Upcoming Changes to the MHS Fee-for-Service Outpatient Therapy Level of Care

November 2022

Alameda County Behavioral Health Care Services

2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
http://www.acbhcs.org/

Presenters:

Contracts: Ariana Frazier, Procurement and MHP FFS Network Administrative Specialist II

ACCESS: Wendy Zastawney, LCSW, Clinical Review Specialist Supervisor

Billing and Benefits Insurance Verification: Sarah Maslin, Patient Services Supervisor and Renee Renteria, Client Benefits and Accounts Manager

Quality Assurance: Danielle Pence, LMFT, LPCC, Clinical Review Specialist

Utilization Management: Janyce Prothro, LMFT, Clinical Review Specialist Supervisor

Billing and Benefits Claims Processing Center: Suzanne Huot, Health Care Claims Processing Center

Introduction

- Federal regulations require Mental Health Plans (MHP) to bring their Fee for Service (FFS) systems into alignment with the Managed Care Final Rule and the Parity Final Rule.
- This means that MHPs, like ACBH, **can no longer require prior authorization for outpatient therapy**.
- This change impacts the FFS providers in multiple ways.
- The goal of this presentation is to review these changes in more detail.

Operational Changes

Some of the changes impacting FFS providers are as follows:

- **Increasing access:** In addition to receiving referrals from ACBH ACCESS, providers will be able to start seeing Alameda County Medi-Cal clients who meet eligibility criteria and Specialty Mental Health access criteria in their practice, without the referral initiating from ACCESS.

- **Transferring service authorization to providers**: ACBH ACCESS and UM departments will no longer preauthorize services and providers will no longer need to submit a Request for Continued Services (RCS) to the UM department every six months.

Operational Changes

- **Monitoring Quality of Care and Compliance**:
  - The Quality Assurance (QA) office will train providers on how to use the Clinical Quality Review Team (CQRT) form to review their documentation to ensure it meets SMHS requirements.
  - Annually, the QA team will randomly select FFS providers for a CQRT review. During this review, providers will be asked to share their completed CQRT forms with QA staff and will be provided with feedback and coaching.

- **Evaluating Best Matched Care**:
  - The UM Department will develop reports to review outpatient service utilization when our billing system transitions to SmartCare in July 2023.
  - Clients who either receive an unusually high amount of services or considerably low amount of services will be identified. A UM staff member will contact the provider to discuss the clinical reasons for what appears to be over or under utilization and explore if the client is in the best matched level of care or may benefit from additional services or transitioning to a different level of care.

Operational Changes

- **Maintaining Service Authorizations**:
  - ACBH will maintain the function of authorizing payments to FFS providers.
  - To manage utilization and ensure access to services, ACBH has created a Utilization Table which identifies a maximum number of sessions by service modality (i.e., individual therapy, case management, collateral, etc.) that a provider can deliver to a client within one month.
  - There will be no change in how Providers currently submit their claims.

Presentation Content

To support you in better understanding these changes, you will hear from the following ACBH teams during this presentation:

- Contracts
- ACCESS
- Benefits and Billing Insurance Verification
- Quality Assurance
- Utilization Management
- Billing and Benefits Claims Processing

Contracts Unit

P: 510.567.8296
F: 510.567.8290
E: procurement@acgov.org

Contracts Unit
c/o MHP FFS Provider Network
1900 Embarcadero Cove, Suite 205
Oakland, CA 94606

Contract Compliance Responsibilities

Provider Action	Frequency of Action	Must be Submitted to	Consequence of Non-Compliance
Update CAQH ProView account and attest CAQH profile.	*Attest every 120 days in CAQH*	*CAQH ProView https://proview.caqh.org/Login*	*Providers who do not regularly attest their ProView profile, or submit up-to-date proof of insurance, licenses and updates are at risk for involuntary dis-enrollment from the MHP Provider Network*
Upload proof of professional liability and general liability insurance coverage meeting the minimum of $1,000,000 per incident and $2,000,000 aggregate.	*Annually, prior to expiration. If there is a delay in uploading your insurance to CAQH ProView, inform the Contracts Unit immediately at procurement@acgov.org*	*CAQH ProView https://proview.caqh.org/Login*	
Submit a photocopy of all applicable state license(s) with a clearly visible expiration date. If your license is revoked or suspended, you must inform the Contracts Unit immediately.	*Prior to expiration date when possible. If there is an issue in renewing your license, inform the Contracts Unit immediately at procurement@acgov.org*	*CAQH ProView https://proview.caqh.org/Login*	
Update the Contracts Unit on all changes to contact information such as, addresses, phone/fax numbers and email addresses. Updates must also be made to ProView profile	*As information changes*	*Procurement@acgov.org and CAQH ProView https://proview.caqh.org/Login*	

ACCESS

Phone: 1-800-491-9099

Fax: 1-510-346-1083

Email: ACCESSReferrals@acgov.org

ACCESS Unit:

2000 Embarcadero Suite #205

Oakland CA 94606-5303

What is ACCESS and Who Do We Serve?

- Alameda County Behavioral Health (ACBH) ACCESS is a 24-hour resource and major entry point for Medi-Cal beneficiaries to obtain mental health services and supportive recovery resources for substance use disorders. ACCESS provides mental health screening and triage through licensed clinicians who evaluate treatment needs and ensure expedient and appropriate access to ACBH services.

- In order to be eligible for Specialty Mental Health Services (SMHS) through ACBH, an individual must be a resident of Alameda County, have Alameda County Medi-Cal or be eligible for Medi-Cal or HealthPAC, and meet Medi-Cal's SMHS access criteria. The SMHS access criteria can also be found in DHCS BHIN 21-073.

How do beneficiaries Connect with Fee for Service (FFS) Providers?

- Through a referral from ACCESS. This process is not changing.
- Through a beneficiary and therapist connecting directly without a referral from ACCESS

Referrals from ACCESS

- Most often beneficiaries will connect to FFS Providers following a screening with ACCESS. Once eligibility is determined, ACCESS staff can make a referral. Referrals to FFS Providers are based upon the beneficiary's mental health needs and provider availability. ACCESS matches beneficiaries to services based upon several factors including preference for a provider with a specific language/cultural background, provider's gender, geographic location and provider's clinical specialties.

- Once a FFS Provider is identified, ACCESS sends a Referral Letter, by fax or US Mail and email that notifies them that a beneficiary has been referred. This notification includes the requested service, clinical information, the beneficiary's insurance plan and special instructions that correspond with that plan. ACCESS verifies Medi-Cal eligibility for the month of the referral only. It is the responsibility of the FFS Provider to verify Medi-Cal status for all subsequent months and preferably before each session.

What to do When You Receive a Referral from ACCESS

- Upon receiving a Referral Letter from ACCESS, the FFS Provider is expected to reach out to the beneficiary and offer the initial appointment that is within 10 business days of the beneficiary's request. If you are unable to offer an appointment date within 10 days, inform ACCESS immediately and a new referral will be made for the beneficiary.

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Therapist and Client Connecting for Services without an ACCESS Referral

FFS Providers can start seeing Alameda County Medi-Cal clients who meet SMHS eligibility criteria in their practice, without a referral from ACCESS. In these situations, the Provider must do the following to bring a new beneficiary into their practice:

Therapist confirms and documents the following on the New Client Attestation form:

- The individual is a resident of Alameda County per the Medi-Cal Eligibility Data System (MEDS). Providers are given access to this system upon becoming an ACBH FFS Provider. If you need information on how to access the MEDS system, please contact our **Provider Help Desk Phone#** (888) 346-0605 **E-Mail:** Eligibilityhelpdesk@acgov.org
- The individual has Alameda County Medi-Cal per the MEDS system. Providers should save the eligibility response as it will need to be submitted with the Attestation form.
- The individual meets access criteria for Specialty Mental Health Services. Providers may use the ACBH Behavioral Health Screening Tool for Outpatient Services to document this.
- That outpatient therapy is the most appropriate level of care for the individual at this time.

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After completing the Attestation Form, the Therapist takes the following steps to bring a new client into their practice:

- Therapist documents this information on attestation form and sends attestation form and accompanying documents to ACCESS for review by the Health Insurance Technician (HIT) at ACCESS and to ACCESS clinical staff.
- HIT staff at ACCESS verifies insurance.
- If beneficiary meets insurance eligibility, the HIT staff at ACCESS confirms this with the outpatient therapist and clinical ACCESS staff.
- Once insurance is verified, ACCESS clinical staff reviews that the attestation form is complete and client meets all other eligibility requirements.
- If attestation form is complete and client meets eligibility requirements, ACCESS staff registers client in systems. the ACCESS staff member informs therapist, QA, UM and BBS Claims Processing Center (CPC) that registration is complete.

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Continuity of Care

- All eligible Medi-Cal beneficiaries who meet access criteria for Specialty Mental Health Services have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to ACBH shall be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or terminated network provider, necessary to complete a course of treatment and to arrange for safe transfer to another provider. Individuals can request Continuity of Care by calling the ACCESS department at 1-800-491-9099.

FFS Providers Ongoing Relationship with ACCESS

- ACCESS is a resource for FFS Providers and can assist with such things as clinical consultation, triage of urgent mental health needs and linkage to community resources. ACCESS clinicians can assist FFS Providers with connecting beneficiaries to higher or lower levels of care and adjunct services when appropriate.

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Insurance Verification

Presenters: Renee Renteria and Sarah Maslin

P: 510.383.1566
P: 510.777.2195

E: Eligibilityhelpdesk@acgov.org
E: Renee.Renteria@acgov.org
E: Sarah.Maslin@acgov.org

Billing and Benefits Unit
1900 Embarcadero Cove, Suite 101
Oakland, CA 94606

Verifying Medi-Cal Eligibility

- Provider responsibility
- State online verification process
- Reading the response

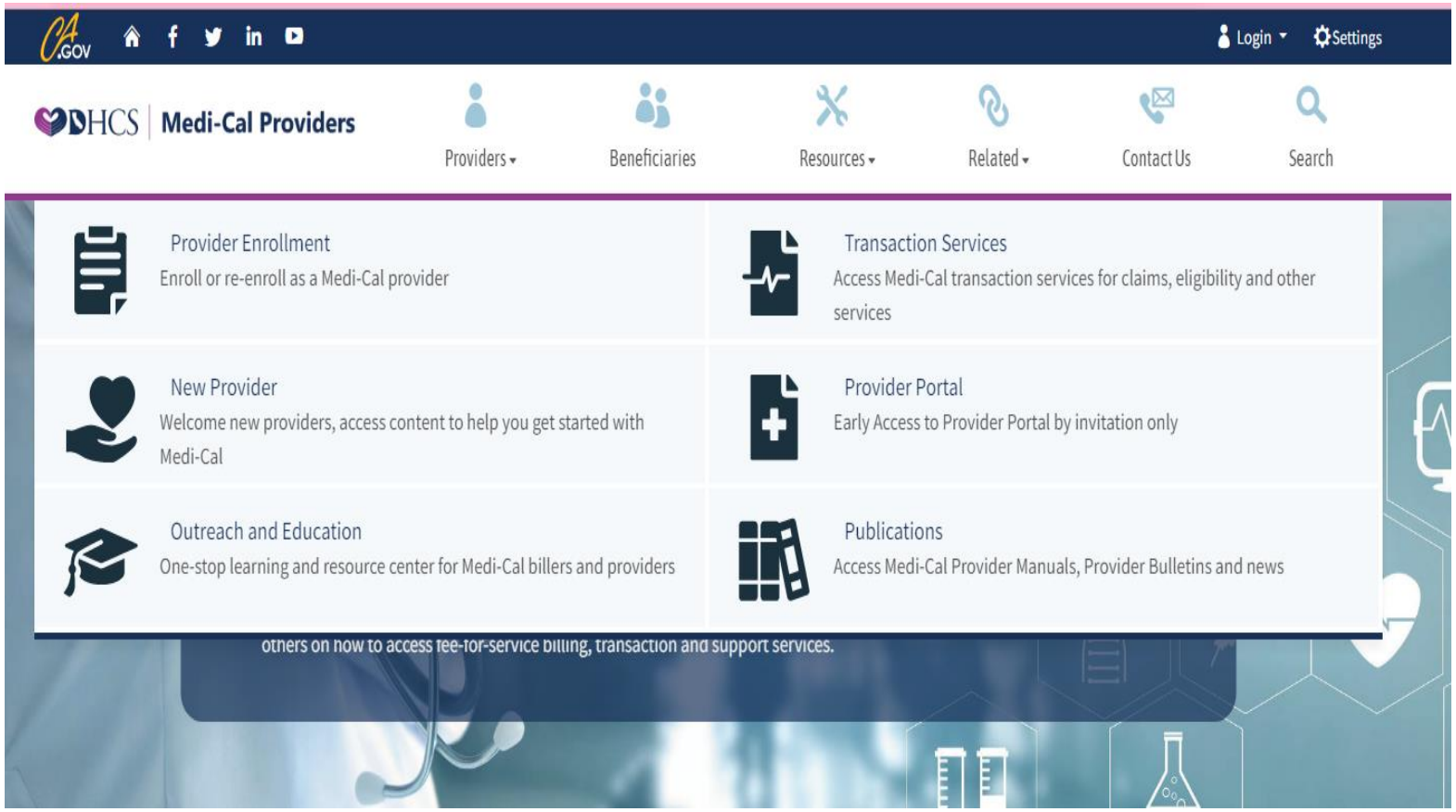
Provider Responsibility

- Medi-Cal providers are required to verify a client's Medi-Cal coverage at a minimum of once a month (at each visit is preferred) via the AEVS or Medi-Cal web site. Please note: AEVS confirmation is for eligibility purposes only, a confirmation code is not a guarantee of payment.
- Providers may use a client's SSN to verify Medi-Cal coverage. When using the SSN to verify coverage, the client's CIN ("Client Index Number") will be returned in the text of the eligibility response. The CIN number must be truncated at the alpha character for entry into InSyst for Medi-Cal claiming.

NOTE: ACBH recommends that providers retain proof of Medi-Cal eligibility for each client each time a service is rendered. Medi-Cal eligibility has the potential to change at any time.

Medi-Cal Website

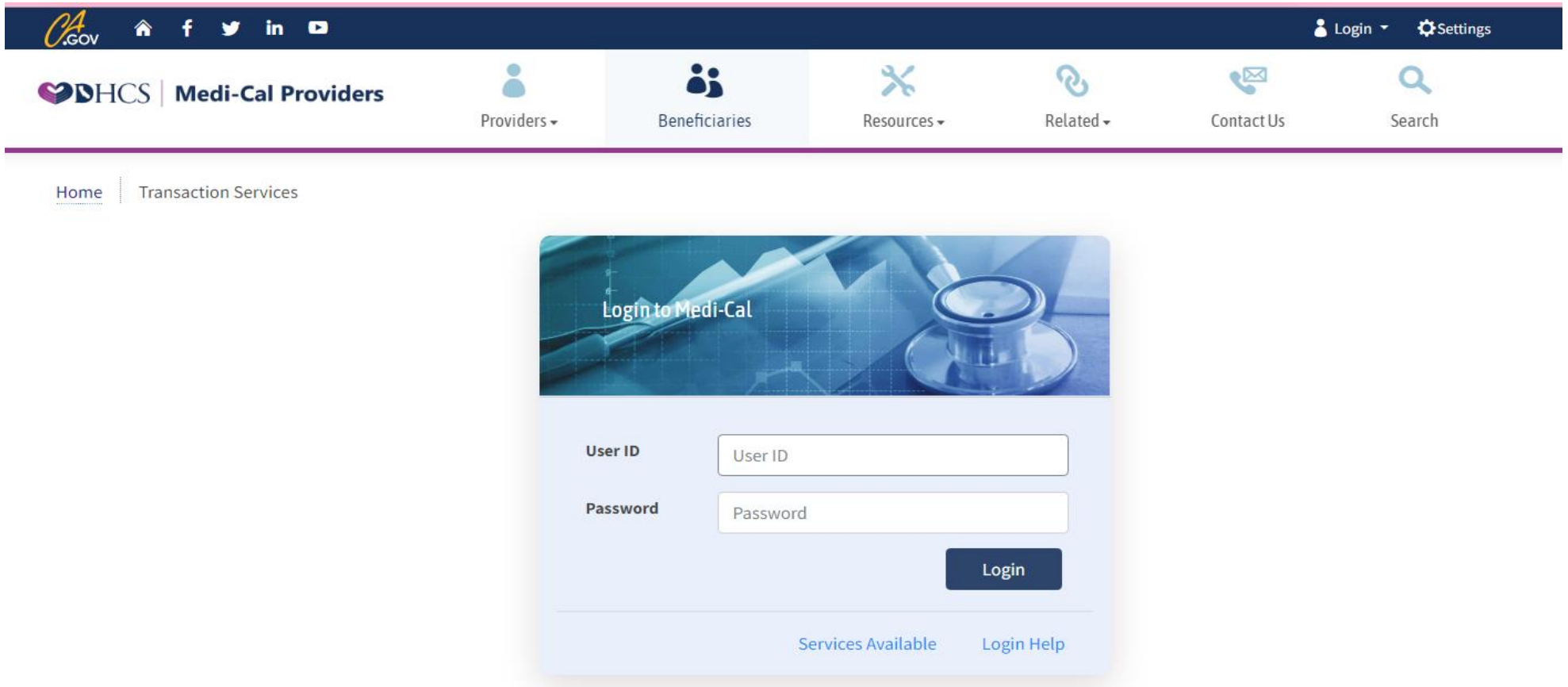
- How to verify Medi-Cal coverage
- Log on to the State Medi-Cal website: www.medi-cal.ca.gov
- Click on “Providers” (top) and then “Transactions Services” on the right hand column



Please note: If this is the first time you are using the state website, you will need to complete internet enrollment forms with the State. See “Transaction Enrollment Requirements” tab .

Logging In

- Enter user ID and Password



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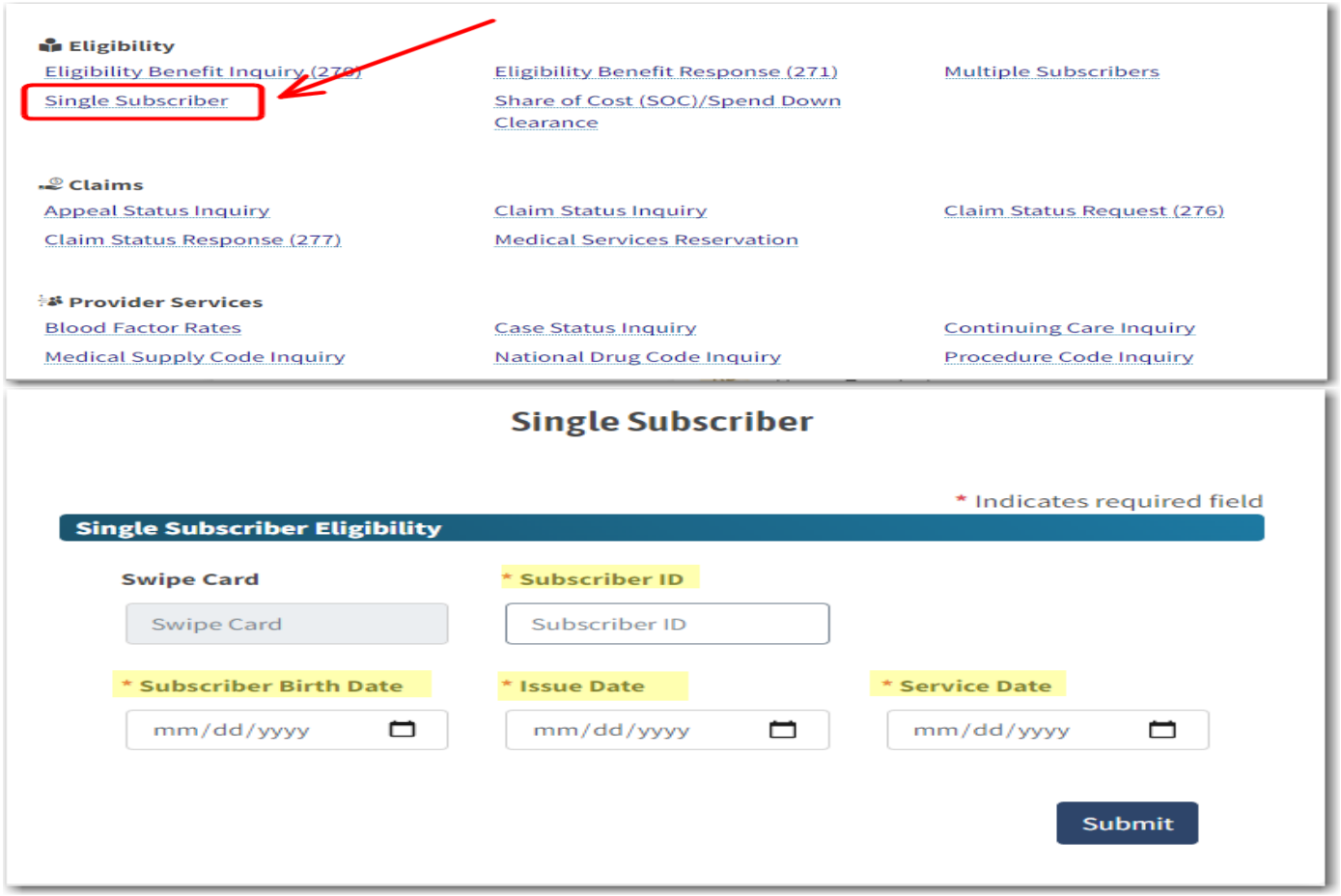
Looking Up Medi-Cal Coverage



- Select "Single Subscriber"
- Enter in required data
  - **Subscriber ID**: SSN or CIN
  - **Subscriber Birth Date**
  - **Issue Date:** Use the current date
  - **Service Date**: Date services are being rendered

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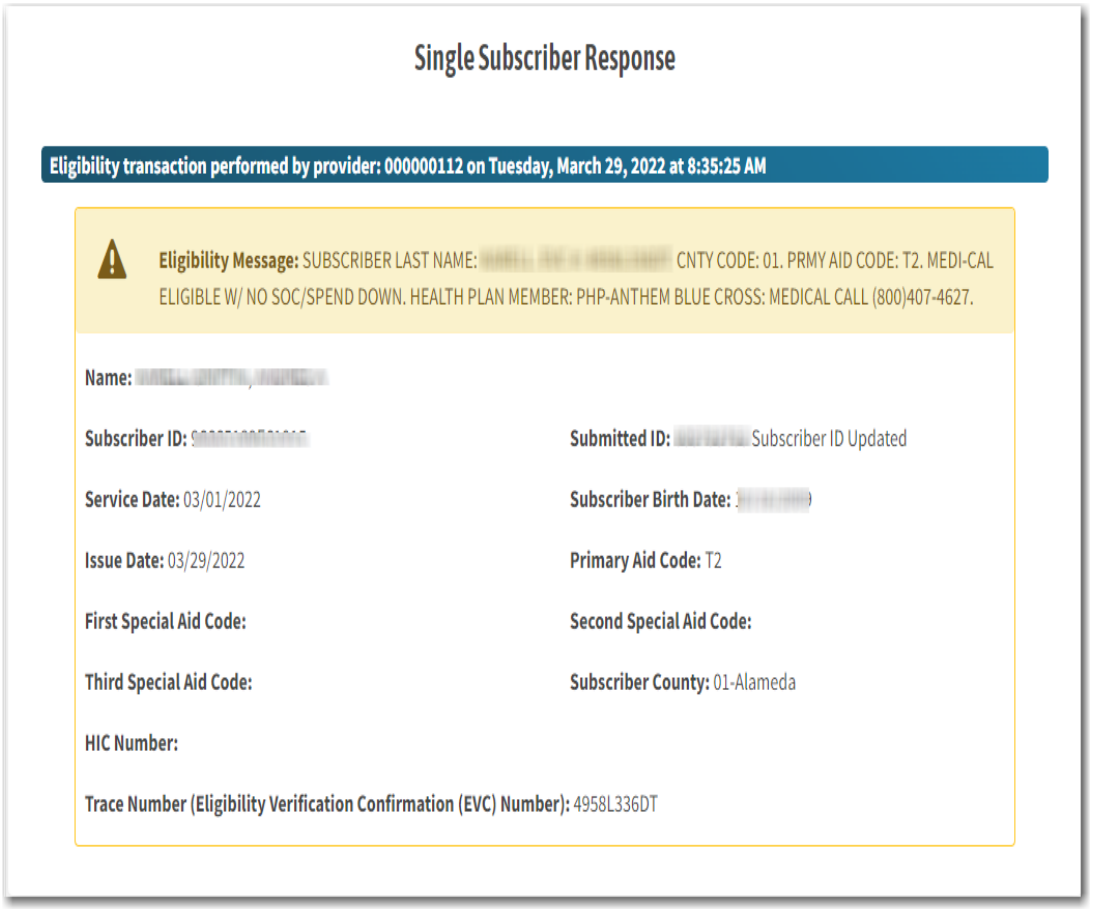
Reading the Eligibility Message



Single Subscriber Response

Eligibility transaction performed by provider: 000000112 on Tuesday, March 29, 2022 at 8:35:25 AM

Eligibility Message: SUBSCRIBER LAST NAME: [redacted] CNTY CODE: 01. PRMY AID CODE: T2. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-ANTHEM BLUE CROSS: MEDICAL CALL (800)407-4627.

Name: [redacted]

Subscriber ID: [redacted] **Submitted ID:** [redacted] Subscriber ID Updated

Service Date: 03/01/2022 **Subscriber Birth Date:** [redacted]

Issue Date: 03/29/2022 **Primary Aid Code:** T2

First Special Aid Code: **Second Special Aid Code:**

Third Special Aid Code: **Subscriber County:** 01-Alameda

HIC Number:

Trace Number (Eligibility Verification Confirmation (EVC) Number): 4958L336DT

The "Eligibility Message" will provide an over-view of coverage including:

- Client name
- County code and aid code
- Type of Medi-Cal
- Medicare Information
- Managed Medi-Cal plan information
- Any OHC ("Other Health Insurance") information

- **Name :** Subscriber first and last name
- **Subscriber ID**
- **Service Date:** This will be the date you entered
- **Issue Date:** This will be the date you entered

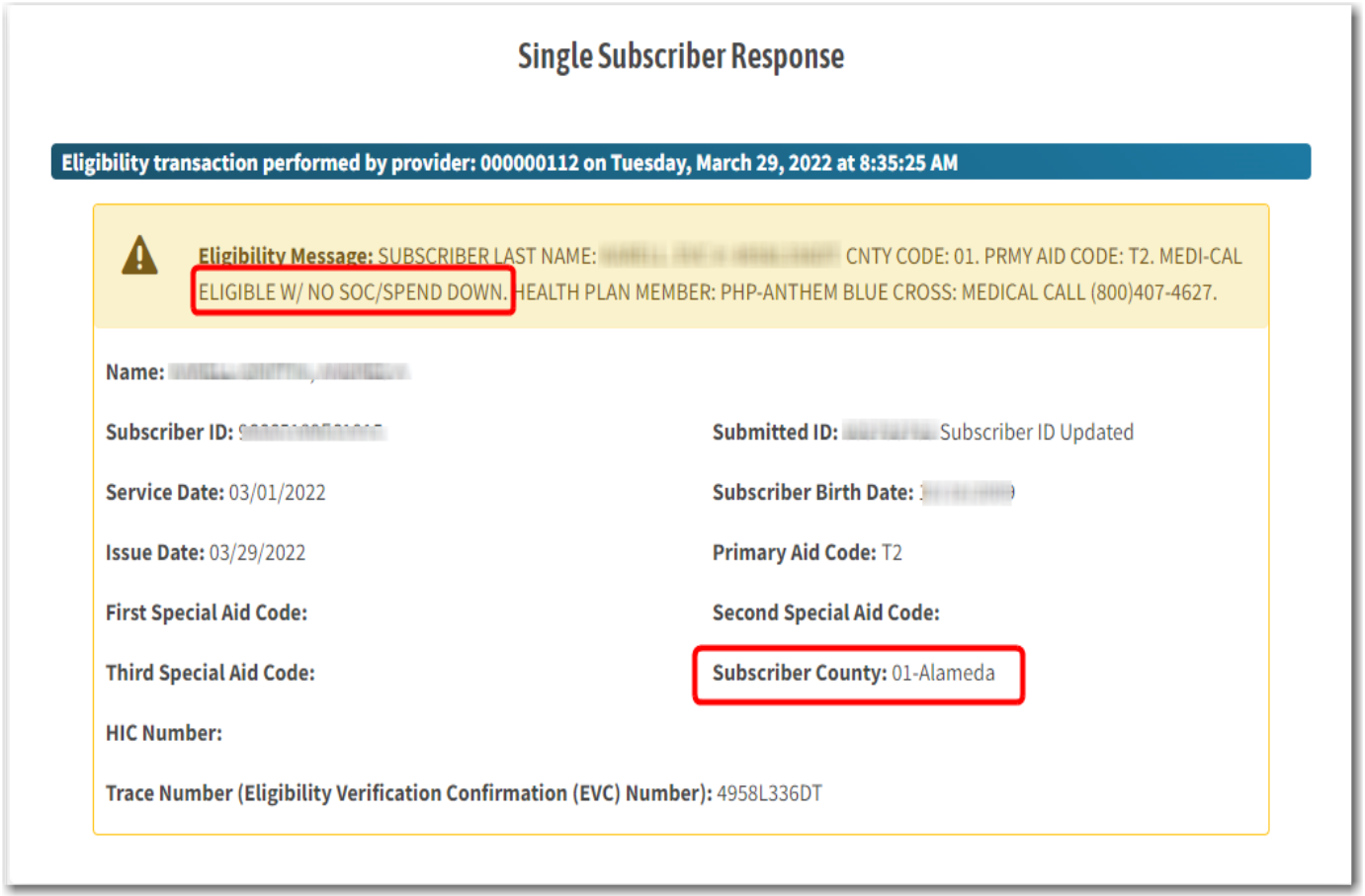
- **First Special Aid Code**
- **Third Special Aid Code**
- **HIC Number:** (Medicare #)
- **Trace Number:** Eligibility Verification Confirmation Number

- **Submitted ID:** CIN or SSN used to look client up
- **Subscriber Birth Date**

- **Primary Aid Code**

- **Second Special Aid Code**
- **Subscriber County:** The county the Medi-Cal is assigned to

Response = Full Scope Alameda County Medi-Cal



Single Subscriber Response

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Eligibility Message: SUBSCRIBER LAST NAME: [redacted] CNTY CODE: 01. PRMY AID CODE: T2. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-ANTHEM BLUE CROSS: MEDICAL CALL (800)407-4627.

Name: [redacted]

Subscriber ID: [redacted] **Submitted ID:** [redacted] Subscriber ID Updated

Service Date: 03/01/2022 **Subscriber Birth Date:** [redacted]

Issue Date: 03/29/2022 **Primary Aid Code:** T2

First Special Aid Code: **Second Special Aid Code:**

Third Special Aid Code: **Subscriber County:** 01-Alameda

HIC Number:

Trace Number (Eligibility Verification Confirmation (EVC) Number): 4958L336DT

- **Eligibility response message:**

MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN

- **What does that mean?**

This message indicates that the client has full-scope, no share of cost Medi-Cal

The “Managed Care” plan is Anthem Blue Cross (this is NOT private insurance)

The Subscriber County displays as Alameda

Response = Managed Medicare (OHC)

Single Subscriber Response

Eligibility transaction performed by provider: 000000112 on Tuesday, March 29, 2022 at 1:30:53 PM

Eligibility Message: SUBSCRIBER LAST NAME: [redacted] EVC #: 5379K057W3. CNTY CODE: 01. PRMY AID CODE: 6H. 1ST SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-ALAMEDA ALLIANCE FOR HLTH: MEDICAL CALL (510)747-4500. PART A, B AND D MEDICARE COV W/MEDICARE ID #[redacted]. MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. OTHER HEALTH INSURANCE COV UNDER CODE F - MEDICARE PART C HEALTH PLAN. CARRIER NAME: UHC OF CALIFORNIA, INC.. COV: OIM R.

Name: [redacted]

Subscriber ID: 94661704G51225

Submitted ID: [redacted] Subscriber ID Updated

Service Date: 03/01/2022

Subscriber Birth Date: [redacted]

Issue Date: 03/29/2022

Primary Aid Code: 6H

First Special Aid Code: 80

Second Special Aid Code:

Third Special Aid Code:

Subscriber County: 01-Alameda

HIC Number: [redacted]

Primary Care Physician Phone #:

Service Type: OIM R

Trace Number (Eligibility Verification Confirmation (EVC) Number): 5379K057W3

- **Eligibility response message:**

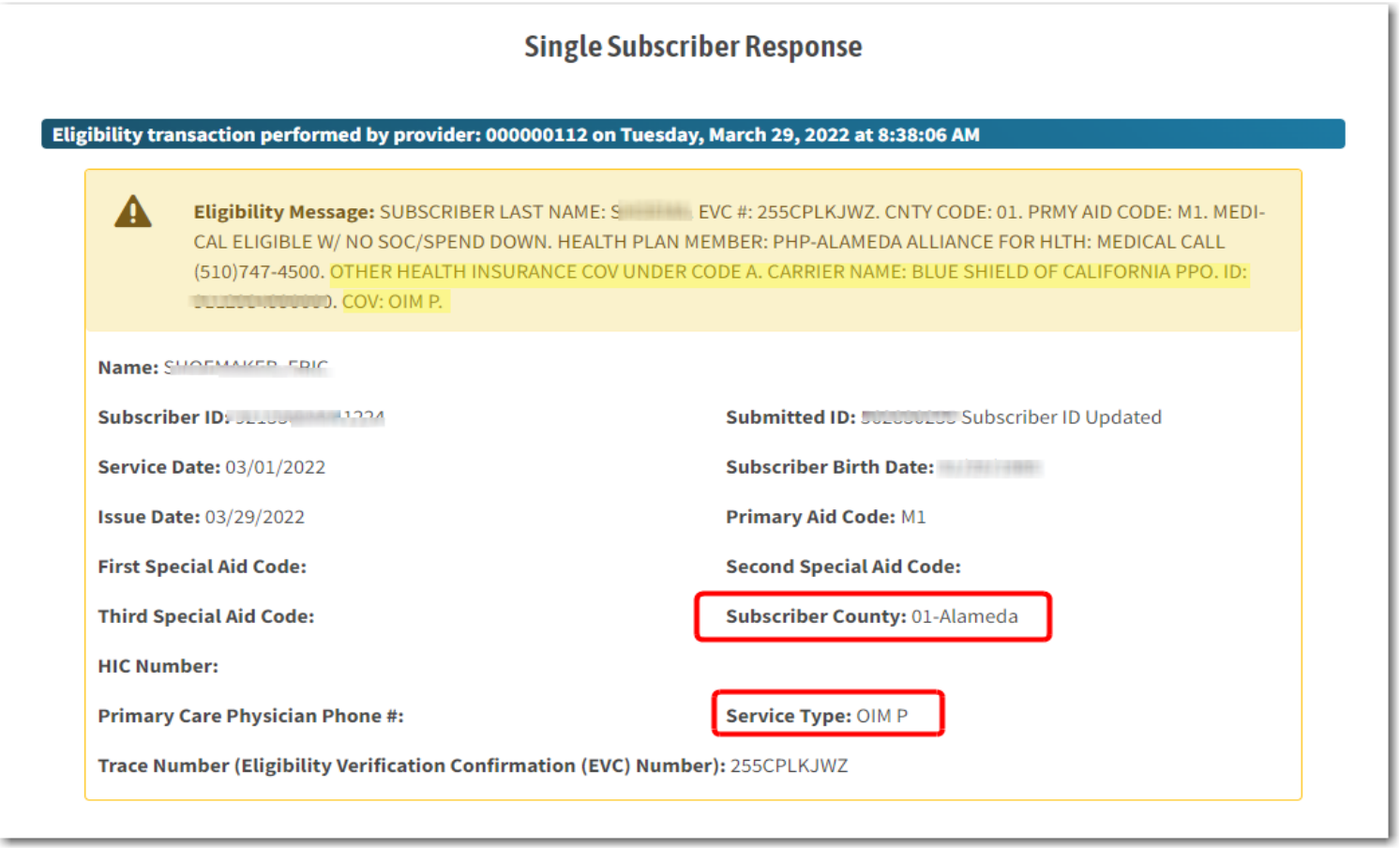
OTHER HEALTH INSURANCE COV UNDER CODE F- MEDICARE PART C HEALTH PLAN. COV: OIM

- **What does it mean?**

This client has a Medicare Part C plan. They are no longer traditional Medicare and must be considered to have private insurance. Note the verbiage **"OTHER HEALTH INSURANCE "** and "**COV: OIM"**

Note: the client's services must be billed to the insurance carrier and **NOT** Medicare. Medi-Cal will not reimburse for services that have not been claimed to the insurance carrier.

Response = Other Health Insurance (OHC)



Single Subscriber Response

Eligibility transaction performed by provider: 000000112 on Tuesday, March 29, 2022 at 8:38:06 AM

Eligibility Message: SUBSCRIBER LAST NAME: S EVC #: 255CPLKJWZ. CNTY CODE: 01. PRMY AID CODE: M1. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-ALAMEDA ALLIANCE FOR HLTH: MEDICAL CALL (510)747-4500. OTHER HEALTH INSURANCE COV UNDER CODE A. CARRIER NAME: BLUE SHIELD OF CALIFORNIA PPO. ID: [redacted]. COV: OIM P.

Name: [redacted]

Subscriber ID: [redacted] **Submitted ID:** [redacted] Subscriber ID Updated

Service Date: 03/01/2022 **Subscriber Birth Date:** [redacted]

Issue Date: 03/29/2022 **Primary Aid Code:** M1

First Special Aid Code: **Second Special Aid Code:**

Third Special Aid Code: **Subscriber County:** 01-Alameda

HIC Number:

Primary Care Physician Phone #: **Service Type:** OIM P

Trace Number (Eligibility Verification Confirmation (EVC) Number): 255CPLKJWZ

- **Eligibility response message:**

OTHER HEALTH INSURANCE COV UNDER CODE A. CARRIER NAME: BLUE SHEILD OF CALIFORNIA PPO. ID XXXX. COV: OIM P.

- **What Does it mean?**

The client has a PPO plan with Blue Shield of California. The plan covers the below services:

O – Out patient

I – In patient

M – Medical

P – Prescription

Note: Providers must contact the insurance carrier to confirm benefits, obtain authorization or transition the client to a provider within the insurance carrier's network. Services must be billed to the insurance plan first.

Other Health Insurance Continued

- The following indicates the client has private/commercial insurance coverage:

  "Medicare Part C"

  "Other Health Insurance"

- Providers must contact the insurance carrier to confirm benefits and obtain authorization to provide services to the client or transition the client to a provider within the insurance plan's network of providers.
- Private Insurance carriers must be billed prior to billing Medi-Cal.
- Medi-Cal will not reimburse for services without a valid denial from the insurance carrier or proof of payment from the carrier.
- Valid denials - these are the **ONLY** valid denial reasons:

* Service is not a covered benefit

* Benefits have been exhausted

* Client is no longer covered by health plan

Coverage Code Definitions

HEALTH INSURANCE SYSTEM:
Scope of Coverage

COVERAGE CODE	SERVICE
D	Dental
I	Hospital Inpatient
L	Long Term Care
M	Medical and Allied Services
O	Hospital Outpatient
P	Prescription Drugs
R	Medicare Part D
V	Vision Care

If coverage unknown, OHC is regarded as comprehensive - Provider must bill OHC carrier for all services.

Order on HIS is as follows: O I M P L D V R

Coverage codes I, O, M and Comprehensive must be claimed to the insurance carrier. Payment or a valid denial must be reported on the Insurance Payment form and sent to Billing and Benefits Support Unit

Resources

Training Questions

- **Sarah Maslin,** Patient Services Supervisor
- **Phone#** (510) 777-2195
- **E-Mail:** Sarah.Maslin@acgov.org
-
- **Renee Renteria,** Client Benefits and Accounts Manager
- **Phone#** (510) 383-1566
- **E-Mail:** Renee.Renteria@acgov.org

Medi-Cal Verification Response Questions

- **Billing and Benefits Support Unit, Provider Help Desk**
- **Phone#** (888) 346-0605
- **E-Mail:** Eligibilityhelpdesk@acgov.org

Quality Assurance

Presenter: Danielle Pence, Clinical Review Specialist

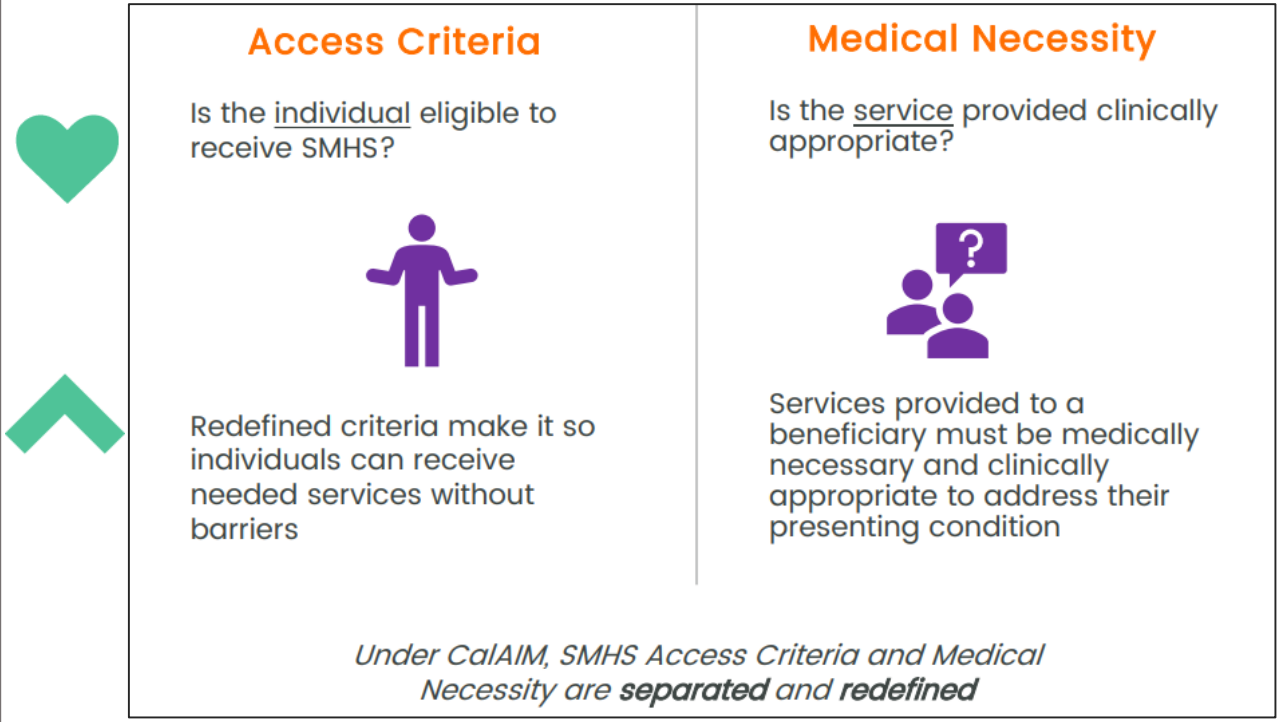
Contact Information : QATA@acgov.org

Learning Objectives

- Understand the new CalAIM Medical Necessity and Access Criteria
- Know where to go to learn about CalAIM Documentation Changes (just provide links to resources)
- Understand the new Clinical Quality Review Team (CQRT) requirements

Access Criteria and Medical Necessity
What has changed?

- Fee-for-service providers are responsible for assessing and documenting that a beneficiary meets Medical Necessity and access criteria for SMHS.
- To remove barriers to accessing care, the criteria to access SMHS has been separated from Medical Necessity.
- A diagnosis is no longer a prerequisite for accessing needed SMHS or DMC/DMC-ODS outpatient services.
- Outpatient services rendered in good faith are reimbursable prior to determination of an official diagnosis.
- The "Included" diagnosis list is no longer used to determine if an individual can receive services.



BHIN-21-073

SMHS Medical Necessity

Definition of Medical Necessity was brought into alignment with Welfare and Institutions Code 1418.402(a) for those 21 and over and with Section 1396(r)(5) of Title 42 of the US Code for Individuals under 21 years of age.

Adults Age 21+	Youth Under Age 21
A service is "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.	A service is "medically necessary" if it is necessary to correct or ameliorate a mental illness or condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition.
Welfare & Institutions Code sections 14184.402(a) & 14059.5	*Section 1396d(r)(5) of Title 42*

SMHS Access Criteria

Adults Age 21+

Must meet *both* of the following criteria:

Criteria 1:

- The beneficiary has *one or both* of the following:
  - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

  And/or
  - A reasonable probability of significant deterioration in an important area of life functioning.

and

Criteria 2:

The beneficiary's condition is due to *either* of the following:

- A diagnosed DSM mental health disorder

or

- A suspected mental disorder that has not yet been diagnosed.

14184.402(f)(1)(A), **Except for psychiatric inpatient hospital and psychiatric health facility services** a mental health diagnosis is not a prerequisite for access to covered SMHS.

SMHS Access Criteria

Youth Under Age 21

Must meet *either* of the following criteria:

The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma as 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
- Experiencing homelessness

Optional Trauma Screening tools:
- Pediatric ACES and Related Life-Events Screener (PEARLS) tool
- ACE Questionnaire

or

The beneficiary meets *both* of the following requirements

The beneficiary has at least *one* of the following:
- A significant impairment
- A reasonable probability of significant deterioration in an important area of life functioning
- A reasonable probability of not progressing developmentally as appropriate.
- 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
- The beneficiary's condition is due to *one* of the following:
- A diagnosed mental health disorder
- A suspected mental health disorder that has not yet been diagnosed.
- Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

SMHS Access Criteria Highlights

- To remove unnecessary barriers to care, an "Included" DSM/ICD-10 diagnosis is no longer required for accessing needed SMHS. Services rendered in good faith are reimbursable prior to the determination of an official diagnosis.
- Eligibility criteria for beneficiaries under 21 years of age now includes **"high risk for a mental health disorder due to the experience of trauma,"** as evidenced by a high score on a state-approved trauma screening tool, child welfare or juvenile justice involvement, and/or homelessness
- A mental health **diagnosis is not a prerequisite** for access to covered SMHS. This **does not eliminate** the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code.

Additional Clarifications and Requirements

Coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service is not excluded under any of the following circumstances:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.*
- The beneficiary has a co-occurring substance use disorder.

These claims will no longer result in disallowances.

*Some SMHS still require an individual plan of care, such as Targeted Case Management. See BHIN 22-019, *Attachment 1, Requirements that Remain in Effect*.

Cal-AIM Documentation Standards

- As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, SMHS changes to documentation standards took effect on July 1, 2022.
- California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority that provides administrative and fiscal services in support of Behavioral Health Departments.
- Alameda County Behavioral Health Care Services (ACBH) has adopted and intends to continue to utilize the resources developed by CalMHSA to support the roll out of the CalAIM initiative.

Documentation Resources available on the CalMHSA CalAIM webpage:

- Clinical Documentation Guide for Clinical Staff: CalMHSA has published a number of manuals for SMHS providers. These manuals are updated by CalMHSA as additional clarification is received, and are available at the CalMHSA webpage.
- Training videos: CalMHSA has published a number of training videos that describe the changes related to CalAIM. To access these training videos, you must first create an account on the Learning Management System.

BHIN 22-019

Z Codes

During the assessment phase when a diagnosis has yet to be established, the following codes may be used:

ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

NOTE: Due to system limitations, these codes will not be available for SMHS until the launch of SmartCare, expected in July 2023.

ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code list, which may include Z codes. For example, these include codes for "Other specified" and "Unspecified disorders," or "Factors influencing health status and contact with health services."

BHIN 22-013

Frequently Asked Questions

Question	Answer
Can **FFS providers** stop using the Brief Screening Tool given the changes to the access criteria?	• Yes. DHCS is developing a set of statewide tools to facilitate screenings and transitions of care for the specialty mental health, Medi-Cal managed care and fee for service systems. These tools are expected to be available in January 2023. • **FFS providers** need to continue to have screening procedures in place to determine if an individual will be served by the Mental Health Plan (MHP) or if they should be referred to the Managed Care Plan (MCP). • ACBH has created a BH Screening Tool for Outpatient Services that can be used by providers as an optional resource.
Since a diagnosis is no longer required for access to services, how will the assessment be completed with a Z code? Will documentation of functional impairment be sufficient?	• Documentation in the medical record must initially demonstrate that the beneficiary meets the specific access criteria for each delivery system. If a diagnosis cannot be immediately established, specific Z Codes are allowed for billing and to start the Problem List. • DHCS has noted that there is no need for Progress Notes to demonstrate full medical necessity in each note; A comprehensive, up-to-date assessment and problem list are sufficient to meet this requirement. • Clinically assessing a beneficiary's functional impairments is appropriate and should be part of an assessment.

Cal-AIM Documentation Standards

As part of the California Advancing and Innovating Medi-Cal (Cal-AIM) initiative, SMHS changes to documentation standards have take effect as of July 1, 2022.

- California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority that provides administrative and fiscal services in support of Behavioral Health Departments.
- Alameda County Behavioral Health Care Services (ACBH) has adopted and intends to continue to utilize the resources developed by CalMHSA to support the roll out of the Cal-AIM initiative. CalMHSA CalAIM webpage

- Documentation Resources:
  - **Clinical Documentation manuals**: CalMHSA has published a number of manuals for both SMHS and DMC-ODS providers. These manuals are updated by CalMHSA as additional clarification is received.
  - **Training videos**: CalMHSA has published a number of training videos that describe the changes related to CalAIM. To access these training videos, you must first create an account on Learning Management System.

Clinical Quality Review Team (CQRT)

Provider's CQRT Process

- Providers are required to use the CQRT Checklist to review their documentation to ensure it meets SMHS requirements.
- The CQRT Checklist should be completed for at least one chart each month and the CQRT Tracking Sheet completed to demonstrate compliance with this requirement.

ACBH Quality Assurance (QA) CQRT Process

- Annually, the QA team will randomly select five percent of FFS providers across our system for a CQRT review.
- During this review, providers will be asked to share their completed CQRT forms and Tracking Sheets with QA staff and will be provided with feedback and coaching.

Utilization Management

Presenter: Janyce Prothro

Contact Information:
Email is the best way to contact the UM Program
Email: utilizationmanagement@acgov.org

UM's phone and fax are:
Phone: (510) 567-8141
Fax: (510) 567-8148

UM's mailing address is:
2000 Embarcadero, Suite 400 Oakland, CA 94606

Ending Preauthorization of Services

- Preauthorization of FFS outpatient therapy services will be ending soon and the Request for Continued Services (RCS) form will no longer be required for review by Utilization Management (UM)

- At the same time, ACBH needs to manage utilization to ensure all beneficiaries have access to timely, appropriate and quality care.

- In order to do this ACBH has developed an Utilization Table.

Introducing our Utilization Table

- The Utilization Table on the next slide provides guidelines for the frequency of service by modality type, by client, by month. For example, per the Utilization Table, Providers can render up to ten individual therapy sessions and up to four case management sessions per month per client.

- All services rendered must be justified and clinically appropriate based on the client's current mental health needs.

Utilization Table for Outpatient FFS Therapy

Level of Care	Core Services	Current Billing Code	Standard (In minutes)	High Need (In minutes)	Monthly Minimum units (Not used for claims processing purposes. Minimum column informs providers of clinical practice guidelines.)	Monthly Maximum units
FFS Individual	Individual Therapy	90834 (60 min) 90837 (90 min)	60	90	2	10
FFS Individual	Case Management/Brokerage	10173 (30 min) 10176 (60 min)	30	60	1	4
FFS Individual	Collateral	90887 (10 min) 90888 (45 min)	45	90	1 if client has collateral contact(s)	4
FFS Individual	Family Therapy	90846 (60 min) X9510 (90 min)	60	90	2 if clinically appropriate	8
FFS Individual	Crisis Intervention	90839	NA	NA	As needed	As needed
FFS Individual	Assessment and/or Plan Development	90791	1 hour 45 min	1 hour 45 min	Initial month and annually: 2 All other months: as needed	6
FFS Organizational Providers	Group Therapy	90853 (60 min) Y9506 (90 min)	60	90	2	8

Claiming for Services with the Utilization Table

- FFS providers will continue to submit payment claims directly to the ACBH Billing and Benefits' Claims Processing Center (CPC) as they do now.
- In order for claims to be processed, the number of sessions for each service type on the claim form must be equal to or less than what is listed in the maximum column for that specific service type.
- For example, a claim will be processed if it states the provider rendered five individual therapy sessions, two case management sessions, and one assessment session in one month.
- However, it will be denied and returned if the claim form states eleven individual therapy sessions or five collateral sessions were provided in one month.

What if the Client Needs More then the Maximum Column Allows?

- If there is a justifiable clinical need for more sessions than the maximum column on the Utilization Table, the Provider shall contact UM and discuss the clinical rational for requesting additional sessions **prior** to submitting claims for sessions that are over the maximum column on Utilization Table.
- If approved, the UM Clinical Review Specialist will determine how many additional sessions over the maximum identified on the Utilization Table are approved and will communicate the specific number of additional sessions approved for the specified client and month to the Claims Processing Center (CPC).

What if the Client Needs More then the Maximum Column Allows?

- If a Provider submits a claim that includes more sessions than identified in the maximum column of the Utilization Table without first getting approval by UM, the claim will be denied and sent back to the Provider.
- At that time the Provider can contact the UM office to discuss approval for the additional sessions.
- This will cause a delay in getting claims paid and we strongly recommend that Providers ensure they contact UM for approval of additional sessions over the maximum, prior to submitting the claim.

Claims Processing

Phone:
Fax:
Email:

Mailing Address:

Claims Processing

The Claims Processing Center (CPC) is one unit of ACBH Billing and Benefits Support Unit (BBSU). The CPC is responsible for ensuring accurate and timely claims processing and prompt payments to Providers.

Payments are contingent on:

- Provider contracting with ACBH
- Provider remaining in good standing with contract requirements.
- Beneficiary's continued insurance eligibility.
- Timeliness of claim submission.
- Beneficiary being open to Provider in billing system.
- Provider delivers and claims for a quantity of services that do not exceed the maximum amount identified in the Utilization Table (see Handbook for more information)

Client and Service Information (CSI)

The State Department of Health Care Services Agency (DHCS) requires all Counties to collect and report CSI data for all clients receiving Mental Health services. CSI data will be used in conjunction with Mental Health Service Agency (MHSA) data to evaluate the achievements of the County's MHSA plan. Due to this state mandate by DHCS, it is essential that every provider complete all client data fields on the forms mentioned below. Fee-for-Service (FFS) providers must complete and submit the Client Registration and Client Episode Opening forms to the ACBH CPC, along with the first CMS-1500 claim form submission for the client's initial service date(s).

Client Registration

All beneficiaries must be registered in ACBHs accounts payable and accounts billable systems. The Client Registration form must be completed and submitted to the CPC along with the first CMS-1500 claim form submission for the client's initial service date(s). Providers will also need to submit a Client Registration form whenever any demographic data is being updated or corrected.

Client Episode

For services to be processed and adjudicated, a beneficiary must have an episode treatment period opened in ACBH's accounts payable and accounts billable system. A Client Episode Opening form must be completed and submitted to the CPC along with the first CMS-1500 claim form submission for the client's initial service date(s).

Episode Update form

A Client Episode Update form must be completed and submitted to the CPC whenever updates or corrections are necessary due to changes in client episode data (i.e. diagnosis codes, income, employment, etc.)

Episode Closing

A Client Episode Closing form must be completed and submitted to the CPC along with the CMS-1500 claim form that reflects the client's final date of service(s). When a provider will no longer be providing services to a beneficiary, the episode must be closed.

Mental Health Service (MHS) CSI forms are available online at https://www.acbhcs.org/providers/Insyst/Insyst.htm, under MHS Client Data Collection (CSI) Forms.

Claim Submission

Providers must mail all original CMS *1500* claim forms to the BBSU – CPC unit within 60 days from the end of the month of service. ACBH may deny claims received later than 60 days after the month of service. Payment of claims is dependent on continued insurance eligibility, medical necessity, and timeliness of claim submission.

***Some services may require a referral.**

Late Claim Submission

ACBH must submit claims to the state within a strict timeline based on the date of service. Thus, ACBH strictly enforces the claims submission timeline of 60 **days** from the month of service. Sometimes there are valid reasons for a late claim submission. In these rare instances, Providers may request a late submission exception by completing and submitting a *Late Claim Submission Exception Request* form (located on the Providers Website) along with the claim form to the CPC. Claims over one year old must include a copy of the beneficiary's proof of benefits letter from Social Services and must be submitted to the CPC within 10 business days from the date of the letter.

Year End Claim Deadline

The fiscal year runs from July 1st – June 30th. At the end of each fiscal year, the CPC will send Providers a minimum of three letters indicating the deadline for submitting fiscal year claims. It is essential for all Providers to meet this annual deadline for all services provided within that fiscal year. Services rendered in June will not be given the 60 day submission time frame due to the fiscal year deadline. Late claims will be denied.

Claims Processing and Payments

The CPC's goal is to adjudicate claims within 21 working days from the receipt of a claim. Claims are adjudicated based on the provider adhering to ACBH policy as outlined in the provider's contract, timely claim submission, medical necessity and beneficiary monthly benefits eligibility. If or when a claim does not meet this criteria, payment or processing may be delayed or denied.

All claims are subject to a comprehensive review for accuracy and audits for compliance. All claims that pass the edits and audits will be adjudicated for payment processing. The CPC will notify Providers, as time permits by mail or phone, of claims requiring further information or action.

There are several potential reasons ACBH may take back or adjust a payment. This action is referred to as a **Revert.** Circumstances may include beneficiaries who receive retroactive Medicare, beneficiaries with an unmet Share of Cost, or with other health insurance, etc. The CPC will process a revert service that reduces the payment amount from the Providers next check.

CPC will issue payments for all adjudicated claims once per week. Payments will be mailed to Providers with a Remittance Advice (RA) that will reflect all paid and/or reverted services. Providers are expected to review the RA to assist with tracking billing and payments.

Claim Returns

CPC may return claims to Providers that do not pass the edits and audits or when additional information is needed in order to process the claim for payment. Providers are allowed up to 45 days from the date of the claims return letter to resubmit the claim. (sample *Claims Return Letter* can be found on the Providers Website) Claims received after this deadline will be returned or denied.

Claim Denials

CPC may deny claims to Providers that do not pass the edits and audits necessary to process the claim for payment. Denied claims may not be corrected, but may be appealed within 30 days of the denial date. All claims over six months old will be denied. (sample *Claims Denial Letter* can be found on the Providers Website.)

Claim Inquiries

Providers who have submitted a claim and have not received a payment, return letter or denial within 30 – 45 days should submit a *Claims Inquiry* form along with an original claim form. The CPC will research the circumstances and respond accordingly via payment, denial or request further information. (sample *Claims Inquiry* form can be found on the Providers Website.)

Claim Appeals

Providers who have received a denial for services and have a valid justification for payment reconsideration may submit a *Claims Appeal* form, accompanied with a copied claim form and supporting documentation within 30 days of the denial letter to the CPC. BBSU will acknowledge the receipt of an appeal within 15 days by sending a letter to the Provider. BBSU will respond with a decision within 45 days from the date of receipt with either a payment or denial notification.

Claim Forms

Providers must submit claims for services rendered as described below:

- The CMS-1500 claim form must be completed by Providers in accordance with ACBH BBSU policy. The procedure code(s) specified in the provider's contract and an acceptable Mental Health Diagnostic and Statistical Manual (DSM-5) diagnosis code(s) must also be included on the claim form (please refer to the Provider Handbook for further details).
- The Authorized Person's Signature in Box 12 and 13 may be designated as "signature on file" with supporting signature documentation kept at Provider's site.
- The rendering Provider's NPI number must be entered in Box 24-J.
- Providers must sign Box 31.

Please mail all forms to the below address:

Claims Processing Center
P.O. BOX 738
San Leandro, CA 94577-0738

You are invited to a **live virtual FFS Provider Meeting** where we will discuss these changes in more detail and have time for questions and answers

When:
December 9th from 10am-12noon

Where:
Via Zoom. You will receive an email invite shortly

thank you.

alameda county
behavioral health

SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS