

Screening Tool Training FAQ's - 9/25/14 & 10/3/14
Provider Questions

Compliance

1. Do we keep the screening tool in the client's record?
Yes, QA will look for it in an audit.
2. When do we complete the screening tool?
Before services begin, whether that occurs during Intake in person or over phone – and re-screen at every Treatment Plan Update.
3. Do we have to do the re-screening with the client/family?
No, the clinician can do it on his/her own.
4. If we can only check two items in List A but we suspect there are more issues, can we do Assessment?
No, providers need to obtain sufficient information during the screening to determine if meet criteria and shouldn't begin services unless screened to meet criteria.
5. When do we have to start screenings?
Now.
6. Do current clients need to be screened?
Yes.
7. Can we complete the screening per the information given by the caller, even if it's not the client (e.g., family member, CWW, etc.)?
Yes, you can take information from anyone who knows the client.
8. What if we don't use the WHODAS scoring (on Adult screening tool)?
That is okay; the WHODAS is usually only used by primary care.
9. What if the client has a Provisional Diagnosis?
Check "Unsure."
10. Can we bill for the screening?
No.
11. Does this mean we don't have to do the CFE or other assessment tools?
All prior paperwork requirements are still in effect. The goal is to incorporate the Mild-Moderate Screening Tool into the CANS & ANSA.
12. Why can't we use existing documents?
The screening is used to refer consumers between providers & insurance systems, so consistency in paperwork is necessary. Other providers should not have to look through a chart to find referral information; also the tool's algorithm is required.
13. Is it okay for providers to create an electronic version of the screening?
Yes, as long as the content remains the same. It is also available in PDF form.

14. Who can sign the form?

Since the screening tool includes a diagnosis, an LPHA must sign or co-sign, per BHCS Documentation Standards. Signature(s) that are acceptable on the screening tool are:

-Licensed LPHA (PhD-Licensed, PsyD-Licensed, LCSW, LMFT, LPCC, LPCC-F)

-Un-licensed LPHA must have a co-signature of a Licensed LPHA (Phd-Waivered, PsyD-Waivered, MFT-Intern, ASW, PCC-Intern)

-Medical Providers (MD, DO, NP, CNS, PA)

Graduate student interns or trainees or other staff are not allowed to fill out or sign the screening tool.

15. May we tell callers to contact ACCESS “for a referral to us” & have ACCESS do the screening?

Network Managed Care providers (fee-for-service contracts) may refer callers to ACCESS for screening. However, they will need to complete their own screening form as part of their Initial Assessment and file the Screening Form in client’s chart. Community Based Organizations (CBO’s or master contracts) do their own screening.

Who Must Complete the Screening Tool?

1. How do we sign the screening tool if we are both the “screener” & “receiver” of the case?
Complete the form as the “screener.” The ‘Referring Provider Name’ section is only required if sending the screening tool to a Managed Care Plan.
2. Do SUD programs need to do screening?
No, only providers that bill for mental health services.
3. Do Adult Level 1 programs do screening?
Not at intake but at each Treatment Plan review.
4. Do Children’s Level 1 programs do screening?
Not at intake, if referred by ACCESS, but at each Treatment Plan review. If not referred by ACCESS, the screening should be done prior to intake.
5. Does the Guidance Clinic need to do screening for their mental health services billed to Medi-Cal?
Not at this time for youth in Juvenile Probation supervision with current placement order.
6. Do EPSDT Probation (outpatient) providers do the screening?
Yes.
7. Does a CalWorks provider need to do screening?
No, CalWorks clients do not need to meet medical necessity.
8. Do Wellness Centers need to do screening?
Only if billing Medi-Cal for Specialty Mental Health Services.

Questions about Certain Situations

1. If a client improves & is stable but gains may be temporary, do we need to transfer the case to the MCP or can we continue services to ensure stability?
For clients ages 0-21, document clearly that EPSDT impairment criteria are met. For adults, document clearly that at least one medical necessity impairment criterion is met. In addition, develop a transition plan that takes into account the need to ensure the gains are solidified before transferring the client.
2. How long can a transition plan be in effect?
As long as the chart documents the need/reason for a longer transition; the plan needs to be reviewed often to ensure the need/reason is still valid.
3. For a Level 1 adult client who has been stable for several years with medication & some case management, must we refer out to a MCP?
If they continue to have four items checked in List A or one item in List B, they can be transitioned to a lower level of Specialty Mental Health Services (level 3) as a step-down to the higher level of care. If the client doesn't meet criteria for Specialty MHS, a transition plan must be developed to step-down to the MCP.
4. How should providers of Level 1 services and programs like CHOICES, where the goal is to increase independence, decide when a client is Mild-Moderate?
Use the screening tool.
5. If a client is stable regarding their primary diagnosis but are diagnosed with a substance use disorder (List C is checked), can they stay with provider?
No- list C is specific to substance use disorders.
6. Can Language/Culture be added to the list?
No, and cases may not be retained for that reason. If the consumer does not meet specialty mental health criteria the MCP's are expected to provide such services.
7. Can a case be retained if a client is screened to be Mild-Moderate but the MCP doesn't provide the most appropriate treatment model (e.g., needs home visits, needs Parent-Infant work)?
No.
8. If a client has private insurance but is screened as Moderate-Severe, can we serve them?
No, their private insurance is responsible for providing their mental health services.
9. Providers cannot always discern from the insurance look-up screen whether the insurance plan is private or Medi-Cal.
If unsure about a specific case, call BHCS Provider Relations at 1-888-346-0605 to verify insurance eligibility.
10. What if the managed care plan screens a client as Mild-Moderate?
They are required to provide services.

11. For children who receive Level 1 services, can their sibling with Mild-Moderate needs continue to be referred by ACCESS to the Level 1 program so that the family has just one provider?

No, if Mild-Moderate, the sibling must be served by their MCP. However, ACCESS can continue to make a Level 1 referral if the sibling is screened as Moderate-Severe but not severe enough to require Level 1 services.

12. What if a provider is contracted with both BHCS & Beacon and a consumer needs to shift to Beacon to see the same provider?

Call Beacon – they may want the provider to complete & submit a current Screening Tool, or they may just begin service authorization to the provider.