumstances are met when the client is NOT present.

1. The family member, relative, close friend, or other person has already been identified by the client as responsible for their care.

2. The PHI is used to notify or assist in the notification of (i.e., identifying/locating) the family member/person responsible for the client's care of the client's location, general condition, or death.

3. The provider determines in their professional judgment that the disclosure is in the best interest of the client.

4. The provider discloses ONLY the PHI directly relevant to the person's involvement with the client's care, payment related to the client's care, or for notification (i.e., minimum necessary).

For example, the provider may infer that it is in the client's best interest to allow the other person to act on behalf of the client in picking up filled prescriptions, medical supplies, or other similar forms of PHI.

For reference, see 45 CFR 164.510(b)(3). https://www.law.cornell.edu/cfr/text/45/164.510

Resources Related to Authorization to Release Information:

Microsoft Word - REQUEST FOR AUTHORIZATION TO RELEASE INFORMATION (final) 3-15.doc (acbhcs.org)

Assessments

Required Elements

What are the required elements of an assessment?

See below for a list of required elements in a compliant assessment.

- Identifying Information
- Communication Needs

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- Medical History (Note: Indicate the client's primary care provider with contact information. If none, make a referral and follow-up to ensure the client is linked with a medical provider.)
- Presenting Problem(s) / Referral Reason
- Relevant Conditions & Psychosocial Factors
- Risks
- Client / Family Strengths
- Medications
- Allergies / Adverse Reactions / Sensitivities
- Substance Exposure/Use
- Mental Health History
- Other History (Employment, Living Situation, Education, etc.)
- For Clients Under Age 18: Prenatal/Perinatal Events and Complete Developmental History
- Mental Status Exam (MSE)
- Complete Diagnosis with required signatures
- Complete Signature of Individual Completing the Assessment (with required co-signatures if applicable)

For Reference:

https://www.acbhcs.org/providers/Forms/Clinical/Adult/Mental%20Health%2018%20yrs.docx

Cultural & Linguistic Considerations

What Sexual Orientation and Gender Identity/Expression (SO/GIE) data must be collected at the Initial and Annual Assessments?

The required data points are shown below:

Preferred Last Name:		**Preferred First Name:**				
What is your Pronoun:	☐ She/Her	☐ He/Him	☐ They/Them	☐ Unknown		
	☐ Prefer not to Answer	☐ Other				
Sex Assigned at Birth:	○ Male	○ Female	○ Other			
Gender Identity:	☐ Unknown	☐ Male	☐ Female	☐ Intersex	☐ Gender Queer	☐ Gender non-conforming
	☐ Prefer Not to Answer	☐ Other				
Transgender:	☐ Male to Female/Transgender Female/Trans Woman			☐ Female to Male/Transgender Male/Trans Man		
SEXUAL ORIENTATION:	☐ Unknown		☐ Bisexual	☐ Prefer not to Answer	☐ Gay	
	☐ Heterosexual/Straight		☐ Lesbian	☐ Questioning	☐ Queer	
	☐ Other:					

Are there suggested SO/GIE considerations for the development of an assessment template or when inquiring with the client and/or family?

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Yes, when asking about family, replace the terms Mother or Father, and consider more inclusive terms such as Parents, Caretakers, or Guardians. Additionally, when asking about relationships, replace the terms Husband or Wife, and consider more inclusive terms such as Partner or Significant Other. If other relevant terms are deemed to have a more inclusive alternative, providers are encouraged to situate their language as such.

Diagnoses

What are the requirements for charting diagnoses?

Diagnoses documented in the client's clinical record, such as a paper chart or an EHR, must represent the client's full DSM-5 diagnostic picture. The diagnoses in the clinical record must be consistent with diagnoses entered into InSyst but can also include additional diagnoses the client may have. Diagnoses in the clinical record must be supported by documentation including specific signs, symptoms, and timeframes. All diagnoses must include an ICD-10 code and the appropriate DSM-5 descriptor (diagnosis name) with specifiers and severity when applicable.

What are the requirements of diagnoses entered into InSyst and how does this differ from documenting the diagnoses in the client's clinical record?

InSyst is part of the County and State Medi-Cal billing system; diagnoses entered into InSyst should relate to claims made to Medi-Cal. Only mental health diagnoses approved by DHCS may be treated under and claimed for reimbursement by Medi-Cal; these diagnoses are required for entry into InSyst. However, if the provider wishes, additional diagnoses may be added to InSyst. Providers must use an appropriate diagnosis for their type of service.

Safety/Risk

If a client is found to have suicidal/homicidal/other significant risk ideation, is a Safety Plan required?

Yes, if at any point a type of risk ideation is identified as having occurred in the past 90 days, both a Comprehensive Risk Assessment and a formal written Safety Plan must be developed in coordination with the client.

What if a client has a history of suicidal/homicidal/other significant risk ideation, but not within the last 90 days and with controlled symptoms?

With a history of symptoms beyond the past 90 days and when stable, the need for a Comprehensive Risk Assessment and a formal written Safety Plan should be carefully considered on a case-by-case basis. If it is determined that a Comprehensive Risk Assessment and formal written Safety Plan are not indicated, there should be documentation of the clinical rationale for this decision.

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What elements must be documented in a Comprehensive Risk Assessment and formal written Safety Plan?

The Comprehensive Risk Assessment and the formal written Safety Plan must be documented in the medical record. The development of the Safety Plan should be a collaborative clinical process with input and endorsement from the client and should be written using their own language. Critical elements of each document type are listed below.

Comprehensive Risk Assessment:

- Reason for Comprehensive Risk Assessment
- Current Episode: Current Intent (Subjective Reports & Objective Signs); Plans; Access to Means; Ideation (Frequency, Intensity, and Duration)
- History of Risks and Attempts (Self-Harm, Risk to Others, and Hospitalizations related to Risk)
- Risk Factors (Internal & Environmental)
- Protective Factors (Internal & Environmental)
- Focused Symptom Severity (Depression, Anxiety, Anger, Agitation, Insomnia, Hopelessness, Perceived Burdensomeness, Impulsivity/Self Control, Chronic Risk, Therapeutic Alliance, and Current Level)
- Status of Safety Plan

Comprehensive Risk Assessment Resource:

https://www.acbhcs.org/providers/QA/docs/2013/TR_Suicide-Homicide_Risk_Assesment.pdf

Safety Plan:

- What are my Warning Signs (Thoughts, Images, Thinking Processes, Mood, and Behavior)?
- What Are My Triggers?
- What Internal Coping Strategies may I Use (Identification of, Likelihood of Use, Barriers, and Problem Solving)?
- What Social Contacts May I Use (For Distraction and/or Support – multiple people in multiple settings)?
- When Will I Contact my Family Members and/or Friends to Assist in the Resolution of the Crisis?
- When Will I Contact Professionals and/or Agencies for Assistance? Which Professionals or Agencies? (Priority & Expectations)

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- How May I Reduce the Potential for Use of Lethal Means?

- The Implementation of Safety Plan (Assess Likelihood of Use and Problem Solve if Obstacles Exist; Regular Review)

Safety Plan Resource: www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc

Timeline

When is the Initial Assessment due?

The Initial Assessment is due within 60 days of the Episode Opening Date; when agency specific alternate requirements exist, they will be defined in their contracts. Although 60 days is the deadline for completion, ACBH recommends as a best practice that assessments be completed as soon as possible to support treatment coordination. Assessment updates are due annually or when contractually required for certain programs, and when a clinically significant event occurs.

Signatures

What are the required elements of a signature on the assessment?

All Signatures must include:

- Date of Service
- Signature of the person providing the service; wet signatures or electronic signatures are acceptable.
- Medi-Cal Scope of Practice (MSW, AMFT, MHRS, NP, MD, MHRS, etc.) See Scope of Practice table with required designations: http://www.acbhcs.org/providers/QA/docs/training/MH%20Scope%20of%20Practice%20Credentialing.pdf
- Type of degree/licensure/credential/job title
- Relevant NPI (if applicable)
- Date the documentation is entered into the medical record

Medical Necessity/Access Criteria

What are the criteria for establishing medical necessity/access for Specialty Mental Health Services (SMHS)?

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Effective January 1, 2022, DHCS issued BHIN 21-073, providing new guidance related to medical necessity criteria:

Beneficiaries **21 years of age or older** can access SMHS if both of the following criteria are met:

(1) The beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in the above criteria is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of DSM-5 and the ICD-10 b. A suspected mental disorder that has not yet been diagnosed.

Beneficiaries **under 21 years of age** can access SMHS if either of the following criteria are met:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

(2) The beneficiary meets both of the following requirements in a) and b), below.

The beneficiary has at least one of the following: i. A significant impairment ii. A reasonable probability of significant deterioration:

a) In an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate. iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described in subparagraph (2) above is due to one of the following: i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM-5 and the ICD-10. ii. A suspected mental health disorder that has not yet been diagnosed. iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

Mental Status Exam

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Can the Mental Status Exam (MSE) be completed by phone?

The MSE may be completed in person, via telehealth, or by phone. If not completed in person, documentation of the barriers to in person completion is required for billing purposes.

CANS/ANSA

When does the CANS/ANSA need to be completed?

The CANS/ANSA must be completed at the following points in treatment:

At Opening: The Initial CANS/ANSA must be completed within 60 calendar days of the Episode Opening Date (EOD), but after completion of the MH Assessment and prior to the completion of the Client Plan. CANS/ANSA data shall be used to inform the Initial Client Plan.

At 6 Months: A Re-Assessment CANS/ANSA must be completed within the calendar month prior to the 6th month from the EOD.

At Annual Re-Authorization: A Re-Assessment CANS/ANSA must be completed during the annual re-authorization period which is within the calendar month prior to one year from the EOD. CANS/ANSA data shall be used to inform the Annual Client Plan.

Upon a Clinically Significant Change: Once the Initial CANS/ANSA is completed, staff must re-administer the CANS/ANSA whenever a clinically significant change occurs, or need arises. This CANS/ANSA re-assessment may prompt updates the Client Plan.

Client Plan Update (New Plan is Created): Given that the CANS/ANSA is used to inform the Initial Client Plan, the CANS/ANSA must be updated with every Client Plan update. That is, when planning to complete a new Client Plan, first administer the CANS/ANSA and utilize the results to inform the new Client Plan.

At Discharge: The CANS/ANSA must be completed prior to closing a case.

If the CANS/ANSA is completed in the Objective Arts database, does it need to be printed?

The CANS/ANSA is a required element of the medical record and must be printed and included in the client's chart if completed in the Objective Arts Database. Signatures with credentials, applicable co-signatures, and dates are required on the printed form. If the CANS/ANSA is completed on paper or within an Electronic Health Record, the data needs to be entered into the Objective Arts Database (Note: This data transfer is not a billable service).

Who can administer the CANS/ANSA?

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Staff who complete the CANS/ANSA must be either 1) A Mental Health Rehabilitation Specialist or 2) Meet the credentialing standard in the category of Eval - CANS/ANSA on the ACBH Scope of Practice Credentialing Grid.

Please use the below link to the grid for reference:
https://www.acbhcs.org/providers/QA/docs/training/MH%20Scope%20of%20Practice%20Credentialing.pdf

How much time can be claimed for the scoring and write-up of the CANS/ANSA?

Completion of an initial CANS/ANSA is expected to take between 30 – 45 minutes. Updates to the initial CANS/ANSA are expected to take between 15 – 20 minutes. (Tip: Staff have an option to copy the original evaluation and make modifications for the updated evaluation in the Objective Arts Database.)

CANS/ANSA Resources: BHCS Providers Website (acbhcs.org)

Pediatric Symptom Checklist

What is the Pediatric Symptom Checklist (PSC-35)?

The PSC-35 is a psychosocial screening tool designed to identify cognitive, emotional, and behavioral challenges to help facilitate timely intervention planning. Parents/caregivers will complete the Parent/Caregiver version of the PSC-35 for children and youth ages 3 years – 18 years.

When is the PSC-35 administered?

The PSC-35 should be completed by 60 days from the Episode Opening Date, every 6 months thereafter, and at discharge.

What are the next steps after administering the PSC-35 to parents/caregivers?

After the PSC-35 has been completed, the results should be entered into the Objective Arts Database and a copy of the form must be included in the medical record.

What if the parent/caregiver is unavailable and does not complete the PSC-35?

Make 3 attempts to administer the PSC-35 and document all efforts. If unsuccessful, agencies can use discretion around administering the PSC-35 self-report if clinically appropriate.

What aspects of the PSC-35 completion are billable?

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See below for specific scenarios:

- Time spent inputting PSC-35 data into the Objective Arts Database is not a billable activity.
- Time spent reviewing a completed PSC-35 initially or as medically necessary is a billable assessment activity.
- If a client's parent/caregiver needs help completing the PCS-35, the time spent reviewing and completing the questions with them is a billable assessment activity. Indicate in the progress note what barriers prevented the independent completion of the PSC-35 and what interventions were employed to assist.

Client Plan

Timeline

What is the completion timeline for the Client Plan?

The initial Client Plan is due within 60 calendar days of the Episode Opening Date (EOD).

- The Client Plan is effective the date of the provider's signature. After this date, all services outlined on the Client Plan may be billed.
- Every subsequent Client Plan is due annually and must be completed during the month prior to the Episode Opening Month (EOM) and is due no later than the first day of the EOM.

Example: EOD 8/18/20

The initial Client Plan is due by 10/17/20.

The annual Client Plan can be completed anytime between 7/1/21 and 8/1/21 but no later than 8/1/21.

- The Client Plan must also be updated whenever there is a clinically significant change.

Events of clinical significance may include but are not limited to:

- Client has made significant progress and reached their target goal
- Client has increased suicidal/homicidal/other significant risk ideation
- Client is hospitalized for psychiatric reasons

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- Client is sanctioned for behaviors (e.g., school expulsion, legally detained, etc.)

Signatures

When a young child is in Foster Care, and has a Child Welfare Worker, as well as Foster and/or Biological Parents, what is the guideline for obtaining signatures on the Client Plan?

The Client Plan belongs to the client and as such the client should sign the plan. Even younger clients – if able to acknowledge that their signature signifies ownership of the plan – may sign or write their name. When unable to obtain a client's signature, such as when a client is pre-verbal, a statement written by the clinician documenting why it is clinically inappropriate to obtain the client's signature is sufficient. When treatment involves parents, such as in child-parent dyadic work, or when reviewing a Client Plan with parents is clinically indicated, it is best practice and appropriate to obtain a parental signature, though not a requirement.

Progress Notes

Timeline

What is the timeline for completing progress notes?

The best practice recommendation for progress note completion is within one (1) business day of the service; however, providers have up to five (5) business days from the date of service to enter the progress note in the clinical record. A progress note completed after five (5) business days will be considered a "late note" and must be clearly identified as a late entry. Note: Late notes are considered out of compliance with documentation timeliness standards. Progress notes must be completed prior to claim submission.

Clinical Quality Review Team (CQRT)

Where can I find the most recently updated CQRT checklist and policy?

The most recent CQRT process may be found here: CQRT Manual (acbhcs.org)
The most recent CQRT Checklist may be found here: 8-2B CQRT Checklist 2022.pdf (acbhcs.org)

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If an agency has their own CQRT checklist, that includes all the items listed on the ACBH CQRT Checklist template, does the agency checklist need to be approved by ACBH Quality Assurance (QA) prior to use?

No, as long as the agency checklist includes all the items on the ACBH CQRT checklist, then no approval is needed. Adding items to the checklist does not require QA approval.

Should there an expectation for agencies to continue to tell all staff to prepare all of their charts for review, even though there is a chance their chart may not be reviewed?

Yes. It is good practice to tell staff to prepare all their charts, that meet criteria, for review since selection of charts is randomized and staff will not know in advance which charts will be selected.

Claiming

General

Do staff claim travel and/or documentation time at the service function rate (e.g., Mental Health Services, Case Management, etc.) of the service provided?

Yes, travel and documentation time must be linked to the service provided.

Can staff claim Medi-Cal for Case Management Services provided while a beneficiary is in an IMD?

Case Management Services cannot be claimed if the beneficiary is between the ages of 22 years – 64 years. If the beneficiary is 65 years or older or is 21 years or younger and is a patient in a hospital or another accredited facility, Case Management Services can be claimed.

Refer to the ACBHCS Mental Health Medi-Cal Lockout Grid for restrictions indicated for each specific institution (or MH service): ACBHCS' Mental Health (MH) Medi-Cal Lockout Grid

Can staff claim Medi-Cal for transporting beneficiaries to mental health appointments as a Specialty Mental Health Service (SMHS)?

Transportation is not a billable service; however, on the occasion that staff provide a medically necessary SMHS while in transit, the intervention(s) may be considered billable. ACBH would recommend judicious consideration of what meets criteria for a medically necessary SMHS and then determine what service type best fits the intervention. Additionally, the scope of practice of the staff person needs to be considered and the service needs to be documented in the record with a description of the intervention and how it relates to the functional impairment and primary diagnosis of the client.

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Refer to the DHCS Transportation page for more information.

Can the time spent preparing an authorization request for a client's medication be claimed to Medi-Cal?

Yes Medi-Cal can be claimed for completing an authorization request for a prescription as it relates to the provision of Medication Support Services. Note: Only providers whose Scope of Practice allows can render and bill for Medication Support Services (e.g., Physicians, Nurse Practitioners, Physician Assistants, RNs, LVNs, Psychiatric Technicians, or Pharmacists).

Can staff claim Medi-Cal for photocopying, faxing, and other clerical type activities as Specialty Mental Health Services (SMHS)?

No, the clerical activities as described above are not considered billable SMHS.

Can staff claim Medi-Cal for payee related activities?

Time spent by staff performing payee activities (e.g., preparing checks, addressing envelopes for bills, etc.) cannot be claimed to Medi-Cal. However, time spent by staff addressing a functional impairment related to fiscal responsibilities (e.g., educating clients on budgeting and money management) may be considered a billable payee related service.

Can staff claim Medi-Cal for phone assessments?

Assessments completed by phone can be claimed to Medi-Cal although face-to-face assessments are encouraged as a matter of best practice.

Can post-mortem services be claimed to Medi-Cal in the event of a beneficiary's death?

No, all mental health services billed to Medi-Cal must be justified as serving a mental health need. Therefore, Medi-Cal cannot be claimed for any services provided after death.

Can staff claim Medi-Cal for court related assessments (e.g., conservatorship investigations)?

If an assessment is completed per court order for a purpose other than determining Medical Necessity for Medi-Cal, the service may not be claimed to Medi-Cal. Following the conservatorship example, if the assessment is defined as solely for the establishment of conservatorship and the MHP limits its assessment to this purpose, it is not billable to Medi-Cal.

What are the current 24-hour claiming limitations listed by service type?

The following are the current 24-hour claiming limitations by service type: California Code of Regulations (CCR), Title 9, Chapter 11, Section 1840.366(b) specifies: "The maximum amount claimable for Crisis Psychotherapy/Crisis Intervention in a 24-hour period is 8 hours." CCR, Title 9, Chapter 11, Section 1840.368(c) specifies: "The maximum number of hours claimable for Crisis Stabilization in a 24-hour period is 20 hours." CCR, Title 9, Chapter 11, Section 1840.372

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specifies: "The maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours."

When one client session provides two different services with separate corresponding rates, how should this be claimed to Medi-Cal? How should progress notes be managed in these situations?

When one session provides differing services, the entire time may be claimed to the lower cost service type, or two claims may be submitted for each separate service type. Providers can prepare one Progress Note with service type differentiation or two separate Progress Notes depending on how the claim will be submitted.

Example: One 60-minute session provides 30 minutes of Mental Health Services and 30 minutes of Case Management. A single claim may be submitted for 60 minutes of Case Management (the lower cost service type), or separate claims may be submitted, each for 30 minutes of the specified service type. There are two options for progress notes, 1) Complete one Progress Note clearly defining the two distinct service types offered in the session and the amount of time spent on each (e.g., one section indicating 30 minutes spent on Case Management and one section indicating 30 minutes spent on Individual Therapy within the same Progress Note) if only one claim will be submitted for the lower cost service type, or 2) Complete two separate Progress Notes, one for each service type, and the amount of time spent on the service if two claims will be submitted – one for each service type.

Can Medi-Cal be claimed for administrative hospital days in an acute psychiatric setting, if Medi-Cal was not claimed for the days of acute status?

If Medical Necessity for acute psychiatric inpatient hospital services is established at some point during the patient's stay, and the administrative days meet criteria specified in CCR, Title 9, Section 1820.220(j)(5), administrative hospital days may be claimed.

Example: Administrative hospital days may be claimed for a patient who otherwise met medical necessity criteria but was ineligible for Medi-Cal because of their legal status at the start of their inpatient stay but for whom eligibility status changes during their stay (e.g., in jail custody at time of admission but the court later releases the patient) and the patient remains in the hospital pending suitable placement.

What are the rules around claiming Medi-Cal for services provided by students, volunteers, and paid consumers?

When all Medi-Cal, supervision, and scope of practice requirements are met, providers may claim for Medi-Cal services provided by students, volunteers, and paid consumers (see definitions below for each type of staff). Note: All additional provider credentialing requirements remain the same.

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A student, also called a trainee, refers to someone attending school in a Social Work, Counseling, or related school placement program (Undergraduate or Graduate level), that works at a provider site as part of their academic requirements.

A volunteer refers to someone who is not employed by the provider but works at a provider site without pay.

A paid consumer refers to a consumer who is employed by the provider to provide peer support to clients.

Refer to the ACBH SMHS Scope of Practice Credentialing Grid

Which Specialty Mental Health Services (SMHS) are eligible for Medi-Cal reimbursement?

SMHS services eligible for reimbursement include:

- Mental Health Services
- Medication Support Services
- Intensive Day Treatment
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services
- Crisis Residential Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Psychiatry Services
- Psychology Services
- Case Management/Brokerage
- EPSDT Supplemental Specialty Mental Health Services

If a client is admitted to an acute care setting for a medical condition, what Specialty Mental Health Services (SMHS) are billable to Medi-Cal during the inpatient stay?

CCR, Title 9, Section 1840.215 and Sections 1840.360 through 1840.374 only address lock-out requirements for SMHS. The regulations do not contain language prohibiting claims to Medi-Cal for the provision of Medically Necessary SMHS while on a medical unit.

Refer to the ACBHCS Mental Health Medi-Cal Lockout Grid for additional information: ACBHCS' Mental Health (MH) Medi-Cal Lockout Grid

Evaluation and Management

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Can staff submit a claim for Medi-Cal reimbursement for medication support services in a group setting?

These services can be billed for when the following conditions are met: Time is prorated per CCR, Title 9, Chapter 11, Section 1840.316(a)(2); the medication support services provided meet the definition of medication support services in CCR, Title 9, Chapter 11, Section 1810.225; the service is provided by staff who are qualified to provide such services. Example: An R.N. facilitates a weekly group discussion on medication education (e.g., the side effects of the medication, overcoming resistance to taking medications, etc.). This intervention and its goals should be addressed in each individual's Client Plan and can be claimed for reimbursement.

Travel Time

Can Medi-Cal reimbursement be claimed for travel time from one provider site to another provider site, from a staff person's home to a provider site, or from a staff person's home to a client's home?

To claim Medi-Cal, travel time must be from a provider site to an off-site location where Specialty Mental Health Services are delivered. Therefore, Medi-Cal cannot be claimed for travel time between provider sites or from a staff person's home to a provider site or a client's home. Note: A "provider site" is defined as a site with a provider number, including affiliated satellite and school site operations.

Groups

Can staff claim Medi-Cal for parenting groups servicing parents whose children have open cases with the agency?

When the services offered in parenting groups are directly related to the mental health needs of the children and not solely based on parental needs, they can be considered billable to Medi-Cal. The clinical rationale for these services must be clearly documented in the child's chart.

How should time be divided when clients and their parents are seen together in a group setting? Should the time be claimed as Mental Health Services or Collateral?

Time should be claimed as Mental Health Services and should be divided equally amongst the clients being represented. The allocation of billed time for each client should be treated as if the group were only composed of the clients being represented, with their parents not being counted as actual group members.

Example: A 120-minute (including documentation time) group is comprised of 3 Medi-Cal eligible clients, 2 Medi-Cal ineligible clients (see Q3 & A3 below for more on Medi-Cal vs non Medi-Cal group members), and their parents, for a total of 5 clients and 10 parents. In this group, 5 clients were represented, so 120 minutes is divided by 5 for a total of 24 billable

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minutes per client. Similarly, if client #5 was absent but their parents attended – thus the client was represented in the group session – the same division of time amongst the 5 represented clients would apply.

When a treatment group contains both Medi-Cal eligible and Medi-Cal ineligible clients, how is staff to divide the time?

If a provider is rendering services to a group comprised of both Medi-Cal eligible and Medi-Cal ineligible clients, the provider should divide the time amongst the total number of represented clients regardless of Medi-Cal eligibility. Example: In a 120-minute group of 6 clients – 3 Medi-Cal eligible and 3 Medi-Cal ineligible – the total time would be divided by 6. That is, 20 minutes is the billable total of minutes per client.

Discharge

What is the difference between a Discharge Note and a Discharge Summary?

See explanations for each below:

A Discharge Note is essentially a Progress Note that includes brief documentation related to a client's discharge or transfer of care. The preparation of a Discharge Note is considered an administrative activity and is not billable to Medi-Cal, unless it is part of a final billable service with the client present which is then treated as a Discharge Summary. See requirements for Discharge Summaries below.

The below Minimum Required Elements should be included in a Discharge Note:

- Reason for discharge/transfer
- Date of discharge/transfer
- Referrals made, if applicable
- Follow-up care plan

A Discharge Summary is a robust accounting of the course of treatment, outcomes of treatment, and recommendations for continued or future treatment. It essentially summarizes treatment and outlines a discharge plan; it is essential for continuity of care. It differs from a Discharge Note in its length, included elements, and purpose. The MHP considers this a billable Plan Development service when clinically necessary for continuity of care (i.e., being forwarded to a referral), or when it is reviewed with the client as a treatment intervention. For example, if the client is relocating or moving to a new level of care and the Discharge Summary is being sent to their new provider, or if a new provider is not yet identified, and the Discharge Summary is provided to the client/guardian for delivery to the new provider when secured.

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The below Minimum Required Elements should be included in a Discharge Summary:

- Summary of treatment provided
- Overall efficacy of interventions (including medications and their side effects/sensitivities and dosage schedules)
- Progress made toward the mental health goals/objectives
- Clinical decisions/interventions
- Diagnostic information
- Reason for discharge/transfer
- Date of discharge/transfer
- Treatment planning recommendations for future services relevant to the final Client Plan
- Referral(s) for aftercare services/community support services
- Follow-up care plan

Is an LPHA signature required on a client's Discharge Summary?

Similar to other documents containing diagnoses, a signature from a Licensed Provider or a Licensed Provider's co-signature is required on the Discharge Summary.

Refer to the Mental Health Scope of Practice Credentialing grid to review services allowed and required signatures by credential type.

CSI Timeliness

Information related to CSI Timeliness can be found in the CSI Data FAQ document and in ACBH Policy No. 100-2-3, both linked below.

CSI Data FAQ

Timeline Access To Service Standards and Tracking Requirements Policy

Special Circumstances

COVID-19

When the COVID-19 Health Emergency ends, will providers be required to secure signatures on documents for which prior verbal consent was obtained?

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Providers will not be required to secure signatures on documents for which verbal consent was obtained, and rationale noted. When in-person services resume, the standard of physical signatures will follow.

Questions related to documentation standards as they relate to COVID-19 can be found here:

COVID -19 FAQs

Sharing of Documentation

If an agency has a client open in more than one program, can they share documentation?

Agencies with multiple Reporting Units (RU) that share a medical record are allowed to share one Mental Health Assessment (if completed within the last 12 months) and Client Plan for concurrent services.

Example: If a client is receiving therapy services in one RU and begins to receive medication services in a different RU, both providers may share the Mental Health Assessment and Client Plan. Each RU should be opened with the date the client was first opened at the agency.

If multiple RUs in one agency do not share a chart, all pertinent documentation must be copied into each chart. This includes documents from the initial Episode Opening Date such as:

- Screening Form (with associated progress notes)
- Informing Materials (with associated progress notes)
- Mental Health Assessments (with associated progress notes)
- CANS/ANSA (with associated progress notes)
- Client Plan (with associated progress notes)
- Release of Information (with associated progress notes)

Note: For ACBH county clinics, one agency is considered one program which has a unique folder in the Laserfiche Database.

Are there other situations where separate agencies can share documentation?

For Initial Assessments Only

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If a full Assessment has been completed for a client, it is possible for separate providers to use this Assessment and update it under the following circumstances:

A full Assessment was completed by the other agency in the last 6 months.

- To use a previously completed Assessment, a copy of the Assessment should be kept in both charts.
- The Assessment content should be reviewed with the client to ensure accuracy. If needed, an Assessment Addendum must be completed that includes:
    - Interim History
    - Any changes in all of the areas of the MH Assessment previously collected
    - A current included diagnosis
    - Signs and symptoms of the diagnosis that meet DSM 5 criteria
    - Functional impairments as a result of the diagnosis
    - Level of impairment
    - Client's ability to benefit from treatment

Lockouts

Under what circumstances do lock-outs apply to billing Medi-Cal for Specialty Mental Health Services (SMHS)?

Refer to the ACBH Mental Health Medi-Cal Lockout Grid for applicable SMHS scenarios:
ACBHCS' Mental Health (MH) Medi-Cal Lockout Grid

Unusual Occurrences

Under what circumstances is an Unusual Occurrence Form to be completed and sent to ACBH?

See the ACBH QA Manual, Section 6: UNUSUAL OCCURENCES/SENTINEL EVENTS and FCR, for information on events that require reporting using the Unusual Occurrence Form.

Specialized Programs

Therapeutic Behavioral Services

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What qualifications must a Therapeutic Behavioral Services (TBS) provider have?

TBS may be provided by a Licensed Practitioner of the Healing Arts (LPHA), or staff that work under the direction of an LPHA. The TBS Clinician is an LPHA and is responsible for the Client Plan and establishment of goals; the TBS Clinician is the Medi-Cal provider. The TBS Coach works under the direct supervision of the TBS Clinician and may implement the TBS Client Plan with oversight by the TBS Clinician.

Where can the training information and manuals mentioned in DMH Information Notice 08-38 related to TBS Documentation and Best Practices be found?

DMH/DHCS worked with the California Institute for Mental Health (CiMH) to develop the training materials mentioned in DMH Information Notice 08-38. The TBS Documentation Manual and the TBS Best Practices Manual are available via the link below. In addition, providers may sign up on the DMH website for updates to the training materials as well as other TBS information.

Refer to: https://www.dhcs.ca.gov/services/Pages/EPSDT.aspx

Who can provide Specialty Mental Health Services (SMHS) to children receiving TBS?

A provider is defined in the California Code of Regulations, Title 9, and Section 1810.235 as any person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide SMHS and who meets the standards for participation in the Medi-Cal program. Providers include, but are not limited to, licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals that are under contract with the MHP.

Can TBS be a "stand alone" Specialty Mental Health Service (SMHS) or does the client need to have an open mental health case with the MHP?

TBS can never be a "stand alone" SMHS. TBS is considered short-term and supplemental to other SMHS. SMHS are defined in CCR, Title 9, Section 1810.247 as rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, EPSDT supplemental specialty mental health services, and psychiatric nursing facility services.

Refer to: https://www.dhcs.ca.gov/services/Pages/EPSDT.aspx

How are clients referred for TBS services?

The TBS referral form can be found on the ACBH provider site. Refer to the link below for the current form.

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Microsoft Word - Initial Screening Criteria for TBS Eligibility 7-9-11.doc (acbhcs.org)

Therapeutic Foster Care

What is Therapeutic Foster Care (TFC)?

TFC is a service for children and youth under the age of 21, who meet medical necessity/access criteria for Specialty Mental Health Services (SMHS) and are at risk for entering a higher level of care, or who are stepping down from a higher level of care. TFC provides short-term, intensive, highly coordinated, trauma informed, and individualized treatment to eligible beneficiaries that have complex emotional and behavioral needs. Clients are placed with trained, closely supervised, and supported TFC parents.

If an agency does not provide TFC, what is the guideline for billing TFC referral and linkage services rendered to a client?

Agencies that do not provide TFC, can claim Case Management services for the linkage and monitoring of TFC services. See outlines of the referral process below.

For Youth Placed by Child Welfare or Probation:

- The Child Family Team (CFT) makes a recommendation for TFC Services.
- The placing agency then completes a referral and submits it to the Interagency Placement Review Committee (IPRC).
- If approved by the IPRC, the client's outpatient mental health provider will update the client's Assessment and Client Plan to include TFC as a modality. If a client is not already connected to outpatient MH services, the contracted TFC provider Alternative Family Services (AFS) will complete the Assessment and Client Plan.
- The Referral, Assessment, and Client Plan will be sent to UM for authorization.
- If authorized, AFS will develop a TFC specific Client Plan or collaborate with the outpatient clinician to redevelop the Client Plan to reflect the client's TFC needs.
- The client can be placed with a TFC parent for TFC services.

For Youth Who Are Not Child Welfare or Probation Involved:

- The client's outpatient MH clinician and CFT make a recommendation for TFC services. (If the client is not already receiving ICC, a referral is made to the ICC coordinator to initiate ICC services. From there, the CFT can recommend TFC services.)
- The client's outpatient MH clinician updates the Assessment and Client Plan to include TFC as a modality and sends a referral to the IPRC.
- The Referral, Assessment, and Client Plan will be sent to UM for authorization.
- If authorized, AFS will develop a TFC specific Client Plan or collaborate with the outpatient clinician to redevelop the Client Plan to reflect the client's TFC needs.

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- The client can be placed with a TFC parent for TFC services.

Short Term Residential Treatment Programs

Which Short Term Residential Treatment Program (STRTP) client forms require the signature of the Child Welfare Worker (CWW)?

Currently, ACBH does not require CWWs to sign the Assessment, Client Plan, or CANS. However, the STRTP Transition Determination Plan should be signed by the Placing Agency Representative to document notification of and involvement in the client's transition planning from the STRTP.

Note: There may be documents that require a signature by the minor client's Legal Guardian or Legal Representative, such as the Client Plan and Informing Materials. When a minor client has been placed by Child Welfare or Probation, it is recommended that the STRTP consult with the Placing Agency to determine the client's Legal Guardian or designated Legal Representative.

When STRTP staff employ Mental Health interventions while transporting clients to external service providers (e.g., transporting a client to an outside clinic for medication management), is the service considered billable?

Transportation is not a billable service; however, on the occasion that staff provide a medically necessary Specialty Mental Health Service (SMHS) while in transit, the intervention(s) may be considered billable. ACBH would recommend judicious consideration of what meets criteria for a medically necessary SMHS and then determine what service type best fits the intervention. Additionally, the scope of practice of the staff person needs to be considered and the service needs to be documented in the record with a description of the intervention and how it relates to the functional impairment and primary diagnosis of the client.

What is the timeline for completing the Initial Assessment for new STRTP clients?

STRTPs must complete the Initial Assessment within 5 days of the client's admission.

What is the timeline for completing the Initial CANS for new STRTP clients?

STRTPs should complete the Initial CANS as part of the Assessment process (Initial Assessment is due within 5 days of admission) and prior to the completion of the Client Plan.

Are there exceptions to the requirement of one note per day for STRTP clients?

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No. The regulations require a minimum of one written daily mental health progress note for each client at an STRTP. Occasionally, a client may not receive a Specialty Mental Health Service (SMHS) while at the STRTP on a particular day (e.g., if the client is unable to or declines to participate in the service). When this occurs, ACBH recommends documenting a daily mental health progress note as a non-billable service.

Progress notes should document the following, when applicable: 1) The specific service(s) provided to the client, 2) A client's participation and response to each SMHS, 3) Observations of a client's behavior, 4) Possible side effects of medications, 5) Summaries of the client's contact for that date with family, friends, natural supports, Child and Family Team, Mental Health Team, Legal Representative, or any public entities involved with the client, 6) Descriptions of the client's progress toward the goals identified in the Client Plan.

What is the procedure code for STRTP non-billable services?

Daily documentation should be entered using InSyst procedure code "197 CG Informational Note."

Intensive Care Coordination

What are the criteria for Intensive Care Coordination (ICC) services?

A Child/Youth/Young Adult (under 21) must meet ALL the following criteria for ICC consideration:

- Primary Mental Health clinician is in place and services are active.
- Involvement in more than one child-serving system in addition to Mental Health (e.g., Probation, Special Education, Drug & Alcohol, Regional Center, Crisis Shelter, or California Children's Services) or has multiple mental health providers.
- Standard Case Management Services cannot adequately address the client's needs and a more intensive level of care coordination is deemed necessary.

Refer to this link for the ICC Referral Form:
http://www.acbhcs.org/href_files/ICC-IHBS_Referral_Form_062917.pdf

In Home Behavioral Services

What are In Home Behavioral Services (IHBS)?

IHBS are mental health rehabilitative services that are available to clients under 21years of age who are receiving ICC. IHBS are individualized, strengths-based interventions designed to

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improve mental health conditions that interfere with a child, youth, or young adult's functioning. IHBS are aimed at helping the client build skills for success in their home and community.

If an agency does not provide IHBS, what is the guideline for billing IHBS referral and linkage services rendered to a client?

Agencies that do not provide IHBS, can claim Case Management services for the linkage and monitoring of IHBS.

Staff Credentialing

Information related to staff credentials can be found in the ACBH Guidelines for Scope of Practice Credentialing (MH) Grid linked below.

Refer to: ACBH Scope of Practice Grid.

Audits

What happens when Progress Notes in a chart selected for audit by Alameda County do not meet Medi-Cal documentation standards?

Providers and regulators have a legal and ethical duty to reduce fraud, waste, and abuse. All claims during an audit period (often 3 months of services) are examined to assure that the services provided support the claims associated with them. If documentation does not meet the minimum documentation requirements to support the service/claim, Alameda County will recoup those funds and return them to the funding source.

What is a Quality Comment? Will a claim be recouped based on a Quality Comment?

Charts may contain enough documentation to support a claim but still have quality issues. When a quality issue is identified, a Quality Comment is issued containing specific feedback on the quality concern(s). Providers are required to develop a Quality Improvement Plan (QIP) based on Quality Comments. Claims with only Quality Comments will not be recouped but should future claims demonstrating the same quality issues be identified, they may be recouped. It is imperative that the QIP be developed and integrated by the Agency to avoid future recoupment issues.

Why are claims outside of the audit period recouped?

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While reviewing a chart, if it is determined that claims outside of the audit period are not supported by documentation, there is a legal and ethical duty to recoup those funds and return them to the funding source.

What type of documentation issues cause recoupment of claims outside of the audit period?

The most common reasons for recoupment of claims outside the audit period include:

- Inadequate Assessments (e.g., sections missing, signatures missing, late completion, etc.)
- Inadequate Client Plans (e.g., sections missing, signatures missing, late completion, service modality claimed is not supported by documentation, etc.)
- The Screening Tool did not identify moderate to severe impairment of functioning making the client ineligible for SMHS under Medi-Cal.

For additional resources related to the audit process, refer to the ACBH Audit Notices, Reports, and Tools web page on the county's Provider Website.

For additional information on documentation standards, refer to the Clinical Documentation Standards Policy & Procedure Manual.